

Health IT Joint Committee Collaboration

A Joint Policy and Standards Public Advisory Body on Health Information Technology
to the National Coordinator for Health IT



Joint HITPC and HITSC Certified Technology Comparison Task Force FINAL Report of the January 15, 2016, Virtual Public Hearing

Name of ONC Staff Liaison Present: Dawn Heisey-Grove

Purpose of Hearing: None stated

Review of Agenda and Opening Remarks

Co-chair Cris Ross reviewed the agenda, which was circulated in advance of the meeting. The role of the task force is to make recommendations on an EHR selection tool and submit them to the HITPC and HITSC next week. The charge to examine the potential of a selection tool was included in the Medicare Access and CHIP Reauthorization Act (MACRA) legislation. Ross complimented the Office of the National Coordinator for HIT (ONC) staff for their excellent work. The panelists were told to limit their testimony to 5 minutes.

Open Data Certified Health IT Product List (CHPL) Presentation

Scott Purnell-Saunders, ONC, showed slides and described plans for the Open Data CHPL, which is due to be launched this spring. The goal is to allow reported product data (e.g., test results, optional certification and testing processes) to be more accessible for detailed product analysis. ONC proposed to require ONC-ACBs to report an expanded set of information to ONC for inclusion in the CHPL upon the conversion from its present form to an open data file represented in both XML and JSON and with accompanying API functionality. The conversion to this new CHPL is in response to feedback from stakeholders regarding the accessibility of information on the CHPL, especially the information contained in the publicly available test reports for certified HIT products. The new CHPL will contain all 2014 and 2015 edition certified products. CMS EHR certification identification number generation will be available in summer 2016. ONC-ACBs will have direct product management access. All data stored on the CHPL will be accessible via XML and JSON via accompanying APIs. Search capabilities will be expanded. Advanced search capabilities will offer detailed searches through the user interface. The ability to compare certified functionality has been added to the Open Data CHPL. Multiple products can be selected and viewed side by side. Each product's certification details are displayed for comparison. Certification details are grouped for a faster review.

Q&A

Ross asked about current users and how this is expected to change. Purnell-Saunders replied that in the past, CHPL was used primarily by meaningful users. More recently, there has been increased interest among the general public. ONC staff wanted to increase ease of use and offer more customized searches. In response to a question about improvements in data provision, Purnell-Saunders said that now ONC-ACBs will have direct access and be able to add information to the CHPL, making the information more current.

John Travis referred to the enhancement of surveillance and disclosures: Will that information be available in CHPL? Purnell-Saunders said that plans are underway to streamline processes so that the current information will be available to the public as quickly as possible. Hyperlinks to reported

information will be available. Staff will make an effort to be more transparent about surveillance data, but the complete detailed reports will not be published.

CHPL Presentation Continued

Karson Mahler, ONC, showed slides and described information and disclosures under the 2015 Edition final rule. The Open Data CHPL will contain an expanded set of information about all certified products. Mahler gave examples. HIT products and their developers will be surveilled in the field to verify that capabilities work as expected and that developers are meeting requirements. If a product fails surveillance, the following information is posted to the Open Data CHPL within 1 week:

- The specific capabilities or requirements that were found to be deficient.
- The ONC-ACB's summary of the deficiencies.
- The developer's explanation of the deficiencies (if provided).
- The date the deficiencies were verified.
- Corrective action timeline (dates started, due, and completed).
- A description of the resolution of the deficiencies.

Developer disclosure requirements include publishing disclosures on their websites and in marketing materials. They must disclose all known material limitations and types of costs that a user may have to pay in order to use certified HIT capabilities for any purpose within the scope of certification. Disclosures must be in plain language; include the nature, magnitude, and extent of the limitations or types of costs; and be sufficiently detailed that a reasonable customer could identify and understand them. Mahler listed many other types of information that must be provided, including the following:

- The specific limitations and the potential costs the user may encounter
- The nature, magnitude, and extent of such limitations and types of costs
- The charges for an annual subscription fee for transfer-of-care (ToC) documents.
- The developer's HISP policy
- How the developer's limited network of supported HISPs and lack of participation in trust networks could impact a customer's ability to exchange ToC summaries within the customer's referral area
- The transaction fee for sending and receiving ToC summaries to third-party HISPs
- The potential impact of these fees and limitations on a customer's implementation and use of ToC.

