Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) EHR REPORTING PROGRAM TASK FORCE 2021 MEETING

August 5, 2021, 10:00 a.m. – 11:30 a.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Raj Ratwani	**MedStar Health**	**Co-Chair**
Jill Shuemaker	**American Board of Family Medicine's Center for Professionalism & Value in Health Care**	**Co-Chair**
Zahid Butt	Medisolv Inc	Member
Jim Jirjis	HCA Healthcare	Member
Bryant Thomas Karras	Washington State Department of Health	Member
Joseph Kunisch	Harris Health System	Member
Steven Lane	Sutter Health	Member
Kenneth Mandl	Boston Children's Hospital	Member
Abby Sears	OCHIN	Member
Sasha TerMaat	Epic	Member
Sheryl Turney	Anthem, Inc.	Member
Steven Waldren	American Academy of Family Physicians	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
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Cassandra Hadley	Office of the National Coordinator for Health Information Technology	ONC Staff
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Fredric Blavin	Urban Institute	ONC Contractor
Kathy Frye	HealthTech Solutions	ONC Contractor
Gary Ozanich	HealthTech Solutions	ONC Contractor
Christal Ramos	Urban Institute	ONC Contractor
Laura Smith	Urban Institute	ONC Contractor

Call to Order/Roll Call (00:00:00)

Operator
All lines are now bridged.

Mike Berry
Thank you, very much and good morning, everyone. Welcome to the EHR reporting program task force. I am Mike Barry with ONC. I just want to thank everyone for getting us ready for our task force meeting today. I want to start with roll call. I will start with our co-chairs. Raj Ratwani.

Raj Ratwani
Present.

Mike Berry
Jill Shuemaker.

Jill Shuemaker
Present.

Mike Berry
Zahid Butt. Kim Jirjis. Bryant Karras.

Bryant Karras
Present.

Mike Berry
Joseph Kunisch. Steven Lane.

Steven Lane
Good morning.

Mike Berry
Ken Mandl. Abby Sears.

Abby Sears
Present.

Mike Berry
Sasha TerMaat.

Sasha TerMaat
Good morning.

Mike Berry
I believe Sheryl Turney. Sheryl, are you on today? Steven Waldren.

Steven Waldren
Good morning.

Mike Berry
All right. Thank you so much everybody and now I would like to turn it over to our co-chairs, Raj and Jill. Take us away.

Opening Remarks (00:01:20)

Jill Shuemaker
Great, thank you, Mike. Welcome everyone and I echo Mike's response. Thank you again for your time in carving out this space for you to contribute. We really appreciate your expertise. We have a lot to cover today. We are going to start by reviewing our public health measures that we talked about last week. We will have Bryant and Sasha present the recommendations and we still have some of those recommendations that are still in the under-consideration bucket that we are going to try to move over to the consensus bucket. Then we are going to dig into the clinical care measures. We have Steven Lane and Abby Sears that will be presenting that and then we will have public comment. Then we will wrap it up and adjourn by 11:30. So, next slide, please. We can go to probably Slide 10. These are just some reference documents that we talked about in the past. They are there if you want to refer to them, but I think you can just keep going to Slide 10. All right. Awesome. So, I am going to turn it over to Bryant and Sasha right now and we will pull up the Google Doc and review the recommendations.

Preliminary Recommendations for Public Health Measures (00:02:48)

Sasha TerMaat
Hey, folks. I was just going to make sure I am looking at the same part that we have on the screen here. All right. So, the first recommendation we had about the public health measures, we had some that I think are agreed upon from our discussion last week and then a couple that I think we need further conversation about. We suggested the denominator of Measure 1 be updated to number of immunizations administered. We suggested that the numerator of Measure 1 be updated to the number of administrations, through the information that is electronically submitted to a registry. We still have down in the recommendations for further discussion, some ambiguity about what success might look like there. So, I am not sure we totally have agreement on success in that metric yet. But the updated denominator and numerator suggestions will help address the confusion of the numerator being larger than the denominator. We suggested that if a stratification is used, it be in the numerator by the registry submitted to.

One of our goals overall was to minimize the burden on provider organizations and data collection and as part of that, we suggest the same reporting frequency as the other measures in the program. Those are a 12-month reporting period with no look back. For further conversation, we discussed, but did not really come to consensus on the fact that developers might have to change their agreement with providers to be able to report any of this data. Data use agreements may not encompass this type of reporting. Any stratifications that we would pick would have to be clearly defined. We have talked about state being one example, although we are actually recommending using a registry-based stratification, rather than a state stratification. Then, stratification will obviously need to be prioritized carefully where we want to spend our complexity tokens.

There is interest in adding. as you saw in the edits of the numerator, a success indicator. I do not know that we have consensus yet on what success would look like there, to be clear about that. I saw, Bryant, you put in one suggestion here. I am not wholeheartedly convinced, personally. I think the complexity there might outweigh the value, but open to other feedback from developers.

Bryant Karras
Yeah. I am just going to chime in as well. I do not have in the stratifications, **[inaudible] [00:05:15]** were also asked to dissolve the ambiguity. I mean, you have New York State and New York City. New York City is not a state, so having any jurisdiction for which you are reporting would be **[inaudible] [00:05:36]**.

Sasha TerMaat
I think I saw Steven Lane; your hand was up, I am not sure if that was by accident, or you had a comment. Okay.

Steven Lane
Sorry, I was on mute. My bad. Sorry, I was talking on mute.

Sasha TerMaat
Okay.

Steven Lane
I did not know whether we were raising hands, given how small the group was. But, that first item about developers may have to change their agreements. I mean, I think I think that is a cross cutting issue. I do not think we need to belabor it in each of our segment discussions. They may. I think it all depends on how those agreements are written today. I think this is something that we need to acknowledge and not worry about it. I support the idea of stratifying by registry, that does make a lot of sense for the reasons that have been discussed. The issue of successful transmission is tricky because I think it depends on how things are set up by each developer and by each customer as to whether or not that data would be readily available. I think it is important that these interfaces be set up in a way that they are useful, that they actually transmit data. But it seems to me that that is a lot to ask in the first iteration of these metrics. So, I would tend to say, let us focus on the submission first time around and think about successful at a later date. Keep it simple.

Bryant Karras
I still that that, Bryant, just to reemphasize successful transmission, successful transmission. I am at the immunization registry conference right now taking place in Portland, Oregon, and 8 out of the 50 state registries have capability to send back acknowledgment messages. If proven and tested against a certification process that **[inaudible] [00:08:01]** American immunization registry association is offering voluntary certification **[inaudible] [00:08:08]** system can do what it is supposed to do. So, I think that five years ago I would have said yes, I agree with you. I do not think **[inaudible] [00:08:19]** acknowledgments but nowadays I think we **[00:08:23]**.

Steven Lane
Well, then let us separate the measures. I mean, let us have one measure for submissions and a separate measure for known successful submissions. I would have no problem with that.

