

# HIT Policy Committee Transcript April 3, 2013

## Attendance

The following Committee members attended this meeting:

- Farzad Mostashari
- Paul Tang
- David Bates
- Christine Bechtel
- Christopher Boone
- Neil Calman
- Arthur Davidson
- Connie White Delaney
- Paul Egerman
- Judith Faulkner
- Thomas Greig
- Gayle Harrell
- Charles Kennedy
- David Lansky
- Deven McGraw
- Marc Probst
- Joshua Sharfstein
- Scott White
- Terry Cullen for Madhulika Agarwal
- Robert Tagalicod

The following Committee members did not attend this meeting:

- Richard Chapman
- Patrick Conway
- Frank Nemec
- Latanya Sweeney

## Presentation

### MacKenzie Robertson – Office of the National Coordinator

Good morning, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is the 47th meeting of the HIT Policy Committee. This is a public meeting of a federal advisory committee. I'd like to note that there are two public comment sessions built into the agenda, both – one before lunch, and one at the conclusion of the agenda. Public comments will be limited to three minutes per speaker.

This meeting is also being transcribed, so I'll please ask that anyone speaking, if you could please identify yourself for the transcript. And for anyone who will be using Twitter, the hashtag is #HITPolicy. And with that, I will go through the roll call. Farzad Mostashari?

### Farzad Mostashari – Office of the National Coordinator – National Coordinator

Here.

### MacKenzie Robertson – Office of the National Coordinator

Thanks, Farzad. Paul Tang?

**Paul Tang – Palo Alto Medical Foundation**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Paul. David Bates?

**David Bates – Brigham and Women's Hospital**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, David. Christine Bechtel.

**Christine Bechtel – National Partnership for Women & Families**

Present.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Christine. Chris Boone?

**Christopher Boone – Avalere Health**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Chris. Neil Calman?

**Neil Calman – The Institute for Family Health**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Neil. Richard Chapman? Art Davidson?

**Arthur Davidson – Denver Public Health**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Art. Connie Delaney? Paul Egerman?

**Paul Egerman – Businessman/Entrepreneur**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Paul. Judy Faulkner?

**Judith Faulkner – Epic Systems Corporation**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Judy. Gayle Harrell?

**Gayle Harrell – Florida State Legislator**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Gayle. Chuck Kennedy?

**Charles Kennedy – Aetna**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Chuck. David Lansky?

**David Lansky – Pacific Business Group on Health**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, David. Deven McGraw?

**Deven McGraw – Center for Democracy & Technology**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Deven. Frank Nemecek? Marc Probst?

**Marc Probst – Intermountain Healthcare**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Marc. Josh Sharfstein? Latanya Sweeney? Scott White?

**Scott White – 1199 SEIU Training & Employment Fund**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Scott. Terry Cullen?

**Terry Cullen – Department of Veterans Affairs**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Terry. Patrick Conway? Tom Greig? And Rob Tagalicod?

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Rob. With that, I will turn the agenda over to Dr. Mostashari for some opening remarks.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Well, usually I start off by telling a little bit about what's been happening and what's kind of – what's on my mind. It just so happens that I just came back from vacation.

[Crosstalk]

[Laughter]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

And I did not – I tuned out, so I have nothing. And I strongly recommend others to do the same, to tune out for some time, and with that, I will turn the agenda back over to Paul Tang.

**Paul Tang – Palo Alto Medical Foundation**

Oh, wow.

[Laughter]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

First ever. Yeah.

**Paul Tang – Palo Alto Medical Foundation**

That's wonderful. Well, congratulations. Request permission to do same.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

Okay. Well, that'll recover a few minutes for us.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

There you go.

**Paul Tang – Palo Alto Medical Foundation**

Because we have a very, very full agenda, as you've seen. In fact, it's so full that we edged ONC update off the agenda. So just a couple of announcements. One is there are two new workgroups that are being formed. You know about the two consumer engagement workgroups that were formed earlier. Accountable Care Workgroup is going to help advise us in terms of how does all of – all of the work that we do, the policies related to HIT, affect or can be – can enable the work that accountable care organizations have to do. And that's with a small A. In other words, how can going – moving into the accountable care era be supported by HIT, which is a goal for all of us?

The other is a request from the FDA – it's a statute under the FDA's Safety Innovation Act that asks for advice on how do you propose risk adjusted regulations of HIT, in a sense, and Congress is looking for HHS to make recommendations, and HHS and ONC has turned around – ONC, FDA, and FTC have turned around and asked for advice from this group, so we're forming a special workgroup for that.

Because of the full agenda, which I'll go over, we're going to try to – we will follow the allotted time so that we can get through it all. It starts off with a special report that Farzad asked the committee to make last time on the CommonWell Health Alliance that was announced at HIMSS. So Farzad asked that we understand this better and see how we can – what it can do to further the mission of this group and how we can help.

It'll next be followed by Rob Anthony and Mat Kendall talking about the updates on the progress in HIT adoption plan from CMS, followed by the IE workgroup, commenting – making recommendations to this group for comments on the RFI that ONC put out related to interoperability and exchange.

Next will be the privacy and security team, again, presenting its follow-up recommendations from last time, having to do with three scenarios related to query and response. We then will conclude the morning with some public comment, have a lunch break, and then followed by a meaningful use update in terms of Stage 3 recommendations. There's a proposal for a different approach to Stage 3 that's based on our experience with Stage 1 and emerging for Stage 2. And we also had a hearing on clinical documentation. As you recall, that was something that Congress actually and HHS was interested in, and it is a pressing topic, and so we had a hearing on that. We'll report on the results of that hearing, as well as some recommendations from a combination of the meaningful use and the Certification and Adoption Workgroup.

We also are going to have – we're going to conclude the afternoon with the – an update on the long-term care coordination. As you know, long-term care is excluded from the EHR incentive program, and so how can we interact with this very important part of a patient's continuum? And we'll conclude, as always, with public comment, and that will include this very long and very informative day, I think you'll find. Any additions to that? Okay. And you all received minutes from last time. Entertain a motion to approve those.

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

And second?

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

Any further discussion or corrections? Okay. All in favor?

**Several**

Aye.

**Paul Tang – Palo Alto Medical Foundation**

And opposed or abstain? Thank you. Okay. Let's begin with a special report from Paul Egerman and Charles Kennedy related to the CommonWell Health Alliance. It's a long distance, Paul.

[Laughter]

**Paul Egerman – Businessman/Entrepreneur**

Good morning. Charles I think is on the telephone.

**Charles Kennedy – Aetna**

Yes, Paul, I'm here.

**Paul Egerman – Businessman/Entrepreneur**

Great. Good morning. Well, as Dr. Tang suggested at the last Policy Committee meeting, Farzad asked Charles and me to sort of look into the CommonWell Health Alliance and to basically give a brief report back to you about what it is all about. And I think the reason that perhaps he may have asked that is a lot of people had different impressions of who they are. And so the goal here is really simply to do my best to explain it, and also I'm trying to do my best to explain it in what I would call a neutral manner. In other words, I'm not trying to like be in any way judgmental or – about who they are or what they're doing, except to simply say that anytime anybody's doing anything with health information exchange, that is a good thing, because it basically advances the knowledge and the technology and the experience. And so, you know, it's certainly viewed as a positive thing that people are trying very hard to do something important and successful.

So this slide, and I have a few slides I'm going to show you, this slide and the subsequence couple of slides actually come from the Health Alliance, and it lists the founding members. These are the five corporations that are founding members. You have McKesson, with RelayHealth, you have Cerner, Allscripts, athenahealth, and Greenway. Basically, CommonWell Health Alliance, as I understand the intended structure of the organization, is intended to be a trade organization. It's a trade organization of EHR vendors.

This is the initial set. It was, exactly as Farzad said, and Paul Tang said, it was created – it was announced during the HIMSS conference. The information that I got about them I got – I spent a couple of hours with David McCallie from Cerner and Arien Malec from RelayHealth, and then I spoke with a few CEOs in the industry, and Charles did also. We'll go through that information.

One of the questions I asked them was I said, well, what do you have that's operational? And they sort of – I suspect they smiled when I asked that, and they said they have a website and a Twitter account, and that is how one starts an organization, is with a website and a Twitter account. But they also have a lot of concepts and hard work. But this is very much a startup enterprise. They're just in the early stages of getting organized. And so what is being presented is sort of like their vision and their direction and their plans.

So what you see here it says solving nationwide data exchange. And if you look at the title, solving nationwide data exchange, the key issue there is this is a national endeavor. This is a single concept for the entire nation. Now in the original slide deck under solving nationwide data exchange, they had some information about the benefits of health information exchange and also some of the challenges, and I kind of took that out, because I think this group already knows that.

Instead, what I wanted to do is to talk about a little bit of the technology, or their technical approach. And so you've got these four different bullets, and these bullets really answer the questions of who, what, where, and how. So the first question is who, like who is the patient, and then what you see here is they are proposing to have basically a national patient – I would call it an index. I'm not sure that's the expression they would use, but a national file to be able to identify patients.

It is not, however, a national patient identifier. In other words, they're not putting forward a national patient identifier. They're using existing identifiers like say cell phone numbers or driver's license numbers, possibly insurance numbers, to identify patients. So that's the way they're going to answer the question who.