Mahler said that developers have the opportunity to voluntarily pledge to provide information about their products in the following ways:

- Targeted—based on customer's or requestor's specific circumstances and needs.
- Proactive—at a time and in a manner most likely to be useful.
- Responsive—responds to specific questions and in format requested (if applicable).
- Open—to anyone who asks.

Organizations that represent HIT purchasers can request information from developers to help them evaluate and compare products. ONC will publish a list of all certified HIT developers, indicating which ones have taken the pledge and which ones have not.

Q&A

Chris Tashjian asked how many developers are taking the transparency pledge. Mahler replied that the requirement was effective January 14; it is too soon to have information on participation. He hopes that all developers will take the pledge.

Ross asked about consumers of this information: What kind of feedback has ONC received? According to Mahler, to date, little feedback has been received. Since the new CHPL has yet to be operationalized, there is limited awareness.

Panel 3: Certified Health IT Developers

Panelists were asked the following questions:

- What specific modules are relevant for the typical ambulatory office, and how do you package those features? Does this packaging change for specialty practices?
- What should be standard features for comparison?
- Does a vendor comparison tool foster competition and innovation?
- Should information on the market focus of the developer (i.e. do they have experience with providers like me) be available for comparison? If yes, what would you want the developer to provide?

Todd Rothenhaus, athenahealth, showed slides and argued that it is not within the role of the government to design and offer a selection tool. The value proposition and feasibility of a comparison tool have not been established. The market promotes shopping. Certification attempted to ensure consistent capabilities across certified EHRs, but this did not lead to consistent outcomes. The main complaint from EHR users is poor usability, but creating an objective, quantitative system for comparing usability is virtually impossible. According to Rothenhaus, a comparison tool would not fuel innovation; promoting shopping and market forces among EHR users and purchasers will contribute to innovation. Currently, shopping is not encouraged. A comparison of features required by certification will have little to no value. More education is needed among purchasers and end users on the relative total cost of ownership for legacy- and cloud-based systems. A comparison tool could provide metrics on things that can be compared, such as true interoperation and proof points that there is no information blocking in a vendor's ecosystem. The government could address switching costs, which are currently high and inhibit the market. Many EHR comparison tools already exist, and private-sector solutions should be leveraged instead of creating a new tool. KLAS Research, AmericanEHR Partners, Gartner, Inc., Forrester Research, Inc., Capterra, ConsumerAffairs, EHR Compare, EHR in Practice, EHR Softwareinsider, and Software Advice have products that can be leveraged.

Robert Hitchcock, T-System, showed slides. He said that meaningful use created a significant shift in EHR purchasing almost immediately, driven by the program's financial incentives and desire to avoid penalties. Meaningful use created a compressed time frame for early adopters to purchase and implement. Decisions were focused on meeting the specific program measures. Physicians adopted technology that they might not have chosen for their specific needs, especially for information on clinically relevant outcomes. In larger organizations, the buyers were not users, and users often had little representation during the purchasing decision process. Consequently, a shift from user-focused solutions (such as specialty and best of breed) was exaggerated. Consistently, a major complaint from end users is the impact on their workflow and the physician-patient relationship. Therefore, the expected outcomes—connected care, patient engagement, and others—were only a vision.

Hitchcock recommended leveraging existing private-sector tools and augmenting CHPL. Presuming that a comparison tool would focus on improving the likelihood of choosing an EHR that would provide the best clinical, financial, and business outcomes and increase adoption, comparing certification measures provides little value. Identically certified solutions can have significantly different adoption rates and impacts on workflow and provider satisfaction. Several EHR comparison tools exist and should be leveraged. They are complex to develop and maintain, and these resources should be used to the extent possible. Hitchcock pointed out that usability and satisfaction are highly subjective. Regarding pricing, the larger the group or the more complex the environment, the greater the variability in total cost of ownership. Likewise, many variables affect interoperability.