Sasha TerMaat
I think that is really helpful. I think that does bring some clarity to that. Are there others that have comments around this? Is this something that we can reach an agreement on?

Bryant Karras
I do agree with Sasha though on the complexity token, the fact that the acknowledgment messages are being sent back does not mean that the EMR, EHR vendor has a way to log or process or even **[inaudible] [00:09:16]**. I think **[inaudible] [00:09:19]** do emphasize that those are logged or cataloged into whether they are successful acknowledgment or acknowledgment that says **[inaudible] [00:09:30]**. **[Inaudible] [00:09:35]** processing and reading those, the data follows better.

Sasha TerMaat
Are there others on the call that have comments or knowledge around this that they can give us some pushback, maybe?

Abby Sears
I guess maybe just asking a question. Is this something that can be reported on by the registry? I guess if so, does that influence if this is where we want to spend our complexity tokens, adding two measures about immunization registry submission? Is that more important to us than other stratifications or other measures in a public health space?

Bryant Karras
[Inaudible] [00:10:29] public health measures are important. So, I think it is a **[inaudible] [00:10:38]** final rules, just **[inaudible] [00:10:49]** provider systems have been **[inaudible] [00:10:54]**.

Sasha TerMaat
Certainly, there are many things that are important, but I guess it is not really a false choice when we think about, that there is a limited amount of development investment available to be put into the EHR Reporting Program. Should we talk about Measure 2? Or I guess maybe to propose a little bit of specificity here, it sounds like we could, I put a comment on the first recommendation that that could be pulled into an overarching section. The second two I think we have consensus about recommending stratification by registry, so I do not know that we need these two any longer. I do not know that we have consensus yet on the success concept. I tried to capture all of the different considerations.

Jill Shuemaker
Okay. Anyone have any further comment about these two points before we move on? I would rather talk about it now than at our future call because I think we will lose some of the context as we move forward so if there is any comment right now, that would be really helpful. All right. Hearing none, Sasha, go ahead and move on to the next one.

Sasha TerMaat
All right. For querying IS, we had agreed upon, again, the goal was to minimize provider burden. Like the other measure, I think we could move this to an overarching section, if that makes sense. I will put a comment to that effect. It is true universally; I do not think we need it specifically in each one. We suggested the denominator being updated to the number of encounters, as with other encounter-based measures, we

would need a definition. We suggested that the numerator be updated to the number of query responses for the IIS received.

That helps address the confusion of the numerator being larger, which could be confusing. Then we had the same reporting frequency recommendation as we did above. We could still move the Agreements Update 1 to an overarching section like we commented on the first measure, and stratification would have to be clearly defined if we decide to recommend any. They are possible, we would have to prioritize. Then Bryant, you added a comment about recommending July 1 through June 30th as a reporting period. I do not have strong feelings about what the reporting window would be personally, but I do think it should be the same across every measure.

Steven Lane
I will chime in. This is Steven. I support the July to June reporting period. I think that makes a lot of sense given that the flu vaccine in particular is a winter weighted activity and having it span across two reporting periods could create some added confusion. Summer is a big time for pediatric immunizations before school, but I think this would suit it well.

Abby Sears
This is Abby and I second that.

Jill Shuemaker
Joe has his hand raised. Joe, go ahead. Joe, if you are talking, we cannot hear you. You might be on mute.

Joseph Kunisch
Can you hear me now?

Jill Shuemaker
Yes, we can hear you now. Go ahead.

Joseph Kunisch
Okay. I was looking at numerator, denominator. So, is the expectation of this is that the provider is doing the query at all their encounters, per se? So, say a family practice comes in, they may not query for immunizations every encounter. Then, would a measure like this be specific to only certain types of providers? So, you have specialty clinics with providers in there that they have no interest in immunizations, they are not going to query, they may not even look at them, because that is not what they are treating the patient for if they are a specialty clinic. So, I worry from a performance perspective if you have that low numerator and that large denominator, it looks like you are performing badly when that is not the real case; it is more of when do you need to actually query for immunizations.

Sasha TerMaat
Yes. We did talk about that, and we actually talked about if it is possible to narrow the denominator, which the ways in which we wanted to narrow it seemed to have problematic side effects. Either they were not standardized in a way that then would impose burden, or they would not give certain certified products an opportunity to report potentially if they were focused on a specialty, for example. So, I think this feeling in the initial review of this was that, it would have to be accounted for in interpreting the data for both sending immunization messages to a registry and for looking at query responses, there will have to be an

understanding that there are certainly specialty clinics where immunizations are not necessarily going to be in their Scope of Practice and where a product particularly serves those areas that will affect the data reported and it will not be possible to simply assume, for example, that every encounter ought to have a query. That is likely not true if the encounter is to have an X-ray or something.

Joseph Kunisch
Okay. I am thinking from an adoption and reporting perspective that something like this should just be the capability and one encounter, and you met. A lot of the interoperability measures are like that, and I know it does not give them many teeth as far as promoting usage of it. But I just would not want to get into where CMS is utilizing this as some type of performance metrics with this type of numerator/denominator. Like setting a threshold, like you have to have at least 50percent of your encounters to do this. If that is the case, then you have to really make it narrow to when it is appropriate versus just –

Steven Lane
But I think that is really a separate step. I mean, we are just defining how to collect the metrics and report them. Whether or not or when CMS utilizes that is another step. I do not think collecting the metrics is a problem. I think getting the level of granularity is a good idea.

Joseph Kunisch
No, I agree with you on that. But living on the provider side and having to explain this to the providers and why it is important. If it is tied to something from a measurement and threshold, then it becomes more difficult. I agree. It is good. I am not saying it is not a good measure. Just that somewhere, I do not know, in the recommendations or something to know that not every encounter will be appropriate if we are going to use every encounter as a denominator. So, just making sure that CMS or any agency looking at this would understand that. That is all. Thank you.

Sasha TerMaat
Thanks. Hey, Bryant. I think we can definitely add that note, to draw some clarity there for that recommendation.

Bryant Karras
I agree. I think we can set an expectation or an indication that success in this particular measure is not 100percent. In fact, 100percent of all your visits system wide having a vaccine query would be a failure, because it would be over burdening the immunization registry with too many queries. For decision support for a visit that was not going to utilize that decision support. So, we could just set an expectation that we expect that this would be a non-100percent goal but would be able to be used for trending and severe limitation identification, something like that.

Joseph Kunisch
Yeah, I like that. I will just note in the chat, that this is not a provider reported measure. This is a developer reported measure.

Jill Shuemaker
None of these measures that we have talked about are going to be 100 percent. Maybe it would be worthwhile for us to call out. I put into the agreed upon recommendations, our interpretive note here. We can call out other interpretive notes, but when talking about the patient access measures, those would

certainly not be 100percent either. If we want to highlight some of the considerations that anyone interpreting the data will need to keep in mind, we could certainly do that. I do not think any of the expectation is not going to be 100.

