The Office of the National Coordinator for Health Information Technology

Health IT Policy Committee

Request for Comment Summary

February 20, 2013

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Comment review process

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- RFC posted on ONC website November 16, 2012, comment period closed January 14, 2013 at 11:59pm - 60 days
- ONC staff has been vigorously working to review and summarize comments
- February 6th HITPC
  - High level review of public comments
  - Feedback from the HITSC
- Following HITPC meeting, workgroups will conduct a deep dive of public comments and HITSC feedback

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Meaningful Use

Michelle Consolazio Nelson
Meaningful Use Workgroup Lead

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Comments

- 606 Comments
- Types of organizations that commented
  - Allied professional organizations
  - Consumer organizations
  - EHR consultants
  - Eligible hospitals
  - Eligible professionals
  - Federal agencies
  - Other (e.g. REC community, individual citizens)
  - Payers
  - Provider organizations (clinician and institutional)
  - Vendors
  - Vendor trade groups

Overarching Themes from Comments

- Focus on clinical outcomes in Stage 3
  - Empower flexibility to foster innovation, limiting the scope of recommendations
  - Too much focus on functional objectives
  - Recommendations are too prescriptive
- Concerns about timing
  - Experience needed from stage 2 before increasing thresholds, accelerating measures, or moving from menu to core
  - Concerns about the readiness of standards to support stage 3 goals
- Address interoperability limitations
- Meaningful Use is one component of provider responsibilities
  - Continue to invest in quality measurement alignment, infrastructure and standards
- Ensure that patient safety remains a high priority and any related requirements are synchronized with Meaningful Use
- Make use of all technology available, everything does not need to happen in the EHR
- Many commenters were confused by certification criteria only items

Overarching MU Comments

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ID#	Summary

MU 01	**Is there flexibility in achieving a close percentage of the MU objectives, but not quite achieving all of them?**
	• 75 Comments
	• Most commenters urged the HITPC to recommend more flexibility in the MU program
	  • Flexibility will be important for full year reporting
	  • Recommendations that providers be considered in compliance if they meet 75 percent of the objectives

Overarching MU Comments

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ID#	Summary
MU 02	**What is the best balance between ease of clinical documentation and the ease of practice management efficiency?** • 59 Comments • Most commenters favored improvements in overall usability that could be expected to make this balance more manageable. • Natural language processing (NLP) was identified as an usability improvement, • Possibility to reallocate practice workflow to evenly distribute the work and increase overall practice efficiency • There were a number of statements that the question was beyond the scope of the Meaningful Use program

Overarching MU Comments

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ID#	Summary
MU 03	**To improve the safety of EHRs, should there be a MU requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance?** • 63 comments • Overwhelming opposition to a MU requirement as premature, but support for the need for EHR users to do a safety assessment

Overarching MU Comments

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ID#	Summary
MU 06	**What can be included in EHR technology to give providers evidence that a capability was in use during the EHR reporting period for measures that are not percentage based.** • 48 Comments • Commenters generally agree that EHRs should be able to track usage for yes/no measures • Many suggested that the audit log would be an appropriate functionality for tracking usage and that providers should have only 'read-access' to the log • Commenters equally noted the difficulty in tracking activities that occur in the EHR and those that occur outside the EHR

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Information Exchange

Kory Mertz
Information Exchange Workgroup Lead

HealthIT.gov

Information Exchange Workgroup

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ID#	Summary
IEWG01	**Query for patient record** • 102 comments • Many commenters expressed support for the inclusion of this objective in Stage 3. • Quite a few commenters seemed confused about the focus and scope of this objective. Many seemed to think it was focused on requiring providers to utilize a HIO leading to concerns about the level of access to fully functional HIOs. • Quite a few commenters expressed the need to complete additional work around the privacy and security implications of this objective. • A number of commenters stated that HIE/HIOs should be able to support providers in achieving this objective. • *Measure*: The majority of those who commented on the measure suggested it should be based on a percentage. Requested additional detail on how the measure will be calculated. • *Patient matching*: A few commenters on this objective requested ONC establish explicit standards to support patient matching. A few commenters felt it was important to establish a national patient identified to support correctly matching patients for this objective.

Information Exchange Workgroup

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ID#	Summary
IEWG02	**Provider directory** • 62 comments • Most commenters agreed that there are not sufficiently mature standards in place to support this criteria at this time. • Comments were fairly evenly split on if the criterion should be kept in Stage 3.
IEWG03	**Data portability** • 56 comments • The majority of commenters felt this criterion was important and that further progress needed to be achieved around data portability. • Requests for a variety of data elements to be added common themes were to ensure new data elements included in Stage 3 be added to this criterion and that any historical data required to calculate Stage 3 CQMs be included as well. • A number of commenters felt this criterion was unnecessary or duplicative of other criteria. • A few commenters questioned if this criterion would add significant value as substantially more data would need to be migrated to maintain continuity.

Information Exchange Workgroup

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ID#	Summary

MU05	**The HITECH ACT has given a lot of emphasis to EHRs as the central distribution channel for health information, but there may be limits on how much we can add on to EHR technologies. As additional program demands are added onto EHRs, what can be done to foster innovation to share information and receive intelligence from other, non-EHR applications and services that could be built on top of that data architecture?**
	
	For example, Is it possible to create an application programming interface (API) to make available the information defined in a CCDA so that systems can communicate it with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information? Are the standards used to communicate between EHR systems (e.g. Direct, Exchange) adequate for communication between EHRs and other kinds of systems? What other technologies, standards or approaches could be implemented or defined to facilitate the sharing of clinical knowledge between EHRs and other systems?
	• 78 comments
	• There were many suggestions for what can be done to foster innovation. Key Points that were identified in the comments were:
	  • Implement standard interface specification to support integration for the EHRs and other systems
	  • Differing views on CCDA and Direct and Exchange ability to communicate between EHRs and other kinds of systems.
	  • Believe that publishing of healthcare APIs will speed the development of truly integrated systems

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Quality Measures

Jesse C James, MD
Quality Measures Workgroup Lead

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Step Back and Look Forward

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For Stage 2 the QMWG contributed CQM sub-domains and concepts to the RFC and Transmittal Letter.

For Stage 3 the QMWG intended to take a broader view of HIT enabled quality measurement.

Conceptual Framework

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Purpose	E-measures	CQM Pipeline	QI Platform
• What problem are we trying to solve?	• How do we achieve this with better measures?	• Which measures should we choose?	• How can we better leverage CQMs for QI?

In the RFC for Stage 3 the QMWG tested these ideas with the general public.