The second concept of what they have is a file that stores, again on a national basis, information about consent and authorization. So basically the intent of this file is to if you are a physician, you're doing an inquiry, is to answer the question, what am I able to look at? So that's the answer to what? So there will be a file that says information about consents and authorization, which reflects patient decisions about that information.

And then the third file is a – basically a index of location. It's a record locator concept. So that's the where. So it will tell everywhere in the country where a patient's record is located. You know, so if Dr. Tang is the patient, then he has records at Sutter, in Palo Alto, and he has records at Intermountain Healthcare in Utah, and then in Pittsburgh, because he travels around. It will list all the locations where his records are.

So once you have answered the questions who, what, and where, the next question is, well, how do you connect, which is what the fourth bullet says. And the intention of how you would connect is that this would be a peer to peer direct connection. So the EHR system from the querying side will then connect directly to the other EHR systems to get the information. So that's an important concept to understand, because what is happening here is – I'll tell you what is not happening here is this sort of nationwide indexing – locating system, it's not storing clinical data. In other words, it's basically a – basically pointers to where you find the data. And so the EHR systems then do their own direct connections.

So that is the basic technology approach that they're taking, and I can talk a little bit more about it. There's some other things that they're doing that I thought was extremely interested – interesting, which actually I didn't see written up very much in the press or I didn't see in the materials, and I wanted to sort of like draw them to your attention. There's really three things that I considered to be – they're not technology issues, but they are what I would call essential components of health information exchange that they are addressing that have either not been addressed so far by us, or maybe only partly addressed.

And the first one of those is basically I call it EHR workflow integration. Part of their entire vision here is not just that you would do this connection and deal with some of the technical aspects, but somehow this – the information that you get has to somehow work within the EHR workflow. And their vision is that the member EHR vendors will really commit to this, and they will actually somehow be – have a certification process to be certified that they have done that, in which case once they're certified, they will be able to use the CommonWell logo.

Their vision of workflow integration as it was explained to me initially does not include what I call consumption of the data. You know, it does not include automatically consuming the data from one EHR system into theirs. So that's what the first what I call essential component, is workflow integration.

There is a second essential component that they have, which is governance, and this includes a governance model. And so governance could be provided, although it's – I have a feeling that it's a little bit fluid right now, because they're still in the early stages, but governance could be provided by the Board of Directors, which are going to be EHR vendors, and probably augmented by some advisory group of consumer advocates and patient representatives. And so there is an explanation of who is going to provide the governance for the health information exchange.

And there's a third essential component besides EHR integration and governance that they are providing, and that is they have a business model to operate their health information exchange going forward, which has been, for some of the HIOs that have been established, there's always been a question about, well, how are they going to be sustainable when government grants disappear? And this does have a business model. Basically, the model is that the EHR vendors are going to pay for it. This is basically a pay to play concept. In other words, for an EHR vendor to be able to participate, to offer this service to their customers, they are going to have to pay some sort of an annual subscription fee, and that fee will be used to, you know, to fund the organization and the technology that is going to be involved in both creating and maintaining the entire concept. And so that's an important, essential component.

Now on the next slide, which I'll show you in a minute, they have a list of things that they would like ONC to do to be supportive of them. But before I do that, let me pause and see, Charles on the phone, what observations you might want to make about them.

### **Charles Kennedy – Aetna**

Sure. Thank you, Paul. Paul did a very good job covering kind of the bits and bytes of the initiatives, and in my conversations, I spoke to several of the CEOs involved in this initiative as well, and all of the information I received in terms of what it is and how they foresee it working is pretty much consistent with Paul – with what Paul said.

I tried to ask – probe in a couple of different areas, and the areas I tried to probe in revolve around a couple of key questions. One, is a private collaboration such as this a workable structure to implement/manage interoperability nationally? And what I mean by that is, you know, you can think of examples in the healthcare industry where hospitals, for instance, have formed consortiums to manage, for instance, purchase of hospital supplies, durable medical equipment, etcetera, for a certain economic benefit.

But you can also point to examples – one that I was very familiar with, that was MedUnite. MedUnite was a collaboration of various health plans who sought to build a intermediary in the administrative claims transmission and submission process that had some analogies – that was, you know, fairly analogous to what this is. Granted, it was just administrative data, but many of the same kind of dynamics apply.

So I asked them, what – you know, what was their motivation in trying to form this organization, and I received a variety of answers associated with data liquidity and recognizing a need for that. Another thing I received was an increasing focus and interest in ACO support, and that they were finding that their customers were, because many of them were forming ACOs, or thinking about forming ACOs, needed interoperability at a more acute level. So I do believe that some of the motivation of this is customer-driven.

But – and I also tried to probe a little bit around how do they anticipate competitors such as this collaborating, and what kind of mechanisms do they have in place, because quite frequently it's very difficult for competitors who have commercial interests to work together toward a common good. I didn't get too many clear answers on this. I think it was still very much in the formative phase. The only theme I was able to – I can report back is that there's a common interest in, you know, supporting the ACO marketplace as well as just data liquidity in general.

But I do think this keys up a lot of questions that the HIT Policy Committee should begin to consider, such as, you know, when you have an organization like this that is motivated by private sector interests and are commercially driven, can that form the basis for a effective interoperability infrastructure, and/or is there some relationship that the HIT Policy Committee could either consider or would be appropriate that might be supportive?

And so the points you see on the next page where their initial response to those questions. So Paul, I'll turn it back over to you to walk through this next slide.

#### **Paul Egerman – Businessman/Entrepreneur**

Yes. Well, the next slide is – and thank you very much, Charles. The next slide is basically their request to us of how they would like to work with the Policy Committee, and so there's some things that they would like us to do, like make sure that Stage 3 of meaningful use is flexible and responsive to their needs. And I'm just sort of going to put this slide up, actually, though, without reading through it and without a lot of comment, because a lot of vendors and industry groups may make requests of us, and so it's up to us to decide, you know, what it is we want to do with that.

And so that's – what I intend to do with this process, though, is to do my best to do a quick overview and simply ask for your comments and questions.

#### **Paul Tang – Palo Alto Medical Foundation**

Thank you, Paul and Charles. Comments, questions from the committee? Deven?

#### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Maybe we could start with clarifying questions, if people want to help understand better what it – what it is and isn't before we –

#### **Paul Tang – Palo Alto Medical Foundation**

Before going to this?

#### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– go to either responding to this, or, you know, kind of discussion of pros and cons. But just first let's dig deeper.

**Paul Tang – Palo Alto Medical Foundation**

Sure. So clarifying questions. Deven?

**Deven McGraw – Center for Democracy & Technology**

Yeah. This is a clarifying question. Paul, I wasn't – I didn't quite understand the point that you were making about sort of impact on workflow and the fact that at this point, the data might not be consumable by the – by the entity who's receiving it after a query. Do you – is this all still in discussion? Is there any more you can add to that?

**Paul Egerman – Businessman/Entrepreneur**

Well, yes –

**Deven McGraw – Center for Democracy & Technology**

I'm trying to wrap my head around that.

**Paul Egerman – Businessman/Entrepreneur**

When I say it might not be consumable, to me, consuming it is sort of like the advanced level of information exchange.

**Deven McGraw – Center for Democracy & Technology**

Right.

**Paul Egerman – Businessman/Entrepreneur**

So you inquiry into another system, you get, for example, a medications list, you take that medications list, you consume it into your own EHR –

**Deven McGraw – Center for Democracy & Technology**

Right.

**Paul Egerman – Businessman/Entrepreneur**

– system, and then you use it for decision support.

**Deven McGraw – Center for Democracy & Technology**

Right.

**Paul Egerman – Businessman/Entrepreneur**

You know, for drug-drug interactions. That would be – that would be an advanced level of integration. My impression, and again, I may be wrong in this, my impression is that when they get started, it's not going to be quite that far. It's going to be more like the information will be visible in the workflow, but may not necessarily be consumed.

**Deven McGraw – Center for Democracy & Technology**

Right. But it's – does that mean it's view only, or it actually does get sort of passed along, but it might not be incorporated in a sort of automatic update function?

**Paul Egerman – Businessman/Entrepreneur**

The impression I got was it was going to be view only and incorporated – I mean, at least the views might be incorporated, but may not – the data may not be incorporated initially.

**Deven McGraw – Center for Democracy & Technology**

Okay.

**Paul Egerman – Businessman/Entrepreneur**

But that's – but that's – you know, I mean, as I answer this, I'm sort of pausing, and I'm on a little bit of thin ice. That's the basic sense I had. You know, I need to check with them to find out what level of integration they're really talking about.

**Paul Tang – Palo Alto Medical Foundation**

Paul, in terms of the first part of Deven's question, though, can you give an example of when you say the advantages, that there is workflow integration for this, can you give an example, I don't know, related to the unambiguously identifying patients? So some of the other pieces of this, were there – what's the – what's the advantage of the workflow? What do you mean by work – what do you actually mean? What's the use case in terms of workflow integration?

**Paul Egerman – Businessman/Entrepreneur**

Well, you know, I mean, what they're trying to do is they want – first, they want to make sure that the vendors that are involved with this process are really committed to information exchange. You know, it's not something they just sort of do to like check the box and say, yeah, I've got it. And so somehow a workflow process might be that, at least in my mind, might be that, gee, you're seeing a patient for the first time, maybe you're an ophthalmologist, and you could get – you could see the list of problems they have, or maybe you can see the list of medications they have. And you do that as part of the normal process of however you treat that patient, that perhaps you could see that information in the same way you saw that information if it was a patient you had seen three or four times before. In other words, it just works, and however it is that you are treating the patient, it does not require you in my vision to like stop everything, you know, log out, go into some other system, and then log back in. That would be – that would not be workflow integration.