Bryant Karras
Yeah. But people always want to get a better score. Implementation teams could inadvertently over utilize an API in an attempt to get to a better score.

Jill Shuemaker
Yeah, this has been really rich discussion. I think we are going to have to wrap this up so we can keep moving on to the clinical care measures. These documents are going to be on the Google Docs for everyone to access, so if you have more thoughts on this or comments that you want to add, please go to that document and add your comments there and this is something that we can continue to work on offline so that we can move everything we can to the consensus bucket before the deadline. So, I am going to turn this over to Raj now and we are going to dig into the clinical care measures. I believe we have Gary from ONC who is going to give us a high-level overview of those measures. So, go ahead, Raj.

Raj Ratwani
Great. Thanks, Jill and thanks Bryant and Sasha for all the good work on that set of measures. The fun continues with a new set of measures in this race to get to all these. So, as Jill mentioned, we will have a quick overview of these, and Steven Lane and Abby Sears are going to lead discussion on this and have put together an extensive slide deck with a lot of great content to drive conversation. So, we can get moving on it.

Discussion of Clinical Care Measures (00:23:52)

Gary Ozanich
Great. This is Gary Ozanich from the urban team. I will do a high level on the slides. Could we please go to the PowerPoint deck, Slide 12? Essentially, there are two measures suggested for clinical care information exchange measures. The first concerns the exchange of summary of care records. The second concerns the use of third-party clinician-facing apps. That second measure is designed to parallel the consumer facing app measure that we discussed two weeks ago. In terms of the summary of care record measure, the suggested measure looks at the percentage of summary care records viewed by end users and clinicians, and it includes a breakout by parsing and integration of the records. So, the suggested first numerator focuses on the viewed summary of care records by users and clinicians and the denominator is the unique summary of care records received using the certified health IT. The second numerator measure focuses on records that are parsed, integrated and viewed by end users or clinicians.

The denominator there is basically the number of summary of care records that are parsed and integrated as they are received. Issues concerning the reporting element is variance in the degree of use of the data as to whether they are integrated. So, the issue of provider use, and the provider use and the provider setting. Second is, to consider one denominator and then have multiple numerators that capture both the total number and then percentage that are parsed and percentage that are integrated so that the denominator stays the same. The suggestion is to require developers to report numerators and denominators, not just percentages, so an average can be aggregated and analyzed in a number of ways. For each measure, collect the numerator and denominator counts by citing specifically inpatient and

outpatient. Aggregate by the developer and the frequency for the look back or reporting period is something to be determined. That is 12-month, 24-month, whatever is appropriate. Next slide, please. The second recommended measure concerns clinician facing apps.

The focus is the percent of registered third-party clinician facing apps with active users. Active user is defined by end user clinician authorizing access. The numerator is the number of registered third-party clinician facing apps with a minimum number of users. Other potential numerators include the average number of apps deployed by customer or average number of apps by product. The denominator is the count of third-party clinician facing apps that are registered. Some issues include the authorization of the app as a proxy for usage.

The question that we had a couple weeks ago too on the API, which is what is the number of end users or clinicians in order for it to really be defined as being in use. Requiring the developers to report numerators and denominators, not just percentages, but once again, like the earlier element, aggregate by developer and a question of numerators and denominators. Next slide, please. So, some questions that arose during the discussion with stakeholders and also during the literature review are summarized here. Also, point out that Slide 15 includes a list of other measures that were considered for clinical information exchange. So, with that, I will turn it back to you, Raj.

Raj Ratwani
Great. Thanks. I am going to be the intermediary here. So, Steve and Abby over to you to jump into your slides and get moving on this.

Steven Lane
Abby, you want to start?

Abby Sears
Sure. Can you go to the next slide? Yeah, go ahead. Keep going. So, I think I moved to the next one. So, we created some guiding principles that we thought would be helpful for us as we explored these metrics. Really prioritizing relying on existing data collection to respond to these. To avoid imposing new costs, new burdens on the EHR vendors and/or any trickledown effect that could impact the providers or clinicians. A couple things we were worried about is for the ability for the vendors to be able to report out this information if it extends and requires computing power to change at the provider level. It would require more data storage, more data collection, and that is going to be a burden that I think will be something we would want to avoid. As much as possible to be automated and have no manual data entry and have no trickle back down to the providers in any way. Then I think, as you said before, it is obvious we want the developers to produce the reporting for this. Another guiding principle was to try to minimize the cost on the providers, and we repeated that again.

Clearly tie the need for the measurement with certification criteria and whether measurement will lead to different outcomes. What are we trying to accomplish with this? Just making sure we are thinking through any unintended consequences. What we do not want to see because of this, is that providers opt out in any way, any of the activities, whether it is immunization or using third party apps, because the burden is too much. I think everyone has that goal, not wanting to actually see people choose to not participate. We just want to make sure we think about, and we are asking for consideration about reducing the number of metrics to one or two and reduce the stratification as much as possible. Next slide. So, we had some key

questions. Are the clinical data received in a CCDA format? How often would it be pushed? How often is it received? Another question that we had was related to the CCDA documents viewed in the receiving system. What does that mean? What is the definition of, viewed by a clinician? Data can be parsed and look different in different systems and how do you know it is being used or viewed?

That is a very difficult and tricky thing to measure. How often do the C-HIT systems parse discrete data from received CCDA data documents and incorporate that parsed data into the local system? Is there value in differentiating different pieces of parsed data, are some pieces more important than other pieces? Which might make it easier to narrow the definition around viewed for the numerator and denominator. How often are they viewed, otherwise utilized? Is there value in differentiating viewing of the data versus actually utilizing it to inform a decision which is incredibly difficult to articulate. Next slide.

Steven Lane

Abby? Abby actually, let me grab it from here if I may because those are the questions that I tried to point out. Can we back up one more slide? Back up to Slide 19? Thanks. So, I really think these are the key questions that we are trying to measure with the metrics. These are not just thought questions, these are the underlying things we are trying to get at. Again, are the data received in a CCDA format? Are the received documents viewed? How often are documents parsed? Is the data incorporated? How often are parsed data viewed? I think the way that the metrics have been published thus far is a little confusing, because it says, how many documents are received, parsed and viewed. It is like, once you parse the data, that is not the question anymore. It is whether the parsed data is being viewed or otherwise utilized. So, I laid these out just to keep us focused on what is really important here. So, if it is okay with you, Abby, we can jump over 20 because that is a restatement of what we heard before, and really dive into these on Slide 21.

I think these are the key considerations that we want to think about as we move forward into recommendations. For Metric 1, which is to say whether or not clinical documents are received and viewed, noted, the information for this metric could be captured in counts and activity logs. As the documents are received or as they are parsed, rather than through look back reporting. I think as Abby was saying, we really want to avoid burden on providers requiring additional computing power, storage power, etcetera. So, our thought is, this is not so much about a look back period for a report, but really for keeping counts as things go on. One of the problems with the reports is they themselves take computing power and they could be erroneous if we overwhelm the computing power of the system that is running the report. So, I think that is a really important consideration. The second, generating, storing and transmitting activity logs for each unique summary of care record could require a lot of computing storage and transport capacity.