Conceptual Framework

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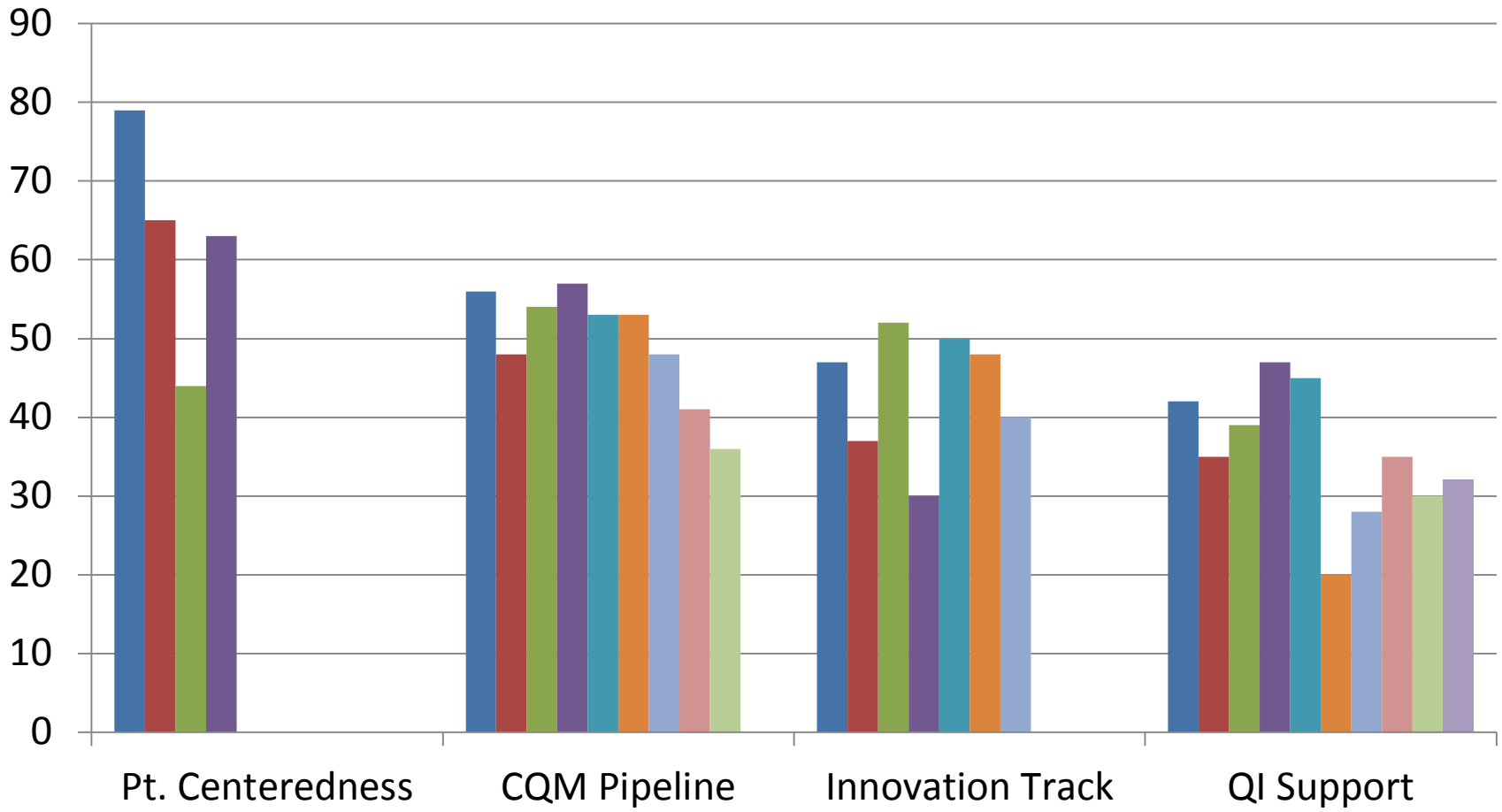
Purpose	E-measures	CQM Pipeline	QI Platform
• **What problem are we trying to solve?** • How de we stay patient centered? •How should we engage with a broader group of stakeholders? .	• **How do we achieve this with better measures?** **- Package Process-Outcome suites** **-Develop *de novo* instead of legacy CQMs** -Align CQMs and components with functional objectives	• **Which measures should we choose?** -Review Prioritized Domains -Identify Exemplars: Expand or Refine **-Promote innovation: ”Democratize “ the measure set**	• **How can we better leverage CQMs for QI?** -Support consistent novel architecture and standards to meet provider QI needs **-Encourage development of Population Management Tools**

In the RFC for Stage 3 the QMWG tested these ideas with the general public.

Comments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Pt. Centeredness
CQM Pipeline
Innovation Track
QI Support

Purpose and Engagement
QMWG 01-08

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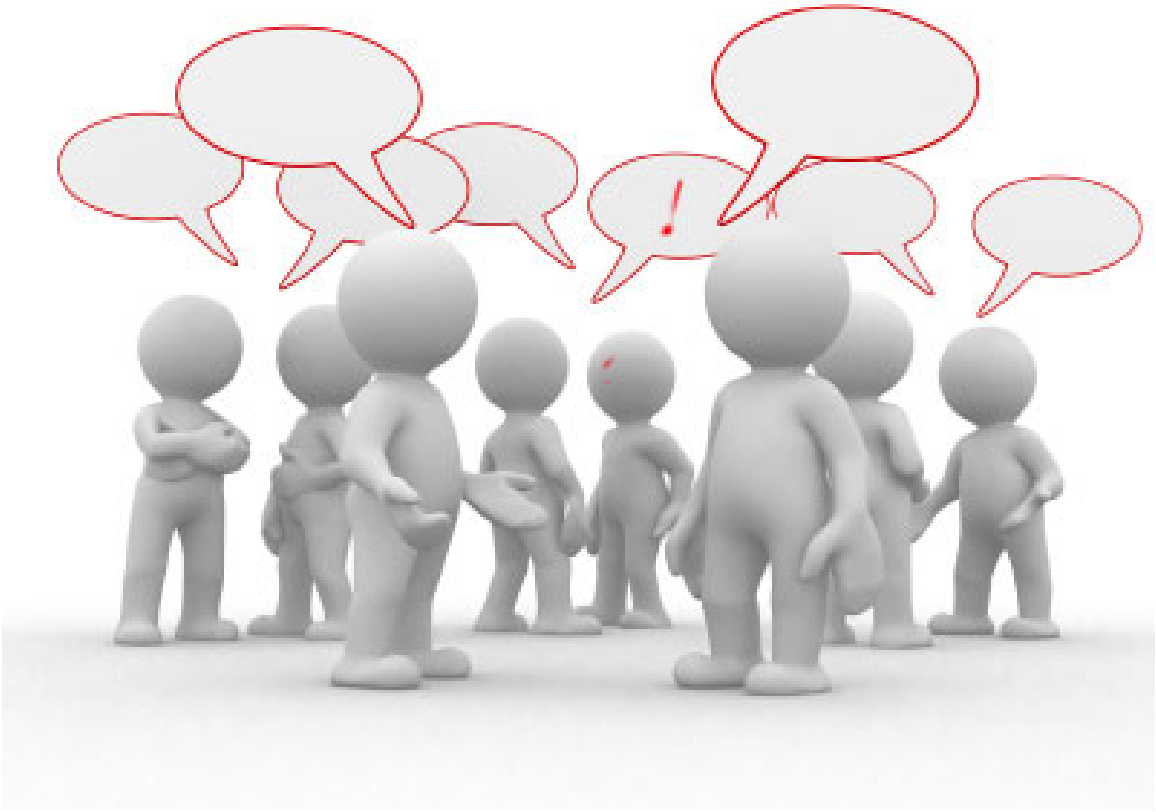
The QMWG intends to capture insights broadly from stakeholders and actively engaged as providers, purchasers and recipients of care.