So that was the sense that I had. And it's an interesting issue, and to me, it's exciting that it's being addressed.

**Charles Kennedy – Aetna**

Yeah. This is Charles. I spoke to a different CEO, and his – I would say two things. Any impression we have at this point is subject to change, because all of this is very much in its nascent phase. And the CEO I spoke with said that whatever workflow there is within the participants' product would be the workflow that would be controlled. In other words, as a part of this CommonWell Alliance, there's no inherent workflow change in and of itself that a user would see. They'd still see the Allscripts workflow, the Cerner workflow, whatever that is. But that it would be up to each individual vendor to figure out on their own how to take this information from the CommonWell Health Alliance and insert it into their existing workflow. So I didn't get the sense that there was any more towards, you know, standardization of workflow, or sharing of workflow, just that each vendor would be responsible for figuring out to insert the data within the existing workflow.

**Paul Tang – Palo Alto Medical Foundation**

So it sounds like what some people call visual integration. Yeah. Okay. Gayle, please.

**Gayle Harrell – Florida State Legislator**

Thank you. Thank you very much. And I – it sounds like it's at the very, very beginning stages, so we could have some impact on this. But can you give us a little more detail on what they envision to be their governance model? I really have great concerns about the privacy and security aspects of things, and want to make sure that that – do you have any sense of where they're going and how they're going to deal with privacy and security within the entire system?

**Paul Egerman – Businessman/Entrepreneur**

Those are two – the way I hear that, and I hear it as like two different questions. I mean, the governance will be –

**Gayle Harrell – Florida State Legislator**

It's a two-for. Two for one.

**Paul Egerman – Businessman/Entrepreneur**

Yeah. Governance, everything is pretty fluid here. I mean, there is governance by – there's a board of directors. That by itself is governance. And they intend to have the EHR vendors and patient advocates and patient representatives involved. And I – there's not a lot more information that I have about that. In terms of the privacy and security aspects, the sense I have is that they are following whatever – you know, obviously, they're following HIPAA, and then following whatever comes out of ONC and what we're recommending. In other words, they are doing things according to the way they're supposed to be doing. They said that they intend to use national standards.

They probably will in some areas sort of push the edge of the envelope. There may be some things that our standards don't – current standards don't cover, and there may be some circumstances that our privacy and security policies don't cover yet. And so they may be coming to us and asking us for guidance in those areas.

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

Which is I think – which I think part of what they're saying in their requests.

**Charles Kennedy – Aetna**

Yeah. The only thing I was able to glean is that they were kind of not at any level of detail around governance. There were just certain principles. And again, I think the principles came more from a commercial perspective than they necessarily came from, you know, what we would consider or be focused on from a governance perspective. So I heard a lot of statements around things like no individual vendor will be preferred over another individual vendor. We will make sure there's a level playing field.

Again, that's very important if you're thinking about this from a commercial perspective. I'm not sure that's as important as we think about, you know, privacy and security and all the things that the HIT Policy Committee would be concerned about.

**Paul Egerman – Businessman/Entrepreneur**

Yeah. That's very helpful, Charles. And the analogy I'd use for how this is going to work is if you think about how the DIRECT project worked, you know, and – which is, coincidentally, Arien Malec was deeply involved with it. But there was sort of like this rapid development project involving pilots with a fair number of participants, and that's sort of the process that they are embarking on. And as they embark on it, that'll probably uncover some interesting issues in terms of both privacy and security, and perhaps, as I said, push the edge of the envelope on some of the standards issues, that they will find some issues that they – you know, standards need to be developed, or, you know, especially around some of these issues around how do you communicate consent. But there may be some issues there also.

**Gayle Harrell – Florida State Legislator**

Follow-up. Do we have a sense – do we have a sense on how far down the road they are in timing, and when do we think that they are going to have something up and running as far as governance goes? And, you know, what – do they have a built-in timeframe that they're setting target dates, and are they – or is this just kind of a conceptual framework that they're working on right now?

**Paul Egerman – Businessman/Entrepreneur**

Well, I mean, it's more than conceptual. There's people working very hard on it, and there's a lot of enthusiasm, which, you know, I'm doing my best to describe it in a very neutral way, but there's a huge amount of enthusiasm for the – on the people who are working with it, and some of the people who are – who are interested in it. So in terms of your answer of timing, I have to tell you, I read two things. I read a press release where one of the CEOs projected out 18 months. I also heard in my verbal discussions that they want to do these pilots, and they want to have some press release or show some results by the time of the HIMSS conference next year. So – which is somewhat consistent with indeed what we saw with the DIRECT project. You know, from the – sort of like a beginning point till they actually had successful pilots and running and things operational, it seems like around that time period, around a year.

**Gayle Harrell – Florida State Legislator**

Thank you.

**Paul Tang – Palo Alto Medical Foundation**

So for the remaining folks, try to keep your questions short to manage time. Neil?

**Neil Calman – The Institute for Family Health**

So I'm trying to understand what the relationship is between this exchange and other exchanges that are developing. So if a provider is using one of these products, will they connect through this exchange to other exchanges, through regional exchanges that they want to participate in? Or is this instead of that? In other words, what's the interaction between this group, the people who would be inside this exchange, and the people who are – who would be outside of it?

**Paul Egerman – Businessman/Entrepreneur**

Excellent question. Reading the frequently asked questions on the website, they say, well, this will like coexist with the other exchanges, and this is – you know, people can still use the – their local exchanges. However, in some of my conversations, I heard sort of a different view, which was to say, well, this is going to be a national exchange, and that some EHR vendors are frustrated with the local exchanges, because each one of them is different. And this is a way for vendors to go national and have only one set of rules to deal with.

So I guess the answer to my question is – to your question is good question. We'll have to see how that works out. So the possibility would be that if you're – if you're participating with one of these vendor products, that you might – they might decide that exclusively you would have to go through this mechanism, and you couldn't connect directly with their product to a regional exchange that you might be part of for care coordination reasons or other kinds of things. I guess that's – well, again, I can't project –

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

I can't project what vendor would do. All I can say is if I was your vendor, I would never do anything to make you unhappy.

[Laughter]

**Charles Kennedy – Aetna**

Yeah. I mean, I talked to a couple of CEOs who said that, you know, one of the founding principles is going to be being open, and so the notion of being able to connect to whoever and through whatever means necessary to make that connection happen is something that was important to the founding of the alliance. And so, you know, they're saying the right words. In other words, the – they see a couple of things, right? One is the state or regional HIE is struggling from a business model perspective. This is in part their idea to solve that problem. So could this potentially replace some of those exchanges, or offer, you know, competition in some way? I think that's definitely possible.

I think the – their thinking is that this will be a stabilizing force for health information exchange, and more of a solid infrastructure that you can trust then from the – from the perspective of being an organization that's well-funded and well-supported, and wouldn't, you know, have some of the challenges we've seen with some of our state HIEs, for instance, closing, and things like that.

That said, I think your question's right, which is there is a commercial interest in all of this, and we just have to wonder, would they maintain that commitment to the free flow of information regardless of where the care occurs or wherever it's needed, or would commercial interests, you know, start to find their way inside? And I just don't think we know.

**Paul Egerman – Businessman/Entrepreneur**

And I would just add, Neil, I made the comment somewhat tongue in cheek, if I was your vendor, I would not do anything to make you unhappy. I mean, these are vendors. They will be responsive to what customers want. And so if there's some reason why users want to make sure they have an open system, I would think that they would try to be responsive.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

But I think a key question here, and what I'm sensing is that we will probably need to go back and dig deeper to get the answers to some of these, but a key question here is fundamentally is this a service that is severable, or is it an exclusive network for information exchange? So let me – let me clarify what I mean by that. One could imagine a layering on of an optional service that provides for patient identification and record locator that rides on top of directed query, based on national standards. And if I happen to know who the patient is or don't want to use a record locator, if the patient can tell me where they got care, if I find their – you know, the – you know, you can use an LDAP.

**Paul Egerman – Businessman/Entrepreneur**

Yeah.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

But you can also send email without the LDAP. Right? Is it a severable service that I can optionally access as a provider that rides on top of it, and I can continue to do queries using directed query or an HIE infrastructure, a plug-in to any of that, and it's an add-on service, or is it it's an exclusive and all – you know, all-encompassing network infrastructure that will require not only use of the service, but use of the – of the network for flowing information as well, I think is a – is a question that is –

**Paul Egerman – Businessman/Entrepreneur**

Well, it's –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– on the table.

**Paul Egerman – Businessman/Entrepreneur**

Well, it's structured to be the former, to be this sort of add-on service, because, again, when the connection occurs, it's a direct peer to peer connection. You know, and so you don't connect through the service, the way I understand it. So that is – it has the right structure to do the kinds of things that seem to be – would seem to be the most flexible. I mean, I can't predict what they are going to be doing, but I can't understand why they wouldn't do it that way. That would seem to be a logical way to do it.