But it seems to me at least, that if you are just making counts as things come in or counts as things are being parsed and data incorporated, that hopefully that would not take too much computing power or storage. One thing that comes up is, that some health IT systems are configured to re-query and download updated versions of previously received documents. Depending how a vendor manages this, this behavior could inflate the number of received documents, potentially increase the proportion. Or potentially decrease the proportion of the received documents viewed, because it may not be necessary to view a document that has previously been received and now it has just been updated. It really depends on the clinical situation. I think that we are not going to be able to solve this problem, but I think the best we can do is set up the metric and see what we learn. It may be that some vendors have either bigger or smaller numbers and we may need to go back and figure that out. I think it is too complex to solve this at this point.

Then there was this point about differentiating clinician from other end users and we do need to make a specific recommendation about this. So, I am suggesting that the clinician include all licensed independent practitioners and all nursing in clinical support categories separate from other users that would be more on the scheduling, billing, etcetera, etcetera. While this separation could increase the complexity of keeping the logs, it seems like we do want to make this differentiation. So, I will just pause. I cannot see the hands, but are there any comments so far about what we have covered, or should we jump into the recommendations?

Raj Ratwani
Steve, there are a few hands up and I am happy to negotiate some of that. So, I think first we have Sasha with her hand up.

Sasha TerMaat
Hey. I totally agree. I think a lot of the complexity tokens that I have been talking about throughout apply not just to the complexity of developing these metrics but the processing power that will be necessary to capture it and then transmit it for aggregation. However, I wonder two things. One, I am worried that the considerations here are overly prescriptive about how data might be gathered and summarized and that that might not be applicable across all the EHR deployment models that are out there. I also do not know that that is specific to this measure. I wonder if we want to move those considerations to an overarching recommendation that we do want to be mindful of minimizing burden on provider organizations in this program. As much as I believe in that, any reporting that we do here is going to have an impact on provider hardware. It is not going to be possible to gather data without using some of the processing power from those systems.

Steven Lane
That certainly makes sense. I certainly support the idea of an overarching statement or acknowledgment of that.

Raj Ratwani
Great. Thanks, Sasha. Then, I see Steven Waldren next.

Steven Waldren
Okay, thanks. A couple of things. So first, on the notion of viewed, I think, is irrelevant. I think, is it viewed or not is all clinical and has nothing to do with interoperability if the denominator is in the system already. So, I would recommend that we not even think about having viewed as part of any of the measuring. I think the real issue here is, it parsed and integrated. Again, I think again the issue here is it actually being able to be integrated in, because if it is integrated, then it had to be parsed. So, I think we should really focus on a measure that talks about integrating the data that comes in from these records if we are going to use the denominator being the consolidated CDA, then I think that is what makes the most sense here for this particular measure.

Steven Lane
Steve, if I can just respond. I think that systems really vary by how well they integrate received data. I think at this point in time, the viewing of outside documents is still the way that this data gets meaningfully transmitted from one organization to another. So, while I appreciate the fact that the viewing document itself is a burden on providers and a lot of providers do not do that, I think it is important to think about how

systems that receive these documents actually put them to use. How do you bring them to the eyes of the user? How do you make users aware of their existence? So, I would personally say that keeping the viewed metric in there makes sense because it is an intermediate measure. In an ideal world, all the data is parsed and integrated and we never need to deal with the source documents, but I do not think we are there yet.

Abby Sears
This is Abby. I think the point of interoperability is actually to move the data for a purpose. At first, I was really leaning towards, I love the idea of not having the viewed, as you were talking about that. But as I sat here and thought about it, there is no reason to even capture data around the movement of data if we are not using it to inform in some way. So, I think it is going to be important to find some way to measure that, whether or not viewed is the perfect way to do that or not, I do not know. I have to process that a little bit more and think about it. But at this point, it is as good as anything else that we have, to have it inform us around the meaningfulness of the data that is being moved. I do think we need to remember that the technological purpose of the moving of the data is for the sole purpose to inform care.

Raj Ratwani
I am a little sensitive of time. Let us move on to the recommendations unless there are other key comments because we have got a lot to go through.

Steven Waldren
Steve, why do not you just go ahead. I too am worried about time.

Steven Lane
Okay. Okay, good. So, on Slide 22, we have got some recommendations for your consideration. One is that the metrics should be based on any valid CCDA document type received, not only the summary of care or CCD documents. Again, more advanced systems can exchange various types of documents and I do not think that we should necessarily be limiting this to those who are exchanging CCDs in different use cases where different documents are relevant. So, we can talk about that. If possible, metrics should count each received document once, avoiding recounting of subsequent updates to or iterations of the same document. To avoid that problem where some systems are designed to keep checking for updates and sometimes getting updates that are not really meaningful nor need to be viewed. Metrics should separate counts of documents received based on a push to the system, such as via direct messaging, versus documents that are pulled into the system. Such as, by a query-based document exchange. This is a new concept.

I want to highlight this. I think this is really important and I think it would be valuable to see, to be able to differentiate vendors by how well they have implemented push versus pull. I think a lot of vendor systems really do not do a lot with push messaging or as much as they could, so this is a proposal for your consideration. Here again, I have put in my recommended definition of clinicians and the recommendation that we discussed earlier, that the activity logs should be automatically generated. Oh, no. This is a little bit different. This is, that the logs should be automatically generated and transmitted from the provider system at a specified interval with a program trigger. Again, with the idea of minimizing the burden on the provider organization to have that be something that requires their manual intervention. No. 6, summary reporting should occur at least once a year but not more than quarterly. I think the annual interval seems to be what we were settling on generally, but it is important that this not be too often. Here again, like the others, we are suggesting that the metrics should be reported at the product level.

You said the care, I think, originally the recommendation was to be done at the care setting level, which I think is more complicated than doing it at the product level. So, if you have a product certified for ambulatory or inpatient, etcetera, I think that is the appropriate breakdown for that. Doing it at the vendor level, really you lose the granularity because different vendor products might do this very differently. So those are the recommendations for Metric 1. Actually, there is a little bit more. So, if you go to the next slide, for Metric 1A, just breaking this down a little bit. This was the metric related to whether the received document was viewed, it is really important to have a clear definition of what viewing means. There is some variability, as I mentioned earlier, in workflows as to how those documents are brought in front of users and incorporated into the workflow. Some systems might inform a user that a document exists but not open it. That should not be seen as viewing.

Then if the data is parsed from a document and displayed or otherwise utilized in workflow, this again is not about viewing the document. That we will be covering in metric two, that we should really focus Metric 1A on the viewing of the document. The recommendation that comes from the observations is that viewing a document should be defined as having an open document displayed to the user, whether the display includes all or a subset of the data received and regardless of whether the user scrolled through or clicked on the data in the document itself. Again, just getting very clear on what it means to view a document. That is one recommendation. Let me put the last Measure 1 recommendation up there from Slide 24, the next slide. In Metric 1B, the real goal is to determine what portion of the received documents had data parsed and integrated into the system. Again, when talking about parsing data, for the most part, we are talking about problems, allergies, medication and immunizations, what they call the PAMI data set.