Michael Sherling, Modernizing Medicine, showed slides and delineated modules that are relevant to the ambulatory office and noted how they vary among select specialties. He said that the standard features for comparison should be value-driven, not feature-driven, metrics. He proposed the following values for comparison:

- I would buy this EHR again today
- It is easy to use this EHR to satisfy regulatory requirements
- Overall this EHR is easy to use
- What do customers really think of it
- Does it slow physician productivity
- Can it help boost physician productivity
- Can it help physicians with value based medicine and population health initiatives
- What's the implementation investment
- How intuitive is the product to learn

Sherling concluded that a value-driven comparison tool would foster competition and innovation. Tools should be specialty specific. Sherling said that the market focus for developers should include the following:

- List number of users they have and by which specialties.
- Average time to complete a note
- Accuracy of billing
- Extra time spent on regulatory, compliance issues.
- Correlation of clinical and financial data.
- Integrity of the organization
- Does the developer have an accessible support system
- Does the customer have buy-in to the software for the roadmap
- Does the developer continue to innovate with industry standards
- Is it easy to use and upgrade
- How frequent are the upgrades
- What's the downtime like
- Access to individual and benchmark data

Richard Loomis, Practice Fusion, testified on behalf of the EHR Association (EHRA). He did not provide slides or written responses. He said that modules may not be the most relevant consideration. Meaningful use regulatory requirements forced the inclusion of many features that are not useful in all situations. Loomis mentioned many factors that are important considerations in EHR selection for primary care and specific specialties, saying that it would be difficult to delineate essential features for comparison. Technical requirements, other software requirements, licensure structure, interoperability, types of devices supported, and availability of complementary technologies are a few of the features to take into account for comparisons. Loomis assured the members that although the EHRA welcomes transparency, a government product is not likely to improve upon what is currently available and would have no added value. In fact, such an ONC tool might contribute to confusion. Loomis believes that the Open Data CHPL will have value in differentiating developers and their products, as well as specialty and care settings. However, another ONC-maintained resource would not be beneficial.

Peter Kaufman, DrFirst, showed slides. Like several other panelists, he listed the needs of ambulatory and specialty offices, saying that the needs of the specific specialty must be taken into account. He pointed out that in considering an EHR comparison tool usable features are more than checked-off features. Important features to measure and compare follow:

- Standardization.
- Interoperability.
- Patient summary.
- Sharing.
- Review and import.
- Implementation time and complexity.

Usability may be the most difficult factor to compare. According to Kaufman, third-party solutions are available and should be used. However, the extent to which a tool contributes to a purchase decision is a major consideration; there is no particular evidence that the existing tools are actually used in purchasing. Survey responses versus objective validation of features are another consideration. Any tool must be usable and interoperable. Information on the number and percentage of physicians in the specialty who are using the solution should be stated.

Q&A

In response to a question from Jorge Ferrer about the purpose of the EHR versus the purpose of documentation, Rothenhaus said that the purpose of the EHR is to gather information across the care continuum. Documentation should focus on the patient in front of the clinician and the current encounter. Hitchcock responded that documentation should tell the story of the patient's encounter for the next provider. The EHR puts the available data in front of a provider and allows that provider to add and modify information for the next provider as one step on the continuum. According to Sherling, the next-generation EHR should be cloud based, mobile, and able to use and contribute to big data and collect structured information at the point of care. Loomis said that the purpose of the EHR is to facilitate the care process of which documentation is a part. Documentation delivers interoperable information and is the key driver for all HIT. Kaufman talked about EHRs needing semantic interoperability to facilitate the straightforward and quick review of patient information. Data should be analyzable yet maintain the nuance of natural language.