**Charles Kennedy – Aetna**

Well, and many of the CEOs have made public statements that, you know, they're going to have kind of a seal or certification that the alliance provides, and that will have a series of requirements associated with it, and I've seen several of them make statements that as a part of that certification, you – that the individual vendors will be required to work on the national infrastructure. So by implication, they've been saying the national – you know, federal infrastructure, which I think is – again, my interpretation of their statements, but again, I do believe they're making an effort to say this alliance will create a framework that will incorporate and support the national standards and NeHM and that type of approach. So I do think they're trying to align with what we've been promoting federally.

**Paul Egerman – Businessman/Entrepreneur**

Yes. And they're trying very hard to do that. They're being very clear that they want to do national standards. And so I don't know if I gave you an adequate answer to your question, Farzad, but it is organized to do exactly the sort of optional add-on service. But I guess with the hope that people will use it a lot, is the best way I can describe that.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Short, please, Josh.

**Joshua Sharfstein – Department of Health & Mental Hygiene, Maryland**

Thanks. I have a very specific question and then one specific comment. The question is, I didn't hear you talk about the state HIEs being able to plug in. It's all EMR to EMR system. Is that true? There's not really contemplation of engagement with state HIEs?

**Paul Egerman – Businessman/Entrepreneur**

Well, I can't tell you what's contemplated. All I can tell you is that's all I heard, was about EHR or possibly – like organizations are – have self-developed EHR systems, you know, being able to plug in. I did not hear about HIE organizations plugging in.

**Joshua Sharfstein – Department of Health & Mental Hygiene, Maryland**

Okay. That would probably be a concern. And then the general comment I think is there are – you could certainly see the potential value of this is the only way you have to figure out where records are, but I think for some of these things, you have to think about whether in kind of taking a step forward, you're really taking a step closer to where you ultimately want to go, or you're actually putting in barriers to where you ultimately want to go. And I understand, Farzad, your point about, you know, DIRECT, but where does the system ultimately want to go? If the system ultimately wants to go to where you could find out wherever the patient sought care, and you could get the records wherever that was, is it – you know, maybe that's not what it is right now, but maybe it's a few years down the road. Is this something that is – moves you closer to that, or further way?

And I think the big concern I would have about – on the further away side is that if you create private value in doing it in sort of the piecemeal way, that you're going to really create obstacles to being able to do it nationally. And that would be my major concern, that you're developing, you know, essentially a reason, a competitive advantage for people to do something that's adverse to the overall direction you want to take the system.

**Paul Tang – Palo Alto Medical Foundation**

Marc?

**Charles Kennedy – Aetna**

I would just say in the comments that these CEOs made to me, they were pretty forthright about saying that's not what they're trying to do. They were pretty strong in saying this is about, you know, a level playing field. This is about finding the information wherever it may exist, and this is about embracing federal standards. And so I think in their minds, they see this as very much complementary to the strategy and the overall direction that the HIT Policy Committee has taken.

You know, that said, I think your point is fair around the commercialization interests and what that could, you know, potentially perhaps in an unintended way do. But in my view, if we just get, you know, some progress on cross-entity patient linking and matching in the next, you know, 12-to-24 months, I think that would be a very good success for this organization.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Marc, please?

**Marc Probst – Intermountain Healthcare**

Yes. And I will be quick. I won't repeat what everyone else said, but – and I agree with pretty much what everyone else has said. I see the issue of national identifier, although I think explicitly it was said they're not trying to develop a national identifier, they're going to have to create some kind of identifier that's unique. They may be using these other components, but they're going to have to create an identifier for all these other systems to use to then identify and do the other things they're talking about.

So this whole concept of are we building another standard, and, you know, in my mind, if we have multiple standards, then we don't have a standard. So, you asked something, Farzad. Could we as a group bring in these like parties? I mean, there are lots of organizations looking at these issues, whether it's patient identification or record finding. We in fact have proposed some policy and some standards on the Standards Committee, and I talked to a couple of these CEOs as well, and that was my plea to them, is could we not just get all these groups together, and rather than do what Josh is saying, potentially build in a barrier to what we're trying to accomplish, but facilitate as the Policy Committee coming up with the solution as a national solution that would solve these problems?

Because they're going after a very real issue. The problem is, they may be creating another challenge, and others of us, by the way, who have been pursuing it, may be creating those same barriers. Someone needs to bring that together and try and resolve it. So those are my thoughts. Thanks, Paul. It's a good report.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Rob?

**Paul Egerman – Businessman/Entrepreneur**

You're welcome.

**Robert Tagalicolod – Centers for Medicare & Medicaid Services**

Thanks, Paul. Question. So you mentioned ACOs, and in a discussion yesterday with ... you know, we recognized that ACOs in this country for the health delivery is about 14 percent through ACOs, and that's including Medicare and Medicaid ... and so I was wondering, what consideration has been given regarding the analytics? So anything from identifying at risk patients, clinical outcomes tracking, etcetera, etcetera. So what are they contemplating, or if they're contemplating it at all, or if they're still figuring out the connection piece?

**Paul Egerman – Businessman/Entrepreneur**

In the discussions with them, I did not hear any discussion about things like outcomes. My understanding is this technology is a thin technology, so it would seem to me it would not be able to produce by itself the outcomes without – but maybe there's some way of doing it. But that didn't strike me that that's what they were trying to solve.

**Charles Kennedy – Aetna**

I would agree with that, that this initiative in and of itself, I didn't hear anything associated with outcomes and analytics. However, when you look at some of the other moves that many of these vendors are making, what you see is they – is development work around ACO enablement, and part of that includes an analytic component. So, you know, you've seen various acquisitions and other moves by some of these vendors in the analytic space. I wouldn't be surprised if part of the motivation for this organization is a recognition that in order to do meaningful analytics, you need a more comprehensive understanding of the patient, and therefore you need, you know, data liquidity and the ability to bring in data from other sources, such as other EMRs.

So nothing in this initiative in and of itself, but I think when you look at the larger context of what these vendors are doing, it makes sense as a objective, and this initiative as an enabler.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Judy, is it important?

**Judith Faulkner – Epic Systems Corporation**

What did you say, Paul?

**Paul Tang – Palo Alto Medical Foundation**

I'm trying – we're out of time, but if you have something quick.

**Judith Faulkner – Epic Systems Corporation**

Okay. We ran into this just as HIMSS opened, because the original keynote speaker scolded us in front of the whole keynote audience for not being part of this group, and we were not aware of it at all, had not been asked to join. And we saw these buttons of saying I'm in it. So we wondered, what is it? Is it a business? A competitive business? Or is it a public service?

So on the service, it certainly felt like a business in that environment, in HIMSS, when we were there. We do know that it is expensive to participate, especially if you're not one of the originals, and I guess my question is things like what about – what components of business will be in it? Will it be favoring those who started it and using those who didn't start it as the means to be the business? Will it sell the data? Will there be patents? Those are some of the questions I asked myself. And then the real question is, then, if it is a business, what is the appropriate role of the HIT Policy Committee and ONC in working with it?

**Paul Egerman – Businessman/Entrepreneur**

And those are good questions. I would just say the tone of everything that I heard was that people were sincerely trying to address an important problems, and I don't see that what they're trying to do is inconsistent with what ONC is doing in any way, and how ONC should address them, it's up to ONC, and up to us, you know, at a minimum, that we ought to address it the same way we would address concepts and feedback from the vendors, or vendor groups, or from HIMSS, that say these are – you know, these are real life issues that we are coming up with, especially if they come up with important issues in their pilot experience. You know, that would be the response. In terms of the level playing field among vendors, they say that they intend to do that. It's – and I'm hearing all of those kinds of words.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. We're out of time, and let me try to summarize sort of the sentiment of the group and see if that's agreeable to folks. It sounds like this is an emerging concept, that you point out from the very beginning, a lot of these questions haven't been defined by the group. They're working actively on it. With regard to – and we want to cheer them on, because those – the issues they're trying to tackle are ones that we need solved.

With respect to – somebody asked, and this may be coming from them, I think this group – the Policy Committee has been intensely interested in health information exchange and everything that can facilitate it, and removing obstacles. So I think we're well-aligned there.

I don't know that given its emerging status, it's emerging – what it is and what it's going to do and some of the answers to these questions, it's unlikely that we would pay specific attention to – you know, that we could address specific issues by this specific group. So I think we are very, very invested in health information exchange, making it better faster, and efficient, but I don't know that there's special dispensation for CommonWell per se. Does that – is that a reasonable response to some of the ... on the slide?

**Charles Kennedy – Aetna**

I think so, Paul. I think the data liquidity remains, you know, a fundamental challenge for everything we're trying to do, and I think, you know, we have to look at this and other initiatives closely to see if they can help us move forward on that agenda. And I think that's a fair summary.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So this – there's – we're very interested in the idea. We're interested in the private sector response to is, and want to do everything we can to facilitate health information exchange.

**Marc Probst – Intermountain Healthcare**

Paul?

**Paul Tang – Palo Alto Medical Foundation**

Yes, Marc?

### **Marc Probst – Intermountain Healthcare**

But even well-intentioned, which I agree it is, I think it's well-intentioned, can create some of these barriers. If we have a way that we can help to facilitate at least aligning everything that's happening, and see how the different players could participate in that – you know, indeed, if it's all well-intentioned, then we ought to be able to come up with some concepts and, you know, pardon the word, standards, but – I'd have to speak – the standards that might be in place to really make this happen. And all this energy and money can then be directed to something that would be a solution in the end, versus just a – you know, another attempt. And that's my concern, is it'll be another attempt that lots of us are going to have to react to, because a lot of us are involved with some of those vendors, if not all of them.

### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I think for me, in general, the question oftentimes is will it work? Will it help move us forward if it – if any initiative doesn't encompass everybody, and – because there have been many, many efforts to kind of be the network. And anything that, you know, adds little value until you get to near 100 percent, and then all the value is accrued, that – you know, that doesn't work so well in a huge, fragmented, different, you know, system.

So any time you have something that is a, you know, known value add if you do our part of the network, you know, but does not inhibit other forms of exchange, then it's part of the, you know, it's all good part of this. If it comes at the price of inhibiting other good activities, then I think there – it creates a different policy driver.

So I think that's the key thing for us to figure out. Is this part of the if you have it, it's better, it's all good, it helps you – provides you with some patient matching or record locator services that does not preclude other approaches to it, or through technology or through governance it creates pressures that actually go against that. That's for me the key question here. Judy?

### **Judith Faulkner – Epic Systems Corporation**

Yeah. Following up on the inhibit, we have tried to find out more, but we have to sign an NDA for that. And my concern with signing an NDA is if an idea is brought up in the NDA, you are therefore precluded from – that becomes their property, and you're precluded from ever doing it yourself, because then you violated it, presumably because you learned of it through their private whatever. And so I think in transparency and openness, that there shouldn't be an NDA for stuff like this, because how do we learn about it, then?

### **Gayle Harrell – Florida State Legislator**

Just one comment. I think ONC has a significant role to play in this kind of endeavor, and as we have the private market stepping up to the plate to really bring new, innovative ideas to play, I think that's a very positive thing. But we want to make sure that we are not closing doors, and that we're not establishing a – you know, a group or a set of vendors that are – then control a marketplace, and that you don't have other alternatives out there, and that you push out small people. And an individual practitioner who happens to have a service through Cerner or whatever then is charged an inordinate amount of money in order to participate in the exchange, and has no other ability to exchange.

So you – there's a – there's a balance there, and I think we want to – we want innovation. We want to create competition, and we want to – but we also – I think ONC has a role to play in that we make sure that there's that level playing field out there, and the little guy doesn't get hurt at the end of the day, and that the individual practitioner can afford to exchange data.

### **Paul Tang – Palo Alto Medical Foundation**

Well said. Very important topic. There's nobody that's more vested in this, I think, than this committee, and we really have been working very hard. It's just a very, very challenging problem. I think what Gayle said about the smaller practices and what Josh said about let's make sure this good idea, well-intentioned, doesn't inadvertently get in the way of something else, not that – and not singling out this particular one, but we've just got to work on the level playing field. And thank you so much, Paul Eggerman and Charles Kennedy, for helping illuminate us. It's still a journey, it appears, and still an emerging concept, but we look forward to hearing more about it as it develops.

Okay. Thanks, everyone, and let's move on to the data update from Rob Anthony and Mat Kendall. What's listed here, Rob and Mat, is that we're trying to make it a ten minute presentation, and so we have a little bit of time, five minutes each, for Q&A.

### **Robert Anthony – Centers for Medicare and Medicaid Services**

Okay. I'm going to highlight just a couple of things this month and then leave more time for my brilliant and effervescent colleague Mat Kendall to discuss where we are with meaningful use. We had – oh, dear, we have the bottom blocked off. I – sorry. We had about 15,000 folks come in. Our overall registration is behind Neil, but it's a little over 380,000, almost 394, as of the end of February.

I did want to highlight this slide, which is going to be absolutely incomprehensible to anybody who's not looking at it on the web, or Paul Tang. But you can see the column here, this is Medicaid, and I did want to highlight the fact of where we are as far as meaningful use program to date. We have about 9,300 people. We have a number of people, about 1,500, on the Medicaid EP side, who came in in February. Obviously, this is from 2012, but we're starting to see more of those meaningful users. There are about 79 I think total Medicaid EP incentive payments, and about 9,300 of them are EPs. So we're starting to see that rise.

Overall, our February totals are about \$12.6 billion. We have 234,000 unique providers who have been paid through the program as of the end of February. This puts us at a little over 85 percent of all eligible hospitals that are registered, a little over 75 percent of all eligible hospitals that have actually been paid either Medicare or Medicaid incentive payments. Actually, for the vast majority of hospitals, it will be both. We are seeing good registrations on the EP side as well. Out of a total of 527,200 EPs, about half of those – I'm sorry, we have almost 73 percent who are registered that are eligible. About half of those are Medicare, and another 23 percent are Medicaid EPs. Obviously, paid is lagging a little bit behind, but we're continuing to see increases here, and we have a little over 44 percent of all eligible professionals that have actually been paid an incentive payment.

So you can see we've got about three out of every four eligible hospitals that have made a financial commitment to an EHR. Actually, 73 percent of eligible hospitals are actually meaningful users at this point in time. About one out of every three, a little over one out of every three, 36 percent of Medicare EPs are meaningful users. And we are closing in on the one out of every two eligible professionals have actually received an incentive payment, which means they're either meaningful users or they've made that financial commitment to an EHR. As of the end of this month, we have surpassed over 230,000 Medicare and Medicaid EPs that have been paid under the program.

Most – usually, we do a draft estimate of what next month's numbers are going to be. Unfortunately, it's too early in the month to pull all of that together. I will just say generally we anticipate that March is going to be a pretty significant month, and you'll see that from some of the attestation data. This is based on some of the end of March figures, and we have 190,000 EPs alone under Medicare who are meaningful users. So if you take that 190,000, you had the 9,300 Medicaid EPs, we are closing on 200,000 EPs who are meaningful users under the incentive program.

I won't go through all of this attestation data. A lot of it is familiar, and we haven't seen a huge statistical change. I did want to highlight what we have here for hospitals. We're continuing to do that comparative performance, and this compares hospitals 90 days in 2011 compared to those who did 90 days in 2012, and now we're seeing 90 days in the first fiscal year. And we'll continue taking a look at some of these numbers. We're getting these added to every month. There was another 70-some eligible hospitals in this month from last month.

Again, we're seeing some areas that are staying mostly the same. We have a couple of areas where we're seeing a little bit lower. But overall, as we look at this, we are – we are still seeing as hospitals come in far above the thresholds that are required for each of these objectives. So even though we may see in the third year some of these people who are on the longer tail, and maybe doing a little bit lower on some of these, a few percentage points lower, they are still significantly above what the required thresholds are for both the core and the menu objectives.

There hasn't been a real change here in EPs. This is the same information that we had from last month, since those were the people who are coming in in those first 90 days in 2012. Now as we move into the coming months, we'll have some EP data for people who are coming in for their first 90 days for 2013, and we'll be looking at that information as well. And I won't go through the rest of this, but we do have some of the returning provider performance data that we had last time, and then of course the overall aggregate performance. If anybody has any follow-up questions, they want to go through any of this, they are welcome to contact me there.

### **Mat Kendall – Office of the National Coordinator**

So what I'm going to talk about a little bit is Rob talking about the folks that are achieving meaningful use. I focus a lot on the people who are working towards meaningful use. And I think one of the things that we're trying to do at ONC is think about the ways of developing tools and best practices that could help people who haven't gotten to meaningful use get there.

And the good news is there's a lot of momentum, there's a lot being said, but the providers I focus on, the really small providers, critical access hospitals, federally qualified health centers, the folks that are working with the regional extension centers, we do have a lot of success to date, but we still have a large number of folks who are working through the process.

And one of the great things that we've been finding with the regional extension center program is we have had some success. We've had great support from GAO that illustrates that providers working with RECs are twice as likely to get paid on the Medicare side. We have over half the people – the registered folks in Medicaid are working with extension centers.

But over the last year, we've really begun to focus on how we can begin doing a better job of channeling not only ONC's resources, but the resources of CMS and our other federal partners to make sure we're getting the right tools and resources available. So with the extension centers, we've really begun to look at practice level challenges that folks are having, and we've collected about 25,000 of them, and we've begun a process of analyzing them, sharing this what we call situational awareness with our partners to really get a better sense of what's happening in the field and how we can move forward.

The tool that we use primarily is our CRM tool that we deployed with our regional extension centers, and this helps us get a really granular look at not only the practice, but some of the other demographics, where it's located, what type of providers it has, systems it's using, what program it's enrolled with. And what we're trying to do is take that data, leverage it with the data that Rob just shared from the CMS registry, and also information from our other federal partners, such as HRSA, the Comprehensive Primary Care Initiative, other CMMI programs, and really try to figure out what different segments of provider population need and to begin focusing on them.

And I think this a slide that Rob has shared in the past. It is a breakdown of some of the top challenges that we're seeing based on provider type. But we're not only looking at provider type. We're beginning to look at things by geography, by whether they're on the Medicare or Medicaid program, or if they're providers who aren't going even for the EHR incentive, and we're really trying to get as granular as we possibly can, because we realize the solutions and tools we push out really have to be targeted to be effective by providers.

So, you know, looking at meaningful use, we see general trends, but it really breaks it down when you look at exactly what people are doing in different segments. And our philosophy is we really want to come up with a new approach in which we can bring together all the information we have and set up monthly meetings with our federal partners to share sort of this is the information we're having.