But some systems will also receive parse and/or integrate some test results, some vital signs, clinical notes, etcetera. There is a lot of different data that could be parsed. I think we need to ask ourselves, should any discrete data parsed and integrated from document qualify as the document having been parsed. If all you pull out is the last head circumference, is that parsing a document? Should there be measurements of each, or the number of data types of parse and/or integrated? Would it be valuable to know if this system can parse three data types or 10 data types? One of the challenges of course, is that the vendor systems may not today maintain sufficient metadata or data parsed from a document to be able to say whether that parsed data was used or otherwise utilized. This is a tricky thing, but I think it is important. The question is, was the parsed data viewed? That is the key question we really want to answer. If the parsed data such as the problem or allergy used to inform a metric or to trigger decision support, does that count as being viewed, because really that is the important thing.

The important thing is that you put the data to use, not that someone is necessarily looking at the data directly. Again, the notion that collection and storage costs could be substantial, because we are really getting down to the details about data parsing and integration and whether that is viewed, so this is a really challenging metric for a lot of systems, probably the smaller ones are nowhere close to being able to support this. Then should this metric be limited to data parsing and integration rather than viewing? Again, I think the viewing issue is really what makes this difficult to measure because of some of the metadata challenges. So, I am recommending that we separate metrics about how often the data was parsed from a received document and integrated into the system.

So, that is the parsing metric. Then how often was that parsed integrated data viewed in the system as opposed to being viewed in the received document itself? Again, I think we will come to the conclusion that that last piece is really hard to do today, and it should be put on a roadmap for a future version of these

metrics, so the vendors have time to prepare for that. Those are all the nine recommendations about Measure 1. I think we want to see if any or all of those can be moved above the line to things we agree on. Maybe you want to jump to the document, Google Doc where we have those outlined there.

Raj Ratwani
I know, Steve, is that there is a few folks that have hands up so let us get to that. Abby, Steve, are either of you able to see the chat and public comments?

Steven Lane
Yeah, yeah, yeah. We can see those, yes.

Raj Ratwani
Okay. So, there is a fair amount of activity there. I am going to let you two manage that in terms of whether you want to have discussion on those. I do want to turn to the folks who have their hands up starting with Steven Waldren.

Steven Waldren
Thanks, and try not to beat a dead horse around the viewed piece. But just a couple things there. Steve, you talked about the notion of the definition of clinician, which I think the word clinician is maybe not the right word then, but I agree with how you were thinking about that being more expansive. But I think the problem now becomes if we do that and we use the definition of view, and I think it is important that we do have one and I like the way that you laid that out. We now have a process that the view has the opportunity not to do anything clinical, right?

So, if it is a support staff receiving these documents, opening them to make sure it is the right patient and it needs to go in the right section of the external document, that it truly is an ophthalmology report, that now counts. Then the other thing, too. If it is clinically valuable to review the addendum, then if we are not using those addenda to be counted toward a view, then again, I think just a view is, I agree. It would be really nice to know if these data are important and are being used, but I just do not think the way that we can measure this, that we are going to be able to get to that. We are just going to get to the fact that these documents have been opened and have no clinical ramification, yes or no in regards to what does 60percent versus 70percent mean for this particular measure. Thanks.

Raj Ratwani
Thanks, Steve. Turning to Sasha.

Sasha TerMaat
Sure. Can we go back to Recommendation 1? I had several comments about some of the early ones. I think the first draft recommendation sounds good to me. Both the second one and the third one talk about capabilities that are outside the scope of certification, so I do not know that those will be practical for this program. There is not a sense of updating documents in certification, so I do not know that that could be reported accurately in the program that relies on certified functionality. Similarly, the whole notion of query-based document exchange is also outside the scope of certification, so I do not know that could be reported accurately here. Four, I think is fine from my perspective, but each health system would have to go identify their user types that would match up with whatever definition is given here.

Then I think 5 and 6 are overly prescriptive to my point earlier across all types of EHR deployments and we should instead, pull those up to a level of saying, we prioritize burden but not try to be overly prescriptive about how every type of EHR deployment would do the data gathering. Then, with 7, I guess my question would be, if you have a patient who is in the ED and then in the inpatient treatment and you receive a direct message or you send a direct message. Do you associate it with inpatient, with ED, with ambulatory, if they also have a follow up office visit? These actions are not product specific, so I do not know that product level reporting is going to be practical.

Raj Ratwani
Thanks, Sasha. So, those are the main comments for those that had hands raised. Again, Abby and Steve, if you can monitor the chat for public comments, see if there is anything you want to raise there and then I will turn it back over to you.

Abby Sears
Yeah, there was just a couple of notes about the importance of the viewing and/or lack of viewing related to patient safety, which I think is important to call out. I do not know, Steve, if you want to say anything related to that.

Steven Lane
Well, I think again, it gets to the importance of viewing or otherwise utilizing the data. I think Jim made a good point, that it does not do a lot of good to brag about the number of documents received if you do not have any idea whether they have been viewed. So, I think it goes back to Steven Waldren's earlier point, that there is value in knowing how many were received and knowing what proportions of those were viewed and then in knowing what proportion of those had data parsed and integrated and whether that in turn was viewed. I think in the original recommendations, the idea of having one denominator and multiple numerators is a good way to approach this. If the overall denominator is just the number of documents received and then we can look at how many of those were viewed. I agree with Sasha that we cannot know whether a document necessarily, I mean, some systems cannot. Whether multiple iterations of the same document were received. It is tricky, the comment that sometimes there is really important data in an updated version of a document, but I just do not think we are at a point where we can get at that.

Jill Shuemaker
Okay. The other comment Grace made around the granularity of understanding non-clinicians using the data or viewing the data or anyone that maybe it is not appropriate to be viewing the data. So, from a patient privacy standpoint, maybe being able to have the granularity around knowing who and when it was accessed. So, that was Grace's comment.

Steven Lane
I think in an ideal world, that would be great. I do not think we can get at that now.

Abby Sears
I think it might be two or three, but it definitely is needed, but it is just a question of how do we get there. Then there is a really interesting comment here from Joe about recalling from the past the capturing of data downloaded and incorporated into the EHR and the vendor telling them they were not able to capture the data that was queried from the HIE and what was used to add to the HR counter. That the HIE is the source

of truth related to that data. I have been kind of thinking through, how does that relate to what we are doing. Steven, do you have any thoughts on that, because that was not jumping out at me?

Steven Lane
I mean, when we get data from HIE, it usually comes in the form of a CDA document so I think the metrics as we envisioned them would still apply. I imagine some folks still have interfaces with HIU informed directly into their system and that would not be captured by the sort of metrics that we are contemplating here.