- **How should the HITPC and QMWG capture input from a wider variety of providers, patients, organizations and societies?**

- **What additional channels for input should we consider?**

Stakeholder Engagement



Stakeholder Engagement-Nearly all of the 56 commenters encouraged the HITPC and QMWG to actively seek input from a broad variety of stakeholders.

Purpose and Engagement

- **Active Outreach Strategies for Stakeholder Engagement** – many felt the RFC and open meetings are a "great start"
  - **Social media**
  - Webinars
  - Open forum per measure
  - **Outreach to professional societies and patient advocacy groups**
  - Establishing an "e-measure steering committee" (Federation of American Hospitals)

The majority of the responders agreed that increased patient input is necessary to improve quality measurement.

eCQM: Process and Outcome QMWG 09-10

The Quality Measure Workgroup in the October 2010 "Tiger Team Summary Report" and the December 2010 Request for Comment, has previously described our intention to support HIT-sensitive, parsimonious, longitudinal, outcomes-focused CQMs.

- Should the HITPC focus its efforts on building point-of-care **process measures** or value-centered **outcome measures**?
- Should we instead consider a third approach, to promote **process-outcome measure "suites",** combinations of end outcome measures that are potentially associated with process measures?

eCQM: Process and Outcome QMWG09

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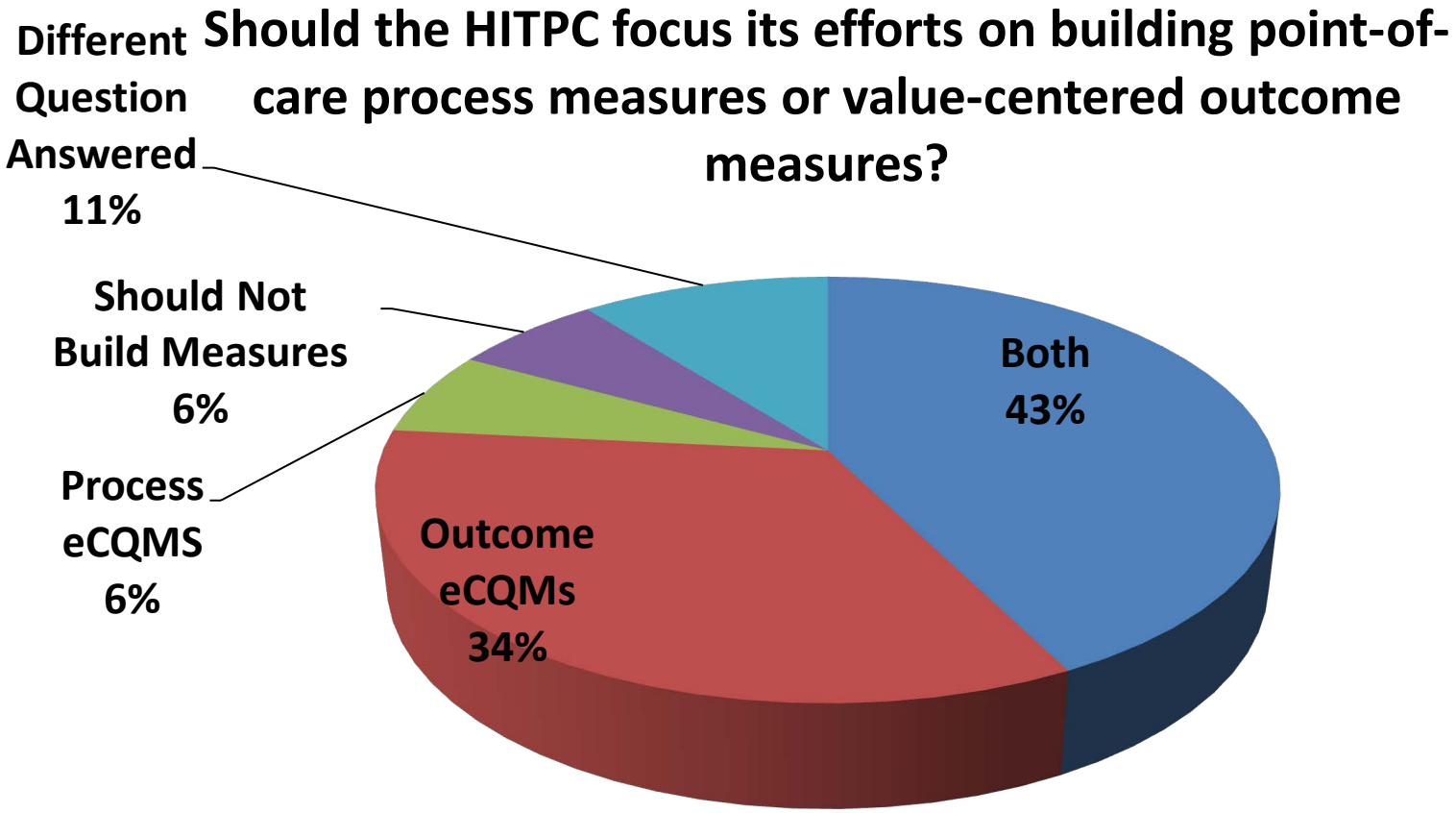
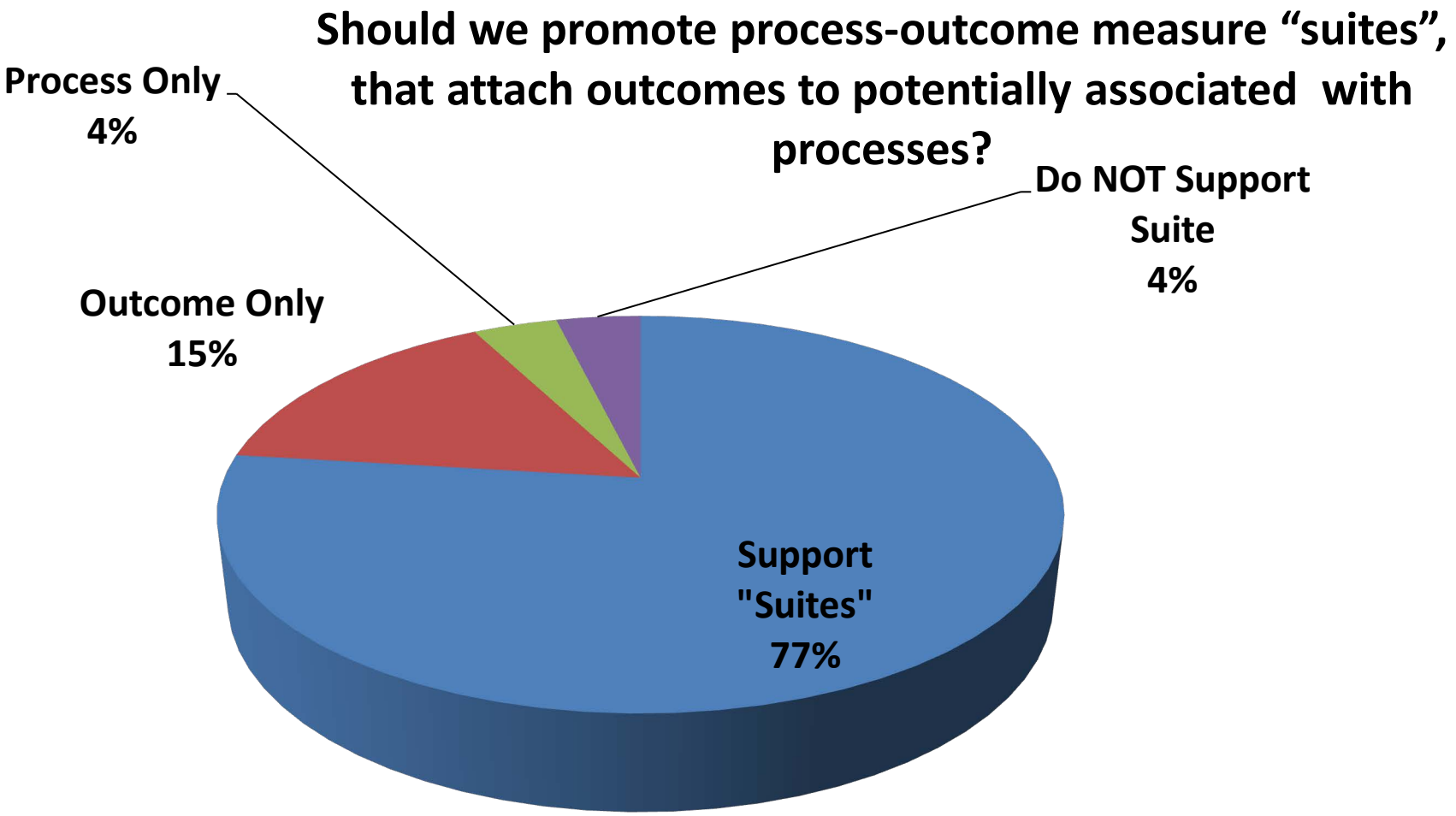