And this is our opportunity to really look across the federal programs to say, what resources are you developing? What do you have in the pipeline? Let's focus our tools and technology and get it out there. We're then using our regional extension centers to test these tools, and then we're making them open and available on not only our internal tools, but on HealthIT.gov, which is our platform. And our goal here is to get the best tools and information out as quickly as possible to the larger community so that we can really help people get the resources they need.

I wanted to share with you just a list of some of the things that we're hearing across the board, because, you know, these come up in the data, but these are also issues that we're seeing all over the place. You know, whether it's motivating practices that have so many other things going on in their lives to focus on meaningful use, or looking at, you know, specific quality measures, we really are seeing that the different segments have different needs, and what we need to do is begin thinking about how we can leverage any resources available.

So critical access hospitals, rural hospitals, a very important area to us. You know, we're working with over 1,300 critical access hospitals and rural hospitals, most of whom have 25 beds or less. We're finding that access to capital is still huge. And what we've been able to do is reach out to the FCC that has some programs, Department of Agriculture, begin bringing those people together, connecting them with these critical access hospitals, and thinking about how we can align the resources.

So this is just one example of how we're working across the board, but, you know, we have to work closely with Medicaid, because moving folks from AIU to MU is going to be a challenge we're seeing across the board.

So what we're doing is once we've identified these challenges, we're developing trainings, handouts, data briefs, tools. We're trying to identify what's working in the field and begin to get it available. And again, the goal is to push everything out from us and put it on our HealthIT.gov website, which we really want to be the go-to source for how to do this. And a lot of this is going to be linking back to the great work that's being done in the field. We are going to take whatever works and get it out there. But we have a constant pipeline of folks – of materials that are going forward.

One material I really wanted to spotlight is some interoperability web-based trainings that we're doing really around preparing people for Stage 2. We've gotten a lot of concerns with folks in the field about what does it mean, and we've developed a number of different trainings that really are designed to help people understand what the requirements are and begin thinking about it. So these are the summaries and the different tools and materials that are going to be out there.

And in terms of moving forward, you know, we love providing input on this. We're trying to get as many minds working, helping us thinking about solutions, because we know they're out there, and pulling them together. So any feedback that you can give us or ways in which we can get the resources out there, we are welcome to input. So there you go.

**Paul Tang – Palo Alto Medical Foundation**

Well, thanks to both of you. Wonderful. Thanks for helping out with the timing as well. So now let's open to questions from the group. And thanks for the special update on the folks who are trying to get there. That was a request I think Gayle had.

**Gayle Harrell – Florida State Legislator**

Yes.

**Charles Kennedy – Aetna**

Question from the phone.

**Paul Tang – Palo Alto Medical Foundation**

Please, go ahead, Charles.

**Charles Kennedy – Aetna**

Yes. In regards to the use and deployment of these tools that you described, I mean, this is all, you know, very good, and I'm really excited to see both the maturity and growth. But one of the things – do we have any way of breaking out certain populations that, you know, might either historically be underserved, or certain populations, such as African-American or Hispanic-American communities, do we have any way of providing any assurance that these communities are being reached as well by these efforts? And any assurance we can provide to organizations that might, you know, ask questions, like the Congressional Black Caucus or other groups within the government?

**Mat Kendall – Office of the National Coordinator**

I think focusing on the regional extension centers, we spent a lot of time making sure that our extension centers are doing outreach to support all kinds of providers. But the ones you're listing are clearly some of our priority communities.

I think when you look at – we've been doing a lot of GIS analysis of the providers we're working on, focusing on HIPSA's and other organizations, such as federally qualified health centers. And I think the regional extension centers at least are doing a good job of targeting them. We're working with over 80 percent of the federally qualified health centers out there. We're working with over 60 percent of all rural primary care providers. So in some of those areas, we certainly are focusing on first of all, identifying the providers and getting them services in those areas, but then also moving them forward.

So a lot of our data segmentation is designed to make sure that we're getting the specific technical assistance needed to make sure that those people get across the finish line, and especially with the Medicaid folks, if there's a lot of, you know, a lot of resources that are needed, a lot of information and a lot of opportunities.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

Great. Thank you.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Just to add to that, that's what we're doing to mitigate any emerging digital divide, but in order to be able to answer the question, is adoption rates or the rate of adoption leading to a furthering of the digital divide, or a narrowing of that gap, I think we need to look at different data sources. And in particular, the attestation data is just numerators, and in order to be able to really look on the meaningful use side, you need to have the denominators as well. And our – working with CMS, our data folks have done some cuts of that, and in the next Policy Committee perhaps we can share some of that – some of those analyses.

But the – I think the – my takeaway from looking at some of the draft – the preliminary data is that we're actually doing a pretty good job, at least in part due to the efforts of the regional extension centers and state Medicaid and others, in making sure that a digital divide does not emerge, either in traditionally, you know, medically underserved areas, or in rural areas.

**Robert Anthony – Centers for Medicare and Medicaid Services**

I will say that we're in the process of taking a look at some of that attestation data geographically as well, so that we can try and break down – obviously, we do have to cross-index to some sources outside of us to try and look by zip code or other indicators to see performance levels, participation rates, based on the attestation data that we do have at this point as well.

**Paul Tang – Palo Alto Medical Foundation**

Gayle?

**Gayle Harrell – Florida State Legislator**

Thank you. I of course am very concerned about especially the rural areas and the underserved areas. Are we looking to see on our regional extension centers which are the high performing ones and which are not performing as well, and what are we doing to assist those lower-performing regional extension centers with low numbers? Because I have a great concern about that, and I've heard from various sections of the country and of the State of Florida on some lower performing ones.

**Mat Kendall – Office of the National Coordinator**

So all the regional extension data is available on HealthIT.gov/dashboard, and you can drill down into a county level to see how many providers they're working with and where they are in terms of performance. So that's all publicly available. And I – what we're doing at ONC is really doing targeted effort for the folks that are behind the curve in terms of moving it forward.

I think that we have a lot of great best practices from across the country that we're deploying to really provide technical assistance and targeted assistance to folks to help them get their numbers up, but, you know, it's a very numeric program. We have lots of milestones, and therefore it's very easy to sort of see who's ahead, who's behind, and to really motivate people forward.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Mat, there was a congressionally required two-year evaluation of the regional extension centers before they got their extension. Can you speak to some of what we found in that, and what was – any actions that were taken by the grantees as a result of that?

**Mat Kendall – Office of the National Coordinator**

Absolutely. There's biannual review, and then we did an update of it at year three. So this is a yearly event that we're looking at. I think the trends that we saw across the board are that there are, you know, project management already see their staff as very important. There are some RECs that were relying on subcontractors, some that are relying on direct staff, and depending on the segment you're going after, different models work better.

So I think partly what we tried to do is assist those RECs that are behind in relooking at their staffing and how they deploy their resources. Other key findings we found were that there are certain markets where you see lots of consolidation, so markets where there were a lot of small providers are now being bought up by larger entities. And this actually causes a lot of problems, because all of a sudden you had a relationship with an individual provider, they get subsumed into a larger entity. That larger entity has different plans. The small provider no longer really knows what's going on. So developing a whole communication program for how we sort of deal with these new emerging practice consortiums has been a big concern, because the healthcare market across the country is evolving very rapidly, and people are making decisions for all kinds of reasons, but again, getting meaningful use there is still important, and we need to make sure we're going back and forth.

So a lot of markets where we've seen this consolidation, we're actually seeing hits on their productivity, because they had timelines that are now on hold, because the new organization has other plans for these providers, and, you know, the last person in is sort of the last person to get assistance sometimes in these rollouts.

**Gayle Harrell – Florida State Legislator**

I have a follow-up.

**Paul Tang – Palo Alto Medical Foundation**

Sure. Go ahead.

**Gayle Harrell – Florida State Legislator**

Also, these were time-limited grants that were put in place for the RECs, with the intention that they were to become self-sustaining. What are doing and what are we seeing happening with business models established to become self-sustaining?

**Mat Kendall – Office of the National Coordinator**

So we have a program called the REC 2.0, which is really – looked at specifically at looking at the business models going forward. And we're seeing, you know, a variety of different business models that are being rolled out. I think it collects them into four different categories right now, and our goal in the next year is really to work with the RECs to support the development of these different models in different places.

We are seeing that people have different regional needs, and different models work better in different parts of the country, and we're trying to dig a little bit more into it. But the four areas that we see very common are one, sort of helping with interoperability, Stage 2 support. A lot of people are interested in, you know, how do I get this information – and so how do I actually begin sending to folks? How do I begin looking at the care transition? Some of the nuts and bolts requirements for Stage 2, getting a jump on that.

We're also seeing an area of interest in privacy and security assessments. There's a lot of confusion in the provider market, and as people are looking for advice, they'd rather have someone who can help them, walk them through it, than try to figure it out on their own. So that's another big area for us. A third area that we're seeing a lot of interest in, and the business models are still evolving on this one, is consumer engagement. How do we set up these patient portals now that we have an EHR to communicate with our providers? A lot of providers just don't know how to do that, and therefore are looking for outside support in doing that, and are willing to pay money to support that.