Co-chair Anita Somplasky asked for opinions about the provision of cost data by customers. Two panelists were not opposed, one adding that cost per se would not be sufficient information to be useful. Other information would be necessary to interpret the information about cost. For vendors with complex systems, it would be necessary to know what components and services were included in the cost. Someone suggested that customers could be asked whether their expectations regarding cost were met. Kaufman also was not opposed; he too cited the great variation in cost, insofar as many factors affect cost. Nevertheless, cost is not as difficult to compare as interoperability. Somplasky reported that the task force members believe that having access to comparative cost information is important for small and medium-sized practices.

Steven Stack observed that it was interesting that the panelists believe that existing comparison tools may be sufficient. He wondered whether the next group of panelists will agree.

David Schlossman noted that for smaller group practices, the time involved in the decision is considerable. Huge time and money investments are required. One unified, transparent source for comparison would be valuable. Schlossman was not concerned with duplicative efforts, as were some of the panelists. He said that if a developer cannot make the case, then there is no reason for HIT. A panelist said that comparisons are made daily in the market. Purnell-Saunders interjected that the Open Data CHPL will allow comparisons on certification criteria. The data will be available for others to analyze.

Travis wondered about the value of buyer's references incorporated in a tool: How would one approach the cost of doing care? Rothenhaus reported that the state and regional extension centers have done something similar to a buyer's guide, but with no evidence of effectiveness. Somplasky said that she found it impossible to design a way to compare apples to apples, due in part to the lack of sufficient historical information. Kaufman repeated that checkboxes are not sufficient.

Staff reported a question submitted via the Web meeting chat box: What do large-organization vendors need to know in order to provide satisfactory specialty products? According to Rothenhaus, organizations are starting to realize that best-of-breed products do not necessarily fit all needs. Products for multispecialty organizations are not yet mature. Not all modules apply to all organizational components. Hitchcock agreed that levels of interoperability to support best-of-breed are not yet available. Sherling referred to best-of-breed for departments within large systems. Interoperability is

required to share data across various platforms. Kaufman said that as systems become more modular, different vendor products can be used.

Ross noted that the panelists' opinions about the availability of consumer selection tools differed from the testimonies of the January 7 panelists. He wondered whether the private-sector tools were adequate and, if not, what market tools could be applied to improve them. Rothenhaus said that although most developers do a good job, they tend to be overly focused on CIOs rather than end users. There are hundreds of products in the ambulatory field, making comparisons difficult. Loomis noted that some companies survey the actual users in addition to managers. Hitchcock said that vendors such as KLAS do a good job, but there is opportunity for improvement. He acknowledged that he is less aware of the ambulatory market. Setting up an infrastructure for comparison would be very difficult. Therefore, leverage of existing organizations and resources may be the preferred action. It makes sense to use the expertise of groups that have done something similar. Ross reported that the task force is not convinced that ONC should design, implement and maintain a comparison and selection tool. The members are considering what could be done to use private-sector resources. Ross is interested in concrete steps to take in that direction.

Panel 4: Health IT Comparison and Informational Tool Vendors

Panelists were asked to respond to the following questions:

- What is the best way to develop a tool that meets the needs of different provider groups?
- What are the barriers to you completely meeting the HIT product comparison needs anticipated by MACRA?
- Are there data that you would like to include in your product that are not currently available to you? How will that benefit the provider?
- What kinds of health IT-related APM or care coordination capabilities do you think should be available for comparison?
- For ACBs/ATLs:
 - What information from the testing reports should be made available for vendor comparison?
 - What information from the disclosures should be made available for vendor comparison?
 - Are there limitations in what can be shared?

Amit Trivedi, ICSA Labs, submitted written testimony. He noted that ONC certification program test summaries contain the following information for comparison purposes:

- Additional software needed to demonstrate the functionality for testing.
- Date the product was tested.
- Required and optional criteria successfully tested.
- Supported standards, when multiple standards are allowed.
- Optional transactions.
- Information about inherited certification and gap certification (though concepts are not always understood by end users).
- A Quality Management System.
- Safety enhanced design – the user center design methodology employed, and summary results of usability testing conducted of modules meeting specific ONC certification criteria (also not always reviewed or fully understood by end users). Usability testing results for other modules is not collected in certification.