eCQM: Process and Outcome QMWG10



eCQM: Process and Outcomes Insights

For HITPC Consideration/General Suggestions

- Outcomes should be the focus. Providers need freedom to choose processes that will allow them to achieve
- It is critically important that pediatrics be included in the development of such suites
- Include specialist expertise to ensure relevance of measures clinically and for patient perspective
- Quality improvement should shift from quality measurement to registry reporting

eCQM Suite will be Challenging

- Suites may require the same denominator for each measure.
- Complexity can hinder reporting

"Suites" are an opportunity for Research

- Use measure suites to evaluate strength of relationship to outcome. With time, refine the process measures used in the suites.
- Preventive health measure suite. To capture - screening, counseling, referral, and follow up

eCQM: *de novo* or Legacy QMWG11-12

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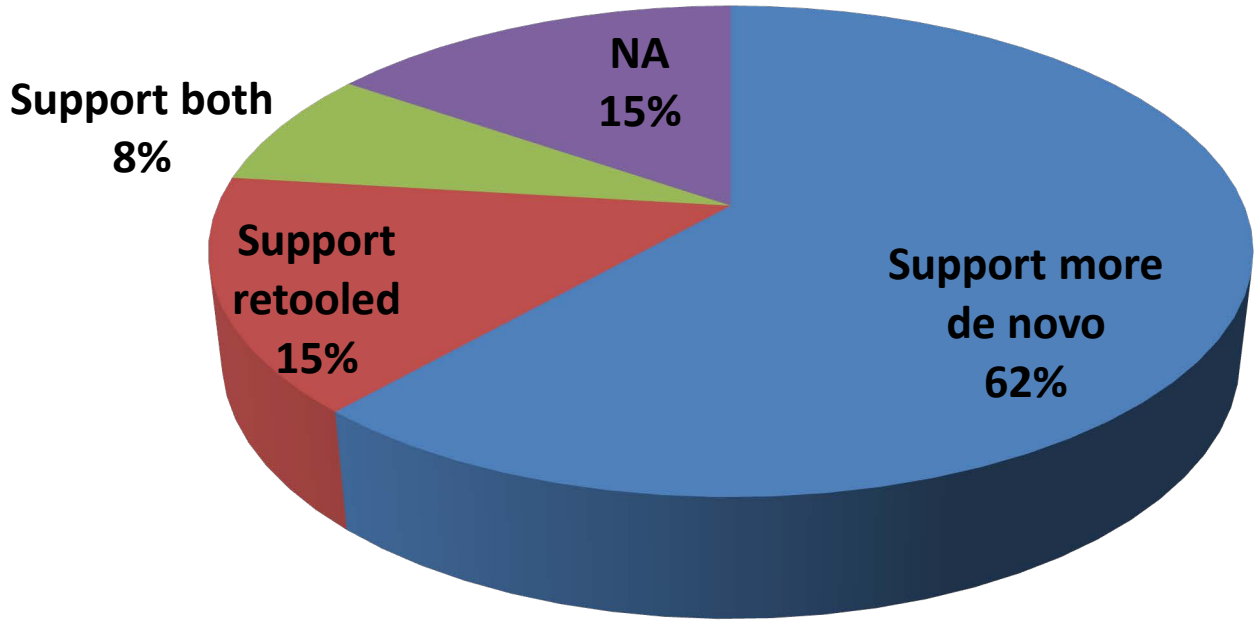
The QMWG will make recommendations both on the types of measures that are developed and on the process for measure development. The QMWG understands that "retooling", the process of translating legacy measures into XML code, at times does not fully preserve the original intent of measures and measure components (logic and value sets). Furthermore, retooled measures often do not take full advantage of the richness of clinical data in the EHR.

- Please comment on challenges in retooling legacy paper abstracted and claims based eCQMs.
- **Is a shift away from retooling legacy paper-based CQMs in exchange for designing eCQMs *de novo* a reasonable and desirable course of action?**

eCQM: *de novo* or Legacy QMWG12

Should development continue with de novo or retooled claims/abstracted measures?



eCQM: *de novo* or Legacy Comments

- Boston Medical Center – "In contrast to legacy paper measures we have found that the de novo measures, if well designed, are easier to complete."