Abby Sears
Yeah. I am not sure how to acknowledge that comment. We have to think about that more if we can. Grace is just playing devil's advocate around enabling and empowering patients and their care partners to report when information has been sent to their clinician has not been meaningfully viewed. I think we all agree with that. It is just a question of how and when and the steps to get to that level of sophistication, we have got to start somewhere.

Steven Lane
In the interest of time, I do not know that we have time to adjudicate all the recommendations and perhaps what we should do is, we should spend some time between this meeting and next giving people the chance to provide feedback as they did within the Google Docs. Maybe what we should do is go ahead and cover the recommendations about the second metric around clinician facing third party apps, get them out on the table so we can get some high-level comments and try to adjudicate them between now and next meeting.

Raj Ratwani
Agreed because I think we are going to run out of time. Steve Waldren, I see that your hand is up, we will come back to you if there is time and then, certainly welcome your comments offline.

Steven Lane
So, moving onto Slide 25. Here again, I think the key questions that we are trying to answer here is, how many clinician facing third party apps are installed in the system? What proportion of installed clinician facing apps are ever used as intended and by how many clinician users? What proportion of those installed clinician third party apps are used on an ongoing basis; I think that is an important question? Just that somebody looked at it once and said oh, that is interesting, but they are actually using it to take care of patients. Then what proportion of installed clinician patient third party apps are used by different clinician subgroups? Just a question I think that we would all be interested in, it is not included in the metric, but I throw it out as a consideration. Do we care whether these apps are being used by clinicians, practitioners, nursing staff, do we care whether primary care versus specialty? I think over time we are going to care. But I would throw that out as future consideration. So, slide 26 reiterates the metrics as Gary took us through them. Jumping to Slide 27.

The considerations I felt we should be keeping in mind as we come up with recommendations. Should the measure focus on functionality offered by the products as opposed to the adoption rate and use? Again, do we care whether this is a product for care management or med-reconciliation, etcetera? That certainly was not included in the proposed metrics. Reporting by product, that is to say certified health IT product may not reflect superior functionality but rather superior marketing and existing market share. So, I think we need to keep that in mind. Could reporting low numerators and denominators in a small patient population increase the risk of potentially identifying patients? This was raised by somebody else, but it is an interesting

thought. If you have an app related to substance use disorder that is used by a clinician in a very small community, is there any privacy risk associated with that? I do not think there is, but that question had been raised.

If we are using authorization of an app as a proxy for usage, how do the metrics account for apps that are authorized but never actually used? I know Gary, you proposed this, a physician authorizing the use or clinician authorizing the use for the app is a proxy for usage. But I would hope that there would be a way to see whether the app was actually used by that clinician. Also then large, complex health IT installations may be more likely to utilize clinician facing apps. My organization, we have got tens of thousands of providers and every specialty and lots of hospitals. So, would it be valuable to normalize and stratify the metrics somehow based on the size of the installation, number of users, clinicians, encounters, etcetera? Again, thought questions more than anything else.

Abby Sears
Steven?

Steven Lane
Yes?

Abby Sears
Yeah, this is Abby. Can we go back one slide? Can I add one other consideration? I am sorry to add this at the 11th hour. I think one other consideration to really think through about the clinician facing third party apps is, how are third party apps impacted by equity issues related to people that do not have smartphones or access to third party apps? How do we want to think through, are we creating more equity issues because we are focusing on third party apps when a lot of patients that are more at risk and high risk may or may not be able to use third party apps? I do not know how to account for that in what we are doing. So, it is something to think about.

Steven Lane
Yeah. Abby, I think that applies more in the earlier metrics about patient facing apps. This is about apps that we install in our systems for use by clinicians. So, not necessarily linked to whether or not the patients have access.

Abby Sears
But if the clinicians are using it and patients are not and the data is not equitably available, it will impact clinicians using it and it will become more of a commercial population usage. It may not matter, but it is something to think about.

Steven Lane
Good point. Good point. Anything else, Raj or Abby, or can we go on to the draft recommendations on Slide 28?

Raj Ratwani
I think you can keep going.

Steven Lane

Okay, on Slide 28 I have captured a few recommendations about this Metric 2. One is to report separately on app registration versus app usage if this is possible. I am not sure I know enough about how certified health IT products keep track of apps that are downloaded, registered, utilized. That would be really nice to be able to demonstrate registration for usage if possible. Here again, we had that problem we had earlier of the granularity of reporting of use. I would again insert the 1000 order of magnitude as a separate category and then report usage using these categories, because I think a lot of these apps really are things, we see in our system that one user will download and use and that is great. One is not the same as nine. So, I would separate out one to the nine, to the 99, etcetera, as listed here. To report number of apps by usage volume of category within the reporting period. That is to say that the clock starts again each year, if we are using July 1, to see whether these apps are being used.

What we have seen is somewhere down the line it will get in and get used for a day or week or month and they will lose interest in it. The fact it was in 2022 does not mean that it was used then. Then I think in the future, it would be nice to look at the recording of range and number of times the app was used by all users within the reporting period. To be able to look at reporting by user class, those might be helpful. These are pretty simple recommendations on Metric 2, as opposed to Metric 1. I will stop there, now having gotten all of our specific recommendations for the metrics out on the table, we do have some global recommendations on the next slide. But I think we can, actually, let us go ahead and pull those up so we have everything out on the table from our work. That ONC should consider limiting the initial number of metrics and complexity, Abby covered this. To ensure the success of initial program implementation. Additional metrics could ideally be identified by ONC when they publish version one as planned for future program versions to inform vendors of the need to develop supporting functionality to keep count of those things.

As we mentioned earlier, automatically generated activity logs with real time receipt parse and filing viewings of this data is preferred over lookback reporting to minimize the effect on computing capacity. That does not necessarily need to be incorporated into the metrics, but a general recommendation that we covered here to avoid burden on the provider organizations. Then as we captured earlier, that for all of these there may be a requirement for negotiation of new contract provisions to authorize access to this data. So, maybe back it up here to Slide 28, in case people want to talk about ideas on these rather simpler recommendations.

Raj Ratwani
All right. Thanks, Steve and Abby. I know there is a lot of content there and we have roughly 13 minutes until public comment, so let us jump into some discussion. Sasha, why do not you go ahead with your hand up.

Sasha TerMaat
So, I actually had a comment on the overarching recommendation on the next slide. I definitely think we want to be judicious about how… Can we look at the next slide? Thanks. We want to be judicious about how we invest in this program and build over time as we have determined what is useful in interpreting the data and what is not. I am very concerned that Recommendation 2 is overly prescriptive in a way, as I said, that does not match all the different EHR deployment models. But also, does not necessarily hold true across all types of reporting. There could definitely be cases where adding activity logs of real time actions is more computing intensive than relying on a reporting database to gather information about how things have happened. I think we really need to generalize this Recommendation 2 to something that is not specific

to every EHR deployment model but simply says that in doing this we want to prioritize minimal burden on the providers who are having their data gathered.