More information will be made available by the latest requirements and accessible via the Open Data CHPL. Trivedi noted that the test result summary reports were not designed to differentiate products. As a result, if one only looked at the test result summary information, it would be difficult to determine how various technologies that have attained the same certification status differ. Certification testing and the information in the test result summary reports should be seen as a floor from which to begin a

general comparison augmented with information from other sources and used to rank, rate, or differentiate technologies.

Trivedi reminded the members that certification testing typically focuses on a product tested in a controlled setting. Many shortcomings identified with products are related to the product once implemented, so gathering post-certification information is important. What is not measured or evaluated as part of the certification test methods is the workflow—or *how* results are achieved. Given that the HIT market is constantly changing, it may be helpful to consider publishing a companion guide alongside a simple HIT comparison tool so that first-time purchasers and small provider practices can better understand what certification does and does not cover, and so they may also obtain a succinct overview of key questions and areas on which they should focus in order to arrive at a decision when comparing technologies.

Raj Ratwani and Aaron Zachary Hettinger, MedStar Health, showed slides. Comparison tools will likely improve transparency, which will support more informed purchaser decisionmaking and competition on usability. Both the process and the product should be compared. This would involve a method for comparing the usability design and development process. In addition, the actual usability of the implemented product must be compared by both subjective user assessment and objective quantitative assessment. Comparison of process is often limited to a statement of process, but no evidence of the rigor of the process to compare across EHRs is presented. Poor adherence to standard reporting makes comparison difficult. When comparing product usability, one must differentiate the certified product from the implemented product. The certified product consists of standard use cases and testing methods, adherence to reporting requirements, and standard reporting templates. The implemented product involves access to EHRs, standard use cases, testing methods, and authority to conduct assessment. They recommended the following considerations:

- Evidence of vendor user-centered design process
- Standard use cases for usability testing
- Usability assessment of implemented EHRs
- Safety surveillance data made available as part of product comparison

Alan Brookstone, Cientis Technologies, submitted written responses and described AmericanEHR, which was developed as an aggregation resource for information from a wide variety of sources, including multiple surveys and government-supplied datasets. Users can view satisfaction data combined with EHR incentive attestation records for each EHR system. Users can filter results using an advanced search function for criteria including practice size, practice setting, EHR certification, geographic location, combined practice management (PM) and EHR system, interface with an alternate PM system, integrated patient health record, and developer code of conduct. Data are collected directly from physicians and validated via their professional organizations, through a detailed 139-question user survey. Meaningful use attestation data from HealthData.gov have been integrated with AmericanEHR satisfaction data since 2014. The database design will allow for the integration of Open Data CHPL information with the ability to link individual survey responses to a specific version of an EHR or present the data in an aggregated format by product. Knowing the version of a product is of the utmost importance. Users can provide narrative feedback regarding their use of any EHR product. Vendors have the ability to respond to user comments.

Jason Hess and Garrett Hall, KLAS, showed slides. Their organization goes to vendors and providers to form questions on which to collect information from providers to rate products and services. The slides showed examples of the questionnaires. Staff compile the responses to develop ratings on select topics, such as population health. KLAS issues approximately 70 reports annually on various topics, such as value-based care. Data are used to identify what is important to providers and which firms best provide it. These data help differentiate vendors and also help vendors improve their products. The reports are for sale, although those persons who contribute to the surveys receive complementary copies.

Steven Waldren, American Academy of Family Physicians (AAFP), submitted written responses to the questions. He described an early foray into providing comparisons with Microsoft in which AAFP developed a comparison tool for PM systems. By the time that the tool was available, it was obsolete, because the products had updated and changed their functionality offering. Several efforts followed. Eventually, AAFP created a product that the physician could use to “find a physician like me in a practice like mine.” A review product for EHRs was designed in which the self-reported data from the vendor was coupled to reviews that also provided profiles of the physician practices. This allowed physicians to find products with an overall score above a threshold and find reviews from physicians like themselves. Members reportedly found this helpful. Not all members were willing to submit reviews because they were concerned about blowback from their vendors for bad reviews. Several members who reviewed products were contacted by vendors about those reviews. Some reviewers asked to edit their review after it had been submitted—most likely after being contacted by their vendor. But even by providing physician reviews of EHR products, the physicians were not able to estimate their potential success with a specific product, because the implementation of an EHR is as important as, if not more so than, selecting the right EHR. By that time, members had very high adoption rates, AAFP’s focus changed from adoption to optimal use, and it was difficult to keep up with the selection resources and reviews, so AAFP partnered with AmericanEHR. Members are now directed to that site for EHR selection assistance.