- HIMSS continues to call attention to the increased burden on the provider to collect data for both manually abstracted measures and eMeasures, and we continue to urge the HIT Policy Committee to reduce this burden.

- Kaiser Permanente - There are too few de novo measures designed and intended for EHR-based measurement to provide an informed comment.

CQM Pipeline: Innovation Track QMWG18-24

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To leverage CQM innovation from health systems and professional societies, the QMWG has discussed a proposal to allow EPs or EHs to submit a innovative or locally-developed CQM as a menu item in partial fulfillment of MU requirements. Health care organizations choosing this optional menu track would be required to use a brief submission form that describes some of the evidence that supports their measure and how the measure was used in their organization to improve care.

- We have considered two approaches to provider-initiated eCQMs.
  - A conservative approach might allow "Certified Development Organizations", to develop, release and report proprietary CQMs for MU.
  - An alternate approach might open the process to any EP/EH but constrain allowable eCQMs via measure design software(e.g., Measure Authoring Tool).
- What constraints should be in place?

eCQM Innovation Track
QMWG 18

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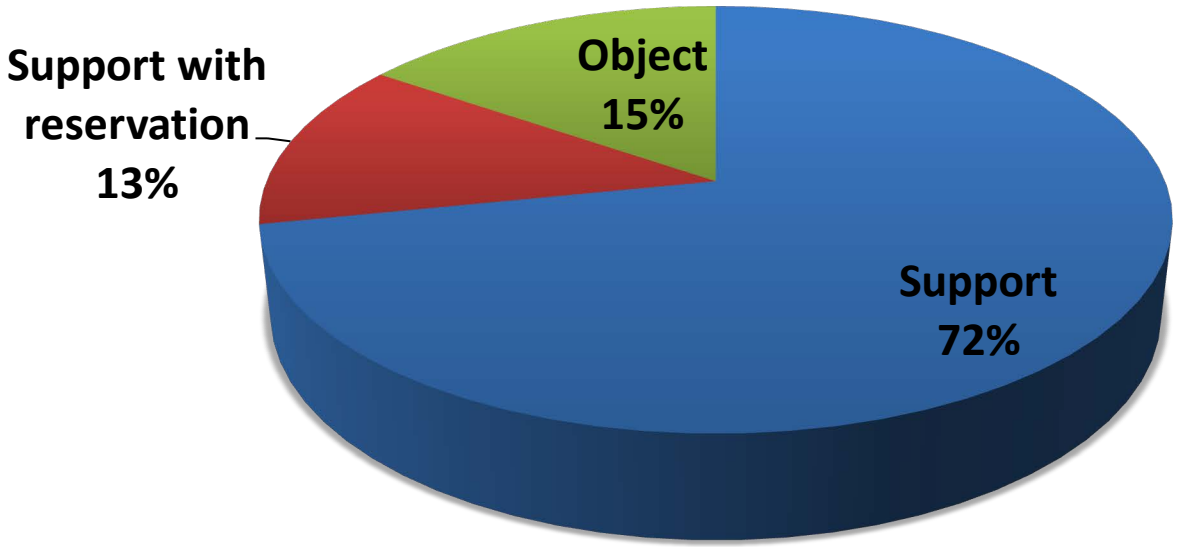
Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.



eCQM Innovation Track Insights

- **Support Innovation Track: 28 comments**
  - **"We fully support this concept,** as it fosters provider level innovation and rewards them for their efforts…**We have found that QI departments want to continue their work and use MU as a stepping stone**." -Boston Medical Center

- **Support…with reservations: 5 comments**
  - "We would **find this to be a very challenging way to develop CQMs**. However, we do believe organizations should be recognized for their innovative work and be paid additional dollars for that work if it is broadly applicable."-Geisinger

- **Do Not Support: 6**
  - "CHIME recommends the MU Stage 3 not engage in the development of new quality measures …"

eCQM Innovation Track
QMWG 19

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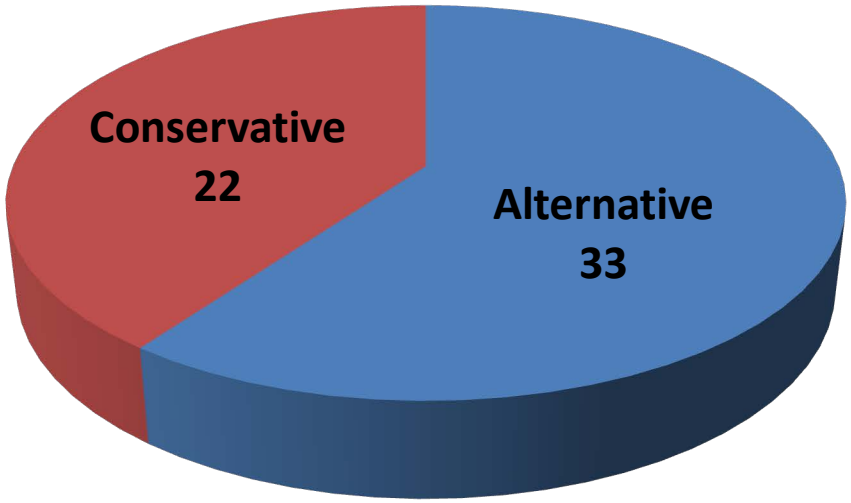
Should we pursue a conservative approach that limits development to professional societies and IDNs ? Or an alternative that opens the process to any EP/EH within certain constraints?



eCQM Innovation Track Insights QMWG19

Conservative approach(22)

- **"We encourage HITPC/ONC to consider the more conservative approach,** which would **encourage adoption and use of EHRs among professionals by ensuring more relevant and feasible CQMs developed directly by professional societies** while also **ensuring a minimum level of consistency** among members of the same specialty so that the data could be analyzed over time for trends and patterns related to performance." -American Osteopathic Association

Alternative approach: (33)

- **"Flexibility needs to be given for the organization itself to determine its own high priority conditions** and report on CQMs relating to those conditions, preferably using a national measure if one exists already but if not, using its own proprietary measure. " -VA
- **"The innovation of eCQMs should be open to all stakeholders who wish to improve the quality of healthcare outcomes**. However, the design standards should include oversight to ensure the consistent creation of eMeasure specifications." -Federation of American Hospitals