Raj Ratwani
Great. Thank you, Sasha. Other comments from folks? I know there is some people that are not able to use the hand raising feature. So, please chime in or let us know verbally if you want to speak up.

Abby Sears
I think I want to comment to what Sasha's saying here. I completely here what you are saying. I think it is a little bit of a dilemma where we are going to really have to navigate this in a careful way because if we require too much computing and it goes down to the provider. I am worried they will self-select out. Remember, many of the providers have trouble keeping up with upgrades, trouble with the purchasing of additional software in the bigger delivery systems that might not be as big of a challenge. But the smaller practices, and we do not want to leave out the community providers as well. I know that we need to do this. It is just I think we need to keep thinking about how do we do this in a way with the least amount of impact or what we are going to get is not really what we are looking for because the data we get back will not be as valid or comprehensive.

Sasha TerMaat
No, I agree. There is no magical way to gather data from every provider who uses a certified EHR in this country with no burden on providers. So, if we are deciding as an industry that the EHR reporting program provides us with useful data and part of what we are doing is making recommendations, is saying where we think the data will be useful and where it is not. We have to make that call as to what data is worth that incremental additional cost on provider systems to gather that data and what data is not. That is, I think, part of why growing incrementally will be really important as we have more information about what is worth it and what is not.

But I also do not want us to short sightedly be overly prescriptive about how this data should work, which limits the data to improve, or use a model that may need better matches. A particular EHR deployment. So, I think we do have to acknowledge there will be some impact on providers because the data ultimately comes from the systems that they are using. This will be incorporated into the use of a certified EHR, in that way, that is part of what that means. We can prioritize in a way that is meaningfully burdensome, but I do not want to lack in an approach that we may short sightedly think is the best that is not the best.

Steven Lane
I think Sasha you are speaking from great experience helping provider organizations deal with reporting challenges in the past. Should we take the time that we have left to move back over to the document in Google Docs and see whether any or all these recommendations are acceptable to the point of being included?

Raj Ratwani
Yeah, let us do that.

Bryant Karras
While that is transitioning, this is Bryant. I am having trouble raising my hand. I wanted to chime in on the earlier comment about viewing the CDAs. It does not take into account the clinical judgment if you get 30

or 40 historical records from a transfer of care for a consultation, it is probably only the most recent three or four that are relevant to the consultation, not the whole history that has been sent. It does not seem fair to make somebody have to click through and open every single document.

Steven Lane
I think that is a really good point, Bryant. I also just do not know if we have the ability to differentiate that, right? It is true. Sometimes I will see a patient and I will just look at the data that came from the continuity of care document and other times I will download the last three years of documents and I may look at those in the future or not. I think that we are going to learn or start to understand the value of this data only once we start collecting it and seeing it across vendors. So, in the page we are looking at, again, I tried to bring over the recommendations to see which, if any, we can move above the line, if you will. So, my first recommendation was, metrics should be based on any valid CCDA document type received, not only a summary of care document. That is a pretty big shift.

Curious, I guess Sasha. Thank you. Does anybody object to us moving this above the line? Sounds like not. Was someone else going to do the mucking with the document? Okay, no worries. The next one was, if possible, metrics should count each received documents and avoid recounting subsequent updates to or iterations to the same document. Sasha says the content of updating a document is not in certification. I am not sure this will be able to be done consistently. That is why I used the word avoid. I do not know. Is this worth including or should we just skip?

Abby Sears
Done, is that useful, then you will have not comparable metrics, right?

Steven Lane
It is, but I just want to point out that you are speaking from a vendor who does a lot of re-query, right? I know multiple versions of a document, many of which do not include meaningful changes and it just seems like that.

Abby Sears
When we report document totals, we usually collapse those into one. So, I am not worried about doing this, but I guess I am wondering this is not in certification. So, if Epic reports our metrics and deduplicates all of these and another system does not do that, their metrics will look different because they do not have the capability to deduplicate. Then that seems so make it impossible to draw conclusions from the data because fundamentally we are reporting different metrics.

Steven Lane
Skip this one?

Sasha TerMaat
Steven, how would you feel about just not moving that up yet, so we have more time?

Steven Lane
No, no, no. I think that is fine. Yeah. I anticipate a lot of these. Yeah, the next one was metrics should separate compounds of documents received based on push versus pull. Here again, I think Sasha makes a good point that the pull is not in certification today. I suspect those systems could differentiate whether

they pull the document versus whether it was received by a push. Some consideration, yes, does it matter? That the recommendation is not exactly consistent in certification. I am curious what people think about this one. Or maybe this should be put on a future roadmap so that the systems would know that they will need to develop this capability of differentiating.

Sasha TerMaat
To differentiate. I thought you were going to require them to develop query-based exchange.

Steven Lane
No, no. Just require the capability to differentiate whether a document was received by push, or they pulled it in. Is that more comfortable?

Sasha TerMaat
They seem to me to be differentiable. Again, I say that from a perspective of a system that does a lot of query-based exchange and does differentiate. But from a certification perspective, if this is an EHR reporting program for certified HIT, I thought one of the overarching principles was to measure the use of certified HIT. So, I wanted to highlight, philosophically, this measure expands beyond that scope.

Steven Waldren
Steve, I like it being on a roadmap just because of the complexity of everything we are talking about, but I think it is really important. I would think it even goes to the point of the data source, too, because if we are talking about later on parsing and integration and may depend upon where that CDA comes from. It may be the same template void, but from certain sources it is able to be integrated and parsed and others it is not and that would be helpful to understand moving forward. But again, I think it is future, not a now.

Steven Lane
So, are you guys comfortable with how I moved that above the line?

Steven Waldren
Yes.

Steven Lane
Okay. All right. The next one was my suggested definition of clinicians including all licensed independent practitioners, plus, nursing NA clinical support staff. We were specifically asked what clinicians means. I think Sasha makes a good point that systems would need to do this and map user classes to this clinician versus non-clinician. That seems relatively straightforward to me. It speaks to Grace's point, that it is actually pretty important to have some concept of non-clinicians viewing documents and Steve's very good point, that this is a very administrative task to make sure it is filed right, and et cetera, but it is still something that happens at clinician viewing. If 99percent of documents are viewed by non-clinicians and only one percent by clinicians, that is important to know. Anybody uncomfortable with moving the clinicians definition above the line? We are making progress, how about that.

Steven Waldren
Steve, just one, and I think you can wordsmith it later on. But I think one of the challenges is you say it includes all licensed okay, and then you add. I am sorry, that is lost because MAs would not be licensed. Yeah.

Steven Lane
LIT is a pretty commonly used term these days. Okay. My next recommendation was that activity log reports automatically generate and transmitted from provider systems at the specified interval, with a program trigger. **[Inaudible] [01:18:45]** which is this is pretty prescriptive and different people may be able to do this differently. I will have to move this below the line. Are we at time?