Waldren recommended a focus on the following key aspects:

- Include a prominent social component to the comparison tool
- Include robust information about compatibility of systems
- Focus on the capabilities providers need to offer not on the individual functions of the EHR
- Create a common infrastructure to be used by multiple medical societies and others
- Make the testing and evaluation granular and transparent

Q&A

Tashjian wondered about developing and using a set of standardized use cases for each specialty. Brookstone said that there are approximately 10 specific questions to address to a specialty or subspecialty. Responses can be used for comparisons. Comparison by use case would not work because of differences in implementation and optimization. Another panelist talked about asking a user for six ways in which they expect to use the product. The first three are given to the vendor for customization. Then one can consider whether the product would work without customization. Hettinger noted that although a wide variety of cases are available on CHPL, there is not always sufficient detailed information. The system must lend itself to testing for errors. NIST is working on standardized use cases. Hess responded that interviews with a representative sample of customers are necessary in order to collect information on the numerous variables involved. Trivedi talked about going above and beyond the testing report and getting the vendor to demonstrate how functionality was tested. It is important to distinguish attestation and evidence.

Ferrer asked Hess whether KLAS reports are free. How deep was the study on usability? Hess noted that during his testimony, he acknowledged that the reports must be purchased. ONC licenses all reports and data. Responders are anonymous and given free access to reports. Vendors are required to pay and given information on customers’ reports on their specific products. The products are rated on implementation. The compiled information goes far beyond opinions. KLAS is always looking for insightful questions. Ferrer wondered how a user could get information on ease of data entry. Hess responded that a user could agree in advance to be interviewed. Brookstone observed that a way to know who is using which version of a product is needed so that the user can be surveyed quickly. Hess added that knowing how long a version has been in use is also critical.

Ross asked Waldren about the fourth point in his written submission: Would medical societies cooperate in the design and use of a comparison tool? Waldren said that his comment may be aspirational, although several societies have indicated interest. In contrast to federal agencies identifying the factors for comparison, medical societies have the expertise and the trust to do so. Some

stakeholders say that the provider community needs to step up and take control. Ross asked about point 3: “Are you talking about use cases?” Waldren responded that he avoids the term “use case,” which has multiple meanings. He focuses on the goals and capabilities of a practice and its gaps. He does not think about individual functions first. Medical specialties, KLAS, and others must be involved in finding a solution.

Stack wondered whether currently available tools are sufficient. He also asked whether the panelists see cloud-sourced content for ratings and filters as useful for HIT. Ratwani responded that, as described in his testimony, current tools are not adequate. The first step is to make data more available in order to make comparisons in a way that is not burdensome to vendors. Many tools are overly dependent on opinions. Ratwani said that although we may never have the right tool, we need work to shed more light on the picture. Waldren agreed, saying that the entire system must be considered. Reducing the risk of purchasing the wrong product will help the market. Hettinger declared that by giving information, vendors can compete on usability. Brookstone commented on crowd sourcing, saying that multiple sources of data are essential. No single organization can do this alone. A key is to use information from validated users. Trivedi interjected that a way to contact users for additional information is needed—something like Amazon.com. Hess talked about convening groups to respond to questionnaires as the best way to close gaps in health care. Even though they may be competitors, individuals are willing to respond to questions. The KLAS approach is to ask the right questions first and then test.