eCQM Innovation Track
QMWG 21

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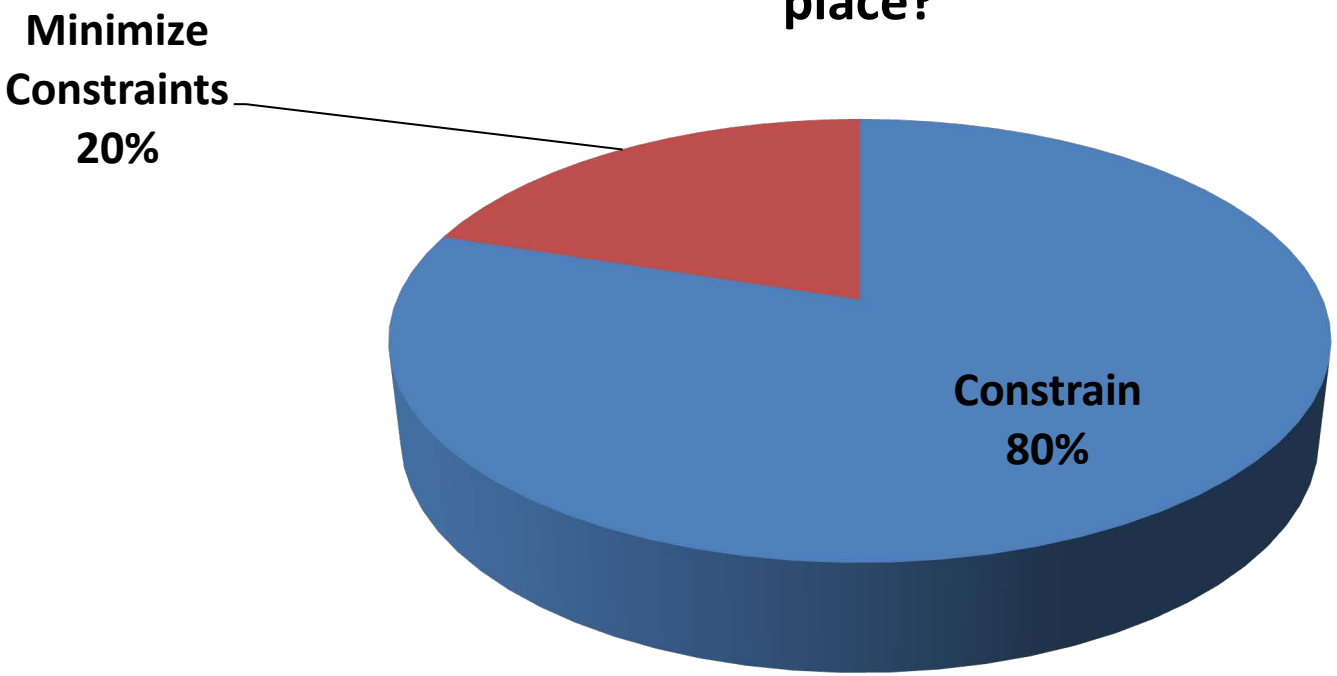
Should we constrain development in the innovation track with standards for e-measures that are already in place?



eCQM Innovation Track Insights
QMWG 21

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- **Constrain to existing Standards and tools for eCQM development: (20)**
  - **Children's Hospital Association**: "Some reasonable constraints, such as conforming to the Quality Data Model, would seem appropriate. Again, the balance between fostering innovation and measurement that is meaningful with allowing comparability across providers and hospitals is one that needs to be carefully thought through. It would be helpful to think through a trajectory for how locally developed measures could become more widely used and disseminated…"
  - Greenway; "If the end goal as stated is to assess innovation, the next logical goal would be to leverage any findings back into the program… **A simple HQMF** would be the minimum level of detail needed to allow for decomposition and ensure reuse in the future. We encourage the use of the **Measure Authoring Tool (MAT) to ensure consistent use of Values sets and QDM elements…"**
  - The Joint Commission: **the use of standardized quality measures, ensures, at least to some extent, comparability of the data across healthcare providers and supports measure alignment across settings**
- **Have no constraints, maximize innovation in measures that fit clinician need: (5)**
  - MN Department of Health: ""100% of the measures should not be constrained. That may stifle innovation. Instead, allow a very limited number with the understanding that the measure logic would be submitted along with the measure result. "

QI Support: Population Management QMWG 28-30

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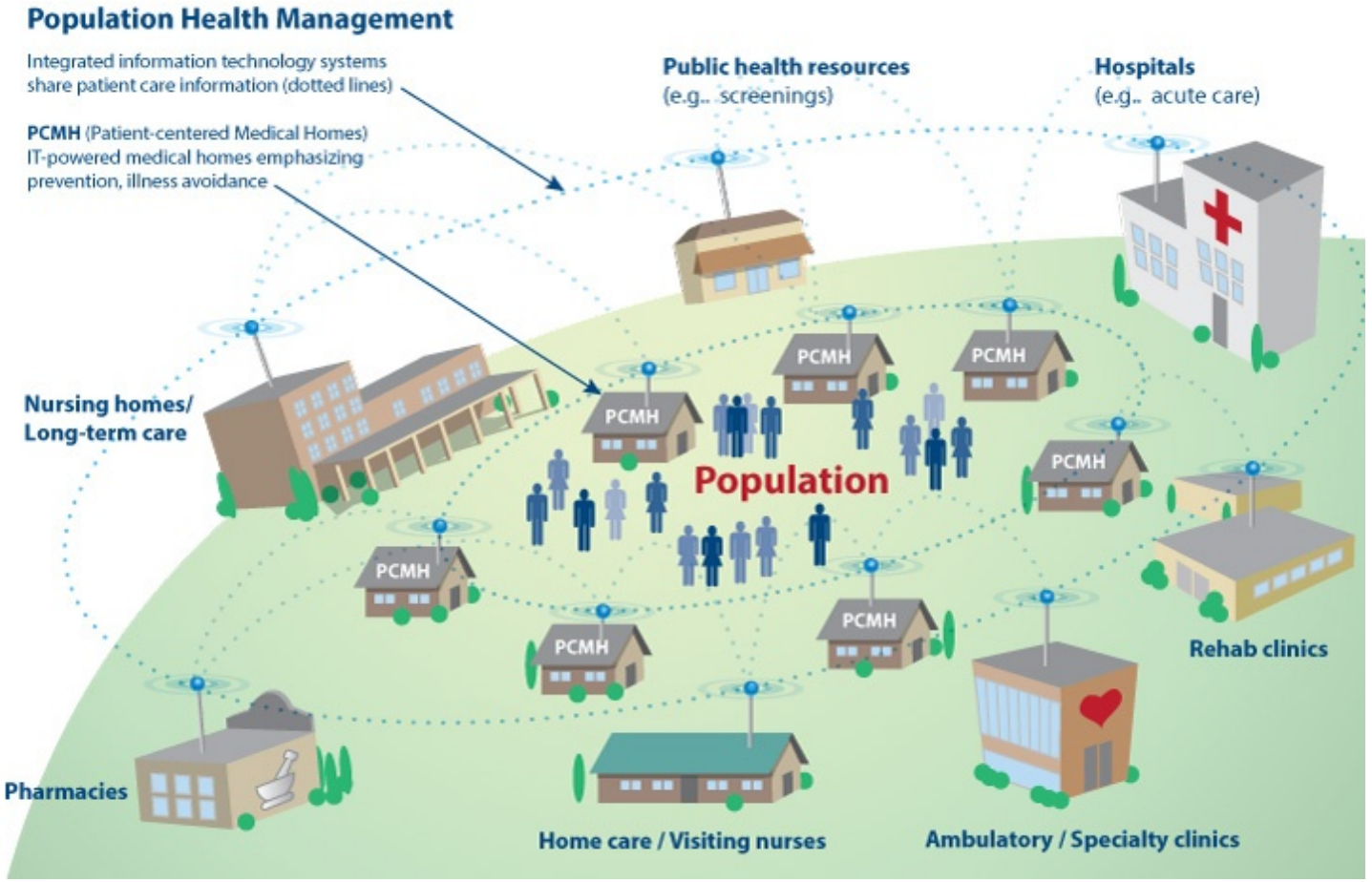

There is strong support for population management software to leverage ECQMs for QI.