And the final thing that we're seeing a lot of support is these new payment models that are going out, how to – such as the, you know, shared savings plans, or the Comprehensive Primary Care Initiative, there's a big overlap between those providers and RECs. I mean, with the CPCI sites, we've got about 50 percent of them. With the Advanced Primary Care Initiative, we've got over 80 percent of those sites. Those providers who are actually working no on these programs are now needing assistance, whether it's enhancing their workflows to hit these new targets, and are reaching out to regional extension centers. So that's a whole other area of supporting some of these other new payment delivery models that RECs are actively developing business models on.

**Terry Cullen – Department of Veterans Affairs**

These are a few questions. One is pediatrics. I know I keep asking about this. Can we get any segment data for pediatricians and whether they're staying abreast of what we're doing?

**Robert Anthony – Centers for Medicare and Medicaid Services**

I think we can. I think that it's a little bit more of a deep dig than we had anticipated. So let me go back and take a look at some of that and see what we can pull out. The challenge for us sometimes in looking at something by a particular specialty is that the provider – this will give us some sense. It may not necessarily give us an entire global sense, because some people who are pediatricians or who provide that service aren't necessarily identified in the system as pediatric.

So we can pull that segment, and that'll give us some indication. I don't know that it'll give us necessarily the word of gospel on this one, but –

**Terry Cullen – Department of Veterans Affairs**

And I had one other thing. Slide 17, 90 day performance hospitals, public health is dropping off. I don't know that that means anything. Is that 90 day – I'm wondering if you guys are worried about those. So those aren't just a few percentage points.

**Robert Anthony – Centers for Medicare and Medicaid Services**

So I talked a little bit about this last time. Part of I think what is happening here is that we've got – as we get more providers in here, we may see more – a closer normalization to what we have of percentages. Part of what may be happening here, too, is that as we move forward, there are some registries that are opening, some registries that are closing, so some of it is also a reflection of availability. Some of it is also going to be a reflection of timeframe for submittal. And that's why I think as we get further down the year, we may see a closer tracking to what we've seen percentage-wise. But we're certainly looking at it as we move forward to see what the overall indicators are going to be.

**Mat Kendall – Office of the National Coordinator**

And Terry, if I can just follow up, with the RECs, we're tracking about 46 – we have 46 percent of pediatricians we think nationally working with the RECs, so we are looking at those guys.

**Terry Cullen – Department of Veterans Affairs**

Well, and that's really my concern. I mean, most pediatricians are taking care of Medicaid populations. They should qualify on Medicaid. And I just want to make sure that this unintentional consequence, we're not leaving them behind. So thanks.

**Robert Anthony – Centers for Medicare and Medicaid Services**

I would say that that actually is going to be something of an additional challenge for us, if we're going to look at how they're performing as meaningful users, because the information that we have on meaningful use is on the Medicare side. So the attestation data is – for Medicaid is going to reside with the individual states.

**Terry Cullen – Department of Veterans Affairs**

Well, and I think one thing that we hear in the communities from pediatricians is many of their patients come from newborns, and they're attending at multiple hospitals, multiple EHRs, having to learn multiple systems, and you're getting a ton of pushback from that community, verbally at least. Not pushback, but concern. I need to be on staff. I need to see these babies. They're how I get my bread and butter. And yet I'm now using four different systems.

**Robert Anthony – Centers for Medicare and Medicaid Services**

And a lot of them will be using an inpatient system and not an ambulatory, so those visits would fall entirely outside of what their official meaningful use scope is on what they report. Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Anything else? Thank you very much, Rob and Mat. Great report. So next we're going to move into the IE workgroup's comments on the RFI. As you recall, we've mentioned multiple times that we're overseeing a – the HITECH provisions having to do with – especially with meaningful use in terms of getting money out and encouraging the adoption and effective use of these systems.

There's the pull side, and that's an important handoff we have from the – from getting these systems in place to making them – helping – having the systems help the provider organizations achieve their missions. And so ONC and CMS put out an RFI asking what are – how best to use these other levers. And we had asked the information exchange workgroup to comment on this on our – or make recommendations this group for us to comment on the RFI. So Micky, are you on the phone?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yes. I'm here. Can you hear me?

**Paul Tang – Palo Alto Medical Foundation**

Thanks, Micky. Go ahead.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Yeah. Well, thank you very much for the opportunity to describe the IE workgroup's deliberations on this. We did have a relatively limited amount of time, so I want to thank the IE workgroup members and Kory Mertz from the ONC staff for – you know, for taking a lot of time in the last couple of weeks out of their busy schedules to help formulate some recommendations here. And since I don't talk nearly as fast as Mat Kendall, I think we should just dive right in. So next slide, please.

So the high level summary that we'll now walk through some of the details is that essentially as we looked at this, it seemed, you know, pretty clear that HIE is advancing rapidly across the market, I think as all of us know, but it is being held back in some ways by friction that's created by variation in federal and state programs that somehow – you know, that sometimes give unequal and sometimes even conflicting emphasis to interoperability. And it was the sense of the workgroup that, you know, an HSS-wide review of some of the main areas of this friction, and thinking about what might be the most effective combination of levers for eliminating it might do much to advice HIE adoption across the country.

I mean, essentially, want to make sure that, you know, kind of everyone's rowing in the right direction at the right pace, and as we started to dive down into it a little bit, it seemed that that wasn't quite what was happening. And so we offer some recommendations that we've categorized into a couple of – I think four main topic areas, and then give a little bit of detail on some of the levers that we came up with within each of the topic areas.

And I should say in the up front of this presentation I just gave a high level review of the four topic areas, and then there's an attached appendix that has more of the details. I won't be walking through the details, but happy to discuss any of them, if there are any questions from the committee. So next slide, please.

So the overall approach that we took was to focus in four topic areas, payment policy, providers ineligible for meaningful use, state level program and policy variation, and then leveraging existing HHS infrastructure. And we considered a variety of levers within, you know, each of those topic areas that I've listed there. We didn't limit ourselves to those, but, you know, as we started to go through, we wanted to make sure that we were thinking as broadly as we could about what are all the various policy and regulatory levers that HHS would have at its disposal as it was thinking about how to – how to orchestrate the entire HHS portfolio of activities toward greater interoperability across the market. Next slide, please.

So in the first category, payment policy, and for each one of these, what I'll do is describe – there's one slide that describes, you know, kind of the background of the topic area, and then the next slide will have the recommendations. So as we thought about payment policy, you know, the first thing that struck is that first of, that, you know, the diffusion of advanced payment models, both on the private side as well as the public side, does seem to be, you know, having a very successful just sort of effect on interoperability in the market, and particularly in provider demand for information exchange, both through a combination of carrots, such as gain sharing, shared savings, things like that, as well as sticks, hospital readmission penalties and other such levers.

It is also true, however, that these models are very nascent, and there are a number of areas where they could probably be improved or better or orchestrated. One is the – there's a complexity of requirements. They are highly complex requirements for any of the programs, and then when you think about the alignment of them for organizations that may be participating in one or two of them, you know, it starts to become even more complex, and somewhat confounding, as they start think about how to align themselves with, you know, sort of a uniform health information exchange approach. And that lack of alignment is, you know, sort of across payer programs on the public side, as well as when you think about, you know, public and private.

The other consideration here is that there's relatively slow diffusion of advanced payment models, and in particular, there's going to be a long tail of the fee for service model. So we don't want to forget about that as we're thinking about, you know, what levers could be pulled in the payment policy area. So let's turn to some of those levers. Next slide.

The first is that, you know, we would recommend that HHS work to simplify and harmonize requirements across all the advanced payment models for public and private payers, and we recognize obviously that there's, you know, limited jurisdiction over the private payers, and so that may be more of a collaboration, you know, sort of in using the convening power the government has, more than it would be about, you know, directly regulating that. But certainly on the public side, you know, there is work – and also want to recognize there is work underway, you know, very aggressive work I think underway to try to harmonize the requirements of that.

And so in effect we are, you know, sort of endorsing that, but also giving as much encouragement as we can to accelerating that, and instantiating it in the market as quickly as possible. Because, you know, one of the things that I think came through in the workgroup deliberations on this is that for providers on the ground, there is a lot of focus on the complex mechanics of the current programs, perhaps to – that somehow – and sometimes can obscure or eclipse a focus on the desired outcomes. And, you know, I know we've certainly talked about that in the meaningful use requirements as well, that we don't want people to be, you know, overly focused on checking the box, and should be thinking more about the spirit. I think the same applies as we're thinking about the advanced payment models.

The second is that there is a lag in adoption of HIE capabilities through the advanced payment models, and two areas that we thought, you know, could be effective levers are really thinking about, you know, supplemental payments, and highly focused supplemental payments to – in each – in two of the categories. So one would be for those who are already in an advanced payment model, perhaps having some highly focused supplemental payments to – for – to encourage HIE specific activities. So to the extent that there's already a capitation for those who are in an advanced payment model, who've leveraged HIE capabilities and are able to demonstrate that, perhaps there could be a supplement payment to encourage that.

But, you know, on the other side, you know, which is equally important, which is the fee for service, to the extent that there's going to be a long tail of that, anything that can be done to motivate HIE-enabled activities in the fee for service model, you know, would do a lot to help move the bottom of the – of the market up, you know, as quickly as possible into having greater incentives for health information exchange. And so for example, one example of the lever could be higher ENM coding for cognitive activities, so-called cognitive activities that use health information exchange, such as medication reconciliation, problem list reconciliation, allergy reconciliation, those kinds of activities that right now are largely uncompensated in the – in a fee for service structure, to the extent that they both would generate demand for HIE capabilities, and that a provider could demonstrate that they are leveraging HIE capabilities to perform those functions that are obviously very high level.