Panel 5: Quality Improvement and Alternative Payment Models (APMs)

Panelists were asked the following questions:

- How might a comparison tool be implemented that would guide providers to select certified health IT components necessary for quality improvement and/or APM participation?
- What specific health IT modules are relevant for APM participation?
- What information do providers need to know when selecting certified health IT to be used for quality measurement reporting?
- What kinds of health IT-related APM or care coordination capabilities do you think should be available for comparison?

Kathleen Blake, American Medical Association, showed slides. She said that a comparison tool is something for providers to use before purchase. The effect on the physician user should be the main consideration. Products must have ease of measurement. The expectation is that a better comparison tool would lead to better EHRs, which will contribute to better patient outcomes. She made the following recommendations on what to compare:

- User experience (number clicks; time to complete; overall satisfaction)
- Quality measurement
- Measures implemented (specialty specific?)
- Ease of measurement
- Timeliness of performance feedback (opportunity to fix)
- Dashboards (my performance; benchmarks)
- Access to registries relevant to my practice
- Participation in APMs (in flux)
- Appropriate use criteria (clinical domains)
- Clinical decision support (breadth, quality)
- Formulary and plan updates (frequency)
- Referral management as a test case for interoperability

Jesse James, Evolent Health, showed slides and described his company as representing the viewpoint of providers, payers, and data aggregators. He said that a comparison tool would be useful for all three. He recommended starting with existing tools. Tools should be Web based and have frequently updated searchable content. Physicians may be the first users; others may come later. APMs should determine

for themselves which modules serve them best. There is a need for tools that can support multisource data warehouses and are flexible regarding modules for export and import. Adherence to national standards is important, as well as quality measure calculations. A system should be able to create measures and support analytics, including stratification by patient and provider characteristics. Financial forecasting is another important function. More than an EMR is necessary. James advocated a light but firm touch.

Simone Karp, CECity, submitted written testimony. She emphasized that EHRs must support high-fidelity data, bidirectional data and information exchange, and timely data. Fidelity means the extent to which the data being aggregated are accurate, valid, organized, packaged into a standard file exchange format, and exported for use in various quality programs. EHRs should support bidirectional data and information exchange, which means interoperability and the capability to send data seamlessly from the EHR to external quality-focused IT systems, such as public health registries. Real-time data are essential as the health care system moves from annual quality reporting programs to APIs, clinical data registries, and other continuous quality improvement (CQI) initiatives. Karp recommended that EHRs be capable of supporting data aggregation and exchange at a cadence that meets the needs of the emerging quality programs. By presenting these capabilities through the EHR comparison tool, providers will be able to understand better in advance which programs they are prepared to participate in.

Q&A

Somplasky asked about comparing the capability for clinical quality measures. Karp replied that testing of the data is required to support APMs. James said that the size of the organization affects IT needs. Large organizations have the resources to create and validate metrics. They are forced to do so. APMs will likely figure it out and use priority code sets. Smaller APMs need to have vendors held to higher standards than they currently are. There must be confidence in output. Blake said that users have different perceived needs, which is why it is important to ask for whom the tool is intended. At a minimum, a system will report accurately on required measures. AMA surveys indicate that 60% of physicians are in one- to two-person practices. These are the users who need help. Somplasky asked whether the quality measure reporting will come from the EHR or some other module. Blake said that in some cases, reporting is via a registry, so it is essential that EHRs can exchange with registries. Karp said that APMs will need various EHRs to be able to exchange with several registries.

Ross referred to concerns about regulations being overly prescriptive. The APM is a new frontier. He wondered how to take into account concern with regulatory restrictions. Blake responded that the factors that she noted in her testimony are necessary for APMs. For clinicians, the issue is incorporation into workflow. An AMA-Rand survey found that physicians want to use EHRs but want use to be easier. Karp agreed: Having reliable, bidirectional data is essential to using data to deliver care. According to James, the purpose of APMs is to improve quality and decrease cost. Financial interests are aligned with HIT, payers, and patients. The metrics desired are not necessarily the same as those required at the federal level. Therefore, a lighter touch is important. Ross responded that, since the federal government is the payer with Medicaid and Medicare, a lighter touch is not realistic. James said that the ACO model is appropriate. The federal government seems to be willing to ask for less information in lieu of evidence of better quality and lower cost. The trend is to reward those systems that show progress by requiring less reporting.