QI Support: Population Management QMWG 28-30

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The QMWG intends to encourage the development of HIT tools that leverage use of eCQMs for population management. The work group is especially interested in development of CQM population mapping and task-management platforms that allow users to view, track, and identify care gaps and assign tasks both for individual patients and for user-determined cohorts. The workgroup understands that this technology is desired by providers and requests comments on the potential role of the HITPC and HHS in this space.

- **Please comment on the value of these tools. Is there a sufficient evidence basis for clinical population management platform use? Is there a business case?**

- **What are the technological challenges to widespread release and adoption? Can the HITPC encourage technology in this area without being prohibitively prescriptive?**

QI Support: Population Management QMWG 28

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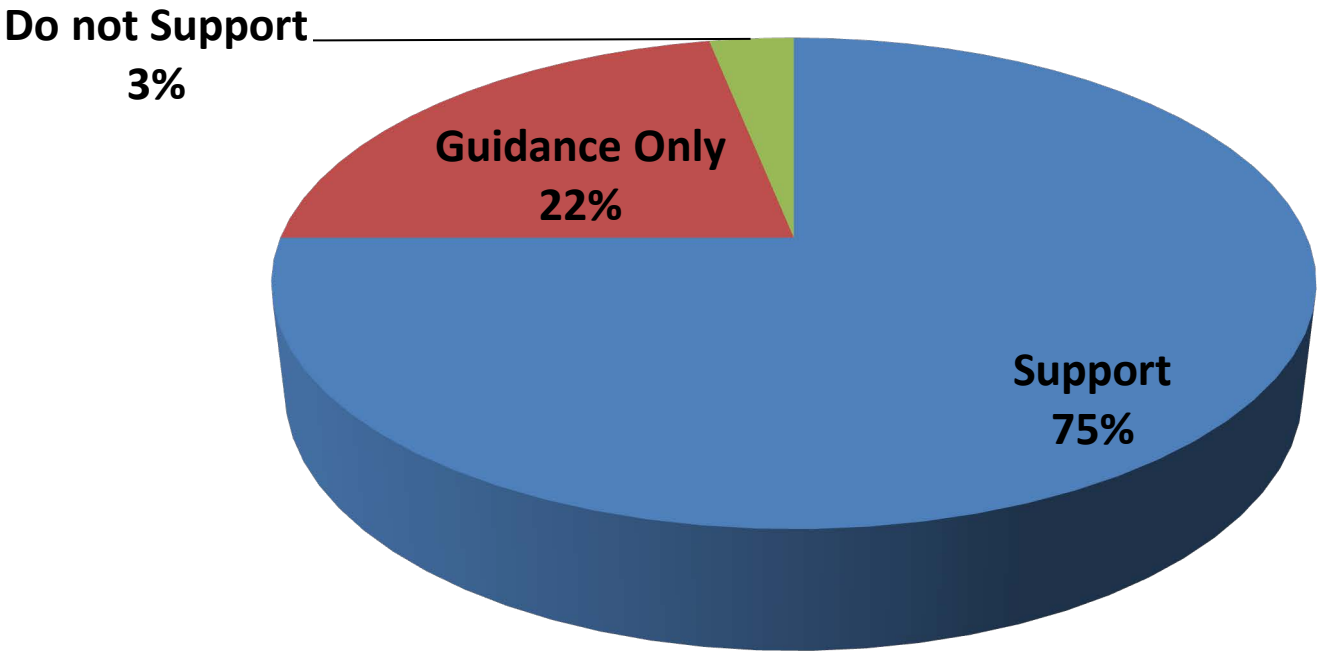
Please comment on the value and feasibility of eCQM Population Management Platforms.



There is broad consensus that a business case exists for population management platforms.

QI Support: Population Management QMWG 28

- Support Population Management Software and standardization:
  - The majority of commenters (24), especially the providers, feel there is a role for increased standards and possibly certification for population health platforms or features.
  - Demonstrated evidence and value- a number of commenters provided specific evidence of value, especially in chronic disease management, managed care and public health
  - A few commenters, especially software companies and some organizations, worry that the market and standards are too immature for certification at this time.
    - They propose a combination of guidance, incentives and grants with continued work on data and interoperability standards (7) rather than certification.

QI Support: Population Management QMWG 28

- "Population management tools should be part of CEHRT. The market will likely lead to the development and implementation of these tools as ACOs and CCOs pick up steam. **However, HITPC can and should set a baseline for functionality of such a system**." Tom Yackel- OHSU

- **"We feel that there will be a role for this type information from a population management platform for ACOs.** Since this is a recommendation we suggest that HITPC takes this back to the industry to look into this issue and talk to providers to see what they are expecting." - AHIMA

- "Given the immaturity of this market, CHIME believes it is better **to let the market evolve** without further federal involvement at this time. The technology is not currently available, and there would be additional cost."

Recurring Themes

- Listen more…engage with specialty societies and patients
- Go *de novo*
- Liberate the data…and the providers
- Care coordination, patient engagement, and safety should be high priority domains for development

Discussion

To members of and contributors to the QMWG:
We appreciate the your time, insight, suggestions, comments and edits.
Thank-you,
-ONC Staff

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Privacy and Security

Will Phelps
Privacy and Security Workgroup Lead

HealthIT.gov

PSTT01 Summary:
Re-use of 3rd Party Credentials

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PSTT01 - How can the HITPC's recommendation be reconciled with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification which strongly encourages the re-use of third party credentials?

- 41 comments received
- Many comments state that strong identity proofing and multi-factor authentication should be required for MU3 and that the NSTIC Model can be adopted in healthcare
  - Existing standards such as NIST SP 800-63, CIO Council Guidance, FEMA, and OMB, and DEA standards are suggested for consideration
- Some comments do not believe that multi-factor authentication should be required for MU3 citing that:
  - The deadline to implement is unrealistic
  - The requirement would introduce burden and increased costs, especially on small providers
  - Multi-factor authentication is not a core competency of EHRs

PSTT02 Summary:
Certification Criteria for Testing Authentication

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PSTT02 - How would ONC test the HITPC's recommendation (for two-factor authentication) in certification criteria?