Raj Ratwani
We are at time. We do need to switch to public comment. That is the scheduled time for folks to jump in. Why do not we go ahead and do that and if there is a few minutes remaining, we can jump back into the document.

Public Comment (01:19:16)

Mike Berry
Okay. Thanks, Raj. Operator, can we open the line for public comments.

Operator
Yes, if you would like to make a comment press *1 on your keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your line from the queue and for participants using speaker equipment it may be necessary to pick up your handset before pressing the star keys. One moment while we poll for comments.

Mike Berry
Okay. While we are waiting, I want to note that our next task force meeting will reconvene next Thursday, the 12th of August at 10:00 a.m. Eastern time. We appreciate everyone being with us today. Operator, do we have any public comments?

Operator
There are no comments at this time.

Mike Berry
Great, thank you. Raj, Jill?

Raj Ratwani
Great, thanks. Steve, Abby, let us jump back into that document. We have about 8 minutes left until we have to adjourn and there is not much to cover in final remarks. So, I think if we have a minute probably will be enough time. Why do you not jump back in?

Steven Lane
So, I think the next key one that I recommended was the reporting at the product level. Sasha has repeatedly raised this consideration that a patient may be seen ambulatory inpatient and ED even within the same "episode of care." I hear that. I still think that is okay with me. If they had an encounter documented in the ED and in the context of that encounter there was exchange of data, that that is important, that is relevant. Similarly, if they had an encounter documented **[inaudible] [01:20:58]** setting. I think it does suggest there could be double counting, right? That a single document might have been received for a patient who had all three encounters, and you do not know which encounter or product to attribute to. But I

still feel like rolling it up to the vendor level, it really decreases the value of the data. But others have opinions on this.

Sasha TerMaat
I guess, and this may not be evident to anyone but me and some of my colleagues, but attributing direct messages, receiving them, which is not an encounter linked activity, is one of the most complicated parts of reporting on interoperability mix. It involves a lot of assumptions about the next chronological encounter being the one to associate it with, which I know from experience, not necessarily clinically relevant, but too complex really to figure out otherwise. So, I would certainly say it merits further conversation. I hear you on wanting to have a product level report. Perhaps we could differentiate the denominator, which is encounter-based, by product, and do that by identifying inpatient encounters separately in a value set from ambulatory encounters and having the products report those. But I do not think access to direct messages cleanly associate with encounters. I mean, I guess I know they do not because of experience with promoting interoperability.

Steven Lane
So, it sounds like this will stay at future consideration **[inaudible] [01:22:49]** but let us skip over this one for right now. The next one was viewing a document should be defined as having an open document displayed to a user, whether the display includes all or a subset of the data received in regard to **[inaudible] [01:23:01]** itself. Again, the time interval for viewing would be, the document has to have been viewed within the reporting period. If we are talking about 12 months, July through June, it would be whether or not that received document had been opened during that time. Obviously, some of us would be interested in how quickly they were opened, etcetera, etcetera. How often were they opened, in what context were they opened? But I think again, we were asked to come up with a definition of viewing a document and I think this is as good as any.

Steven Waldren
We have to have a look back then, because if you just received it on the last day of the reporting period, there are not 12 months to view it. So that was kind of my point.

Steven Lane
I do not know. I feel like it is unavoidable. If we say the metric is, how many documents were received and how many received documents were viewed, which is how the measure is proposed, this just attempts to define viewing. You received 10,000 documents and 3,000 of them were viewed. Then it is going to go out year-to-year based on the time frame of viewing. To me, and again, the documents viewed, that is an interesting point. Okay. So, it was of those documents that were received how many were viewed, not of all the documents that have ever been received. But even so, I think it normalizes over time. Can I move that one above the line? Abby did it. All right, Abby. Thank you. All right. It is gone.

Abby Sears
Steven before you move on, the summary reporting should occur at least once a year but not more than quarterly. I see why we moved past the activity log report but if you go back up, do we want to talk about timeline, timing?

Steven Lane
I mean, I feel like everyone is settling on once a year.

Abby Sears
Yeah.

Steven Lane
But I am not sure it adds to what we have already covered.

Abby Sears
Well, I was going to move it up above.

Steven Lane
Oh, okay. Any objections?

Sasha TerMaat
What does it mean? When you say summary reporting, are you talking about data collection from providers to the vendor who will aggregate, or are you talking about from the vendor to ONC?

Steven Lane
I think the latter. This is all about vendors reporting to ONC.

Sasha TerMaat
I guess my feeling would be that that should be in a comprehensive recommendation, not on this specific measure. If we are saying overall, we think it should be annually, then we can pull that out of a specific recommendation and put it into our overarching.

Bryant Karras
I think that is fair.

Sasha TerMaat
Me too.

Steven Lane
Okay, let us see if we can squeeze out one more. My concept about separating metrics, about how often was data parsed from received documents and integrated versus how often was parsed data actually viewed. I earlier stated I thought it was just too hard to know when parsed data was viewed. So, I would suggest that we leave the parsed data viewing for future iteration but leave in this iteration **[inaudible] [01:26:51]** data parsed and integrated.

Sasha TerMaat
Do we need to define parsed and integrated? Those are not terms that are in certification. Would they have a common understanding?

Steven Lane
I mean, it seems pretty obvious to me, and I suspect Steve and the other clinicians as well. But yeah, you have a better view from the vendor side.

Sasha TerMaat

Well, in the certification process they talk about received, incorporate and reconcile as the action. It seems like parsed and integrated are different. Reconciliation might be one form of parsing and integration, but I am getting the impression you actually think of other things too, even where reconciliation does not take place.

Steven Lane
Exactly.

Sasha TerMaat
So, I just want to make sure that that would be clear so that it would be implemented consistently across vendors. It might be worth a couple sentences of clarity on that.

Steven Lane
Totally agree. Perhaps we can take a stab at that between now and next week.

Abby Sears
Sure.

Final Remarks (01:28:06)

Raj Ratwani
Okay. So, we are right at time. So, just a couple quick things before we wrap up. Jill, feel free to chime in here. Reminder to folks, please jump into the shared document to review these recommendations and make comments. We are going to need to have a lot of offline asynchronous work here to get resolution to these and hopefully in one of the next meetings we will be able to go back and get some more reconciliation of these so we can move them into that generally everybody approves category. We will see everybody here next Thursday, same time. Anything else from ONC, urban teams or Jill, from you?

Jill Shuemaker
Raj, just one thing, we still have an outstanding meeting to schedule between Steve Waldren and Zahid. If you guys could send your availability so we could schedule that meeting to talk about the SNOMED codes and CPT codes to define denominators for the public health measures. Thanks.

Raj Ratwani
Will do.

Mike Berry
Okay. Thanks everybody. Appreciate all the hard work on this and more work to be done but we will get through it and see everybody next Thursday.

Jill Shuemaker
Thank you, everyone.

Adjourn (01:29:24)