Travis inquired about APMs and registry reporting. Considering a comparison tool for small practices, what information not currently available would be helpful? Karp referred to the three things mentioned in her testimony. Fidelity of data will contribute to easily calculated measures for reporting. Users also want to be able to calculate measures that matter to the practice. Timely data are needed for CQI. James talked about consistently populated and validated data elements across multiple systems being useful. Travis continued: What should be made transparent about audit methods and means of validation? He referred to a CMS RFI on measure specification. Blake replied that physicians want information such as the rate of acceptance of submissions and the rate of required modifications. They

understand that there is a learning curve and would like to know how long the curve is. They want to know the number of similar practices that are using the system. Karp added that showing validation of data across measures and gaps in care for improvement are important for users.

Tashjian said that he expects and must assume that the data from his system are accurate out of the gate.

Closing Remarks

Somplasky thanked the panelists. Ross noted several themes in both hearings. Better support can be given to providers in using automation and digital tools. The purchase environment is extremely complicated. Engagement of stakeholders is important. Travis added that the panelists had informed the task force about various resources for a selection tool. They reinforced the importance of a peer-to-peer conversation to evaluate EHRs. Joe Wivoda observed that there was a lot of content to absorb. Panelists were not all of the same opinion, especially regarding the role of government in a selection tool. More analysis of and information on usability are needed. Comparison for specialty EHRs should be on value rather than modules. Stack agreed with Wivoda.

Next Steps: The task force is scheduled to meet January 19 to draft recommendations for submission to the HITPC-HITSC on January 20. Staff will compile and distribute materials for the January 19 meeting.

Public Comment

David Tao (ICSA Labs) submitted three written comments via the chat box: “I have these comments, divided into multiple messages. This is David Tao from ICSA Labs. Thank you for seeking the testimony of a variety of stakeholders, and for your effort to make life easier for providers. I commend your prioritizing the capabilities of the tool rather than saying everything is necessary. I hope you will also recommend time to market, and the price that can the market can bear. Any developer of this tool – or an existing tool developer looking to enhance it – needs to make tradeoffs among the ideals of ‘fast, good, and cheap’ – in other words, time to market, product capabilities, and cost. The saying goes, ‘pick two of these’ because you can’t have all three as you’d like.”

“Unless there’s guidance for when the tool must become available, how often and quickly it should be updated, and the maximum acceptable cost, the tradeoff can’t be made. This information would also impact the choice of building a new tool vs leveraging existing tools. Price is usually related to development costs spread over the anticipated market, so more features typically increase cost and time to market. I hope the Task Force will consider these points in your final recommendations.”

“Secondly, it may be late in the game, but I suggest that physician and other provider end users be involved in usability testing of the Open Data CHPL prior to its release, and that similar usability testing be done for future CTC tools, following similar principles to those required for EHRs. Thanks for the opportunity to comment.”

Flag to ONC Staff for Coordination: None

Meeting Materials

- Agenda and questions
- Panelist bios
- Written testimonies
- Presentation slides

Attendance

| Name | 01/15/16 | 01/08/16 | 01/07/16 | 12/01/15 | 11/17/15 |
|-----------------|----------|----------|----------|----------|----------|
| Anita Somplasky | X | X | X | X | X |

| | | | | | |
|----------------------|---|---|---|---|---|
| Christine Kennedy | | X | X | | X |
| Christopher Tashjian | X | X | X | X | X |
| Christopher Ross | X | X | X | X | X |
| David Schlossman | X | X | X | X | |
| Dawn Heisey-Grove | X | X | X | X | X |
| Elizabeth Johnson | | X | X | X | X |
| Joe Wivoda | X | X | X | X | X |
| John Travis | X | X | X | X | X |
| Jorge Ferrer | X | X | X | | |
| Steven J. Stack | X | X | X | X | X |