- 26 comments received
- Comments suggest possible approaches including:
  - Developing a checklist to verify the system set-up, while also requiring appropriate documentation
  - Requiring vendors to attest to having an architecture that supports third-party authentication and demonstrate examples
  - Checking for use of a federation language standard
  - Developing a model audit protocol for the community to use to self-test
  - Developing an iterative and phased testing program covers the population of organizations
- Existing standards and guidance that could be the basis of test procedures include:
  - DEA Interim Final Rule (IFR)
  - NIST 800-63
  - FIPS 201
  - HSPD-12
  - NSTIC/Identity Ecosystem Accreditation Standards
- One comment suggests that the domain is not mature enough for certification

PSTT03 Summary:
EHR Certification - Standalone or w/3rd Party

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PSTT03 - Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third-party authentication service provider?

- 30 comments received
- Many comments support both models
- Several comments suggest the EHR and third-party authentication service be certified independently of each other
- Logistic suggestions for the two models include:
  - Third-party dependencies could be handled the same way that database and operating system dependencies are handled in sectors such as the Payment Card Industry
  - In lieu of requiring certification ONC could implement NSTIC
  - Certification could be carried out to an ONC recognized healthcare trust framework by an NSTIC Accreditation Authority
  - Use external labs capable of and experienced in testing identity and authentication technologies in accordance with FIPS 201 for third party authentication providers

PSTT04 Summary:
MU Attestation for Security Risks

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PSTT04 - What, if any, security risk issues (or Health Insurance Portability and Accountability Act (HIPAA) Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3?

- 46 comments received
- Workforce security training:
  - Comments for - cite the importance of the workforce in keeping health information secure
  - Comments against - cite attestation is either burdensome or duplicative of the HIPAA Security Rule
- Safeguard and training areas to emphasize include:
  - Access controls
  - Audits
  - Data integrity
  - Encryption
  - Identity management
  - Implementation of backup and recovery plans
  - Policies and procedures related to prevention of local PHI storage
  - Malware on all workstations accessing EHRs and EHR modules
  - Social media, bring your own device (BYOD), and mobile devices
  - Local data storage security controls
- Some comments say more HIPAA Security Rule guidance and education is needed for providers

PSTT05 Summary:
Certification Standard for Audit Logs

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PSTT05 - Is it feasible to certify the compliance of EHRs based on the prescribed [ASTM] standard for [audit logs]?

- 30 comments received
- Majority of comments state prescribed standard is feasible
- Many comments focus on whether or not there should be a standard
  - Many comments suggest there should not be a standard yet
  - Some comments suggest MU standards premature until final Accounting of Disclosures Rule issued
  - Some comments say question implies combining audit log and accounting of disclosures requirements
    - Audit logs require more information than necessary for an accounting of disclosures

PSTT06 Summary:
Attestation for Length of Time Logs are Maintained

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PSTT06 - Is it appropriate to require attestation by meaningful users that such logs are created and maintained for a specific period of time?

- 37 comments received
- Comments suggest waiting until the Accounting of Disclosures Rule requirements are finalized before addressing attestation
- Comments supporting attestation also suggest other audit log requirements
  - Be able to certify a separate audit log system
  - Rely on NIST/Federal or State regulation
  - Incorporate into risk assessment
  - Credential users
  - Base on standards that give guidance for content
  - Specify period of time
  - Identify a minimum data set
- Other comments suggest attestation to all requirements in the HIPAA Privacy and Security Rules

PSTT06 Summary:
Attestation for Length of Time Logs are Maintained

- Majority of comments are neutral toward attestation requirements, citing a need to:
  - Wait for final Accounting of Disclosures Rule
  - Complete additional feasibility studies/research
  - Leverage audit log requirements in other industries
  - Defer to providers and hospitals for feedback
- Some comments do not support attestation requirements, citing:
  - Administrative burden
  - Need to also require demonstrating function
  - No improvement to security
  - Audit log is functionality of EHR, not a provider attestation requirement

PSTT07 Summary:
Standard Format for Log Files

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PSTT07 - Is there a requirement for a standard format for the log files of EHRs to support analysis of access to health information access multiple EHRs or other clinical systems in a healthcare enterprise?

- 32 comments received
- Many comments state that there is no adequate standard format requirement
- Most comments support a need for standard format requirement
- Some comments are neutral toward standard format requirement, suggesting that:
  - Government should dictate what but not how
  - Variability on details captured presents a challenge to creating a standard
  - Use of SIEM standard
- Some comments disagree with need for standard format requirement
  - Requirement elements can be mandated and should define a minimum data set
  - Burden on health care organizations and vendors
- Some comments state there is no need for MU based standards related to Accounting of Disclosures Rule

PSTT08 Summary:
Audit Log File Specifications

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PSTT08 - Are there any specifications for audit log file formats that are currently in widespread use to support such applications?

- 37 comments received
- Some comments mention specifications that could be considered for audit log purposes, such as:
  - IHE ATNA Specification
  - HL7
  - DICOM
  - ASTM E E-2147-01
  - World Wide Web Consortium (W3C)
  - SYSLOG
  - UNIX-based operating systems
- Some comments state there are no existing standards or no existing standards in widespread use
- Other comments oppose new MU requirements based on proposed rule

MU4 Summary:
Patient Consent

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MU4: Some federal and state health information privacy and confidentiality laws, including but not limited to 42 CFR Part 2 (for substance abuse), establish detailed requirements for obtaining patient consent for sharing certain sensitive health information, including restricting the recipient's further disclosure of such information. *Three questions were put forth.*

- 74 comments received
- ***Question 1: How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange?***
  - Approaches suggested include:
    - Metadata tagging
    - Data segmentation , such as…
      - Data Segmentation for Privacy Initiative
      - VA/SAMHSA
      - SATVA
  - Concerns expressed:
    - The necessary segmentation capabilities do not exist today
    - It is better to focus on identifying and punishing inappropriate use of data
    - Use PHR to give patients control of their data

MU4 Summary:
Patient Consent

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- ***<u>Question 2:</u> How can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on a consent form, manage consent expiration and consent revocation, and communicate the limitations on use and restrictions on re-disclosure to receiving providers?***
  - Create and adopt standards to improve the capacity of EHR infrastructure
  - Create standardized fields for specially protected health information
  - Require all certified EHRs manage patient consent and control re-disclosure

- ***<u>Question 3:</u> Are there existing standards, such as those identified by the Data Segmentation for Privacy Initiative Implementation Guide, that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?***
  - Many comments call attention to segmentation-related initiatives that might be leveraged , such as:
    - S&I Framework's Data Segmentation for Privacy Initiative (DS4P WG)
    - HL7 confidentiality and sensitivity code sets
    - SAMHSA/VA pilot
    - eHI developed the "eHealth Initiative Blueprint: Building Consensus for Common Action"

Next Steps- Meaningful Use

- Outcome of February 6th HITPC discussion, exploring alternative pathways
  - Performance based deeming
  - Clustering /consolidating objectives
- March 15th in-person meeting to explore options
- April 3rd will review details with HITPC