Using the ENM coding would be one way that you could use the existing structure to be able to provide greater incentives for that. There are obviously a variety of levers you could pull there, but that's just an example.

And then finally, the third would be – and I see here as I was reading this, as I was reading this, that I wrote this third one down too fast. The voluntary certification program would apply to technology that incorporates HIE functions that enhance enablement of value-based purchasing initiatives. So in the appendix, there are some examples of this, but the idea would be that to the extent that there are HIE functions that would better enable accountable care type of activities that go above and beyond what the meaningful use foundation will lay through Stage 2 and Stage 3, that perhaps there should be a voluntary certification program of technologies that could be enabled in that way to perform those functions.

And again, we recognize that there may be limited to what the current statutory authority that ONC has in this area, and so, you know, it's all within that context that, you know, sort of figuring out what would be the best approach, whether it's something that could be direct in nature, to have the private certification entities develop such programs, and some, like CCHIT, are in certain areas. Or it might be more of a – an encouragement, you know, sort of approach with the private certification entities to develop it, to the extent that ONC doesn't have the full authority to spend dollars on it right now.

So that would be – that covers the payment policy recommendations. Let me turn next to the next category, which is the providers ineligible for meaningful use. So the background here is that while Meaningful Use Stages 2 and 3 area expected to create significant incentives for broader and deeper HIE adoption, they are – I think as we all know, there are significant sectors of the care continuum that don't qualify for such incentives, and also the corollary, they're not subject to the corresponding regulatory authority.

And we grouped those into three large categories. One is long-term care and post-acute care providers, and that, you know, really covers a very complex and diverse ecosystem of providers, but we, you know, kind of put them in one large category. The second is pharmacists, and the third is commercial laboratories. And, you know, just note that it was very clear in the discussions that, you know, the inapplicability of meaningful use to these types of providers, you know, leaves a lot of gaps in the HIE incentive and regulatory framework that really does create some structural impediments to progress in interoperability. So this seemed like to us to be a very important area to think about how to pull any levers available to start to move them forward with some incentives to incorporate interoperability and health information exchange, aligned with the meaningful use requirements, to the greatest extent possible. So next slide, please, on the recommendations.

In general, the first recommendation was that HHS try to harmonize the required documentation and reporting across the programs to be aligned with the meaningful use framework. So there is a lot of documentation that's CMS required documentation for a large number of these providers. So home healthcare, long-term care facilities, a variety of other providers, have, you know, have specific documentation requirements, like MDS/OASIS, you know, home healthcare plans, a variety of things that are required by CMS, and those – that documentation isn't right now aligned with the C-CDA.

Now the long-term care workgroup of the standards and interoperability framework did brief the Standards Committee I think last week on the work that they're doing, and that would be very consistent with the recommendation here, which is essentially to say there ought to be some harmonization of all of that required documentation with the C-CDA elements, so that, you know, so that interoperability can happen both way, to the extent that there is transactions that happen across the care continuum with meaningful use eligible providers that better enable that, but it also allows these organizations that don't participate right now in meaningful use to be able to benefit from the standardization that's occurring in other parts of the market.

Another part would be to have incentives to part D providers to motivate HIE-enabled and HIE-enabling activities, where the idea here is that there are certain things that are specific to the part D program, like the Stars rating program and medication therapy management programmatic requirements that right now are not fully aligned with the interoperability approach that's contained in the meaningful use and HITECH activities. And so aligning that better could move significant parts of the market as well.

And then finally, to the extent that administrative simplification is something we want to be able to move forward on, areas where it intersects with clinical standardization, you know, would seem to be an area ripe for alignment with the ongoing activities from HITECH. And in particular, one of the things that we talked about is just the basic documentation requirements for prior authorizations. To the extent that those exist within CMS, if we're able to align those with C-CDA content requirements, that would, you know, better align that and put us on a path toward interoperability in the areas where it makes sense across the clinical and the administrative interoperability sides.

Focusing on laboratories, there – you know, a specific recommendation is really to – I think as everyone knows, commercial laboratories, though a significant part of the market, are not covered by meaningful use, which is, you know, sort of a gap in an area that's of critical importance in interoperability generally. And so one specific recommendation that the workgroup developed was to provide some safe harbor from certain CLIA requirements related to review and validation of the way lab results are presented in specific technologies, to provide that kind of safe – to provide a safe harbor to commercial laboratories in that review process if the providers are compliant with meaningful use and they're using certified technologies from – through the ONC certification program.

And that might be, you know, an inducement to the commercial labs to align themselves with the – with the meaningful use program through – in a way that would we think smooth the path toward greater alignment across the clinical lab results and ordering process at large.

The second recommendation would be specifically focused on hospital labs, and in particular to increase the aggressiveness of the Stage 3 requirements related to eligible hospital lab results delivery. Right now, that's a menu set item, and it's also connected to lab orders coming in. The recommendation from the workgroup would be that we sort of open that up a little bit more and try to be as aggressive as we think the market can take, and perhaps a little bit further than that, to challenge the market to have hospital labs moving much more aggressively towards standardization as well.

And then the final requirement is, you know, is really consistent with what was in the previous – the payment policy recommendation, which is about a voluntary certification program to the greatest extent possible of technology used by providers ineligible for meaningful use. So long-term care, electronic health records, systems used by VNAs, home healthcare, what have you. And some of that, again, is happening in the private market, but to the extent that ONC in particular can help encourage that and catalyze that among the private certification bodies, it seems that that would be a great enabler of technologies that would facilitate greater adoption of interoperability at large across the industry. So next slide, please.

The next category, the third category of the four, is the state level program policy variation. So there's, I think as the committee is well aware, there's a lot of variation at the state level, and program requirements and policies, some of which, you know, impedes HIE adoption by making it more difficult really for national nationwide vendors or vendors or organizations, provider organizations that have a national market in scope, to create scalable processes, services, and products. And certainly some of this variation lies in differences in programs that have some federal and state components.

So the federal government isn't completely separate from – you know, in some cases, and they, you know, have some ability to influence what happens at the state level. So Medicaid reimbursement, Medicaid waivers, public health, what have you. It's not solely the jurisdiction of the state, and so there are some hooks that the federal government has in trying to influence that.

Recognizing also that there are other types of variation that really are solely rooted in areas where the states have independent policy authority. So we kind of separate those out as we – as we think about that. So next slide, please.

The first is that – is very – is a very broad recommendation, that CMS include in HIE requirements, really in all the programs that include – that they're engaging in with respect to healthcare delivery, and that would include state waivers, future advanced payment demonstrations, and, you know, so as a broad recommendation, being able to have some type of HIE approach, a consistent HIE approach that really is inculcated in each of those programs, so that they're all, you know, sort of moving in the same path with the same, you know, kind of broad roadmap available to them.

And then the second would be to the extent that it makes sense, program by program, to require coordination with the state HIT coordinators, recognizing some – with some programs that may not be practical. There may be reasons not to do it. So that's why we say, you know, as much as possible. But to the extent that that coordination can happen, that would, you know, just be a, you know, another way to ensure that there's a coordination of activities across the various federal programs.

The second is related to public health. I think as we know, the – there is – though a lot of work has been done to harmonize I think standards related to public health transactions, there is still a lot of variability that's allowed at the local level, at the state level, with respect to standards for public health reporting. So to the extent that we can keep moving aggressively, and with the CDC in particular working to harmonize that, that would be a better enabler or a great enabler of greater interoperability.

The third category would be if HHS could create some model language for inclusion in state level programs, some of which they have a little bit of say in, so like Medicaid NCO contracts, some of which the federal government doesn't have say – necessarily have a say in, like state employee health plans, to encourage HIE activities.

So the idea here is that even though there may not be a direct policy hook, that the provision of model language that those state level programs could incorporate and perhaps with the strong encouragement of the federal government, might, you know, be a pathway to getting greater alignment of these programs, and in particular, using some pretty effective – or some levers that ought to be, you know, quite effective in enabling health information exchange at the state level, when you think about the size of state level employee health plans, for example, and the growing penetration of managed care in the Medicaid program. You know, to the extent that those could be orchestrated in a more uniform way than they are now could, you know, provide a great boost.

And then finally the area of privacy and liability, I will say we didn't have a whole lot to add there to, you know, where we are I think as an industry, except to just, you know, confirm and identify that, you know, the variation in privacy policies across the country, and potentially variations in liability policy, although this is an area that we didn't have, you know, as much insight into, do certainly create barriers to broader interoperability at a nationwide level.

And we didn't have any more specific recommendations, other than, you know, HHS should identify and encourage any opportunities for reducing this variation to the greatest extent possible. There was the HISPC program, and to the extent that there are lessons learned there that may be able – that we may be able to draw and where the environment may be more ripe for federal action now than perhaps at the time that the HISPC results were documented, you know, that may be an opportunity area. But we didn't have anything more specific to say there, expect to reflect that it is a need, and there's a lot of complexity there.

So the last area, if we could move to the infrastructure, so the infrastructure topic area is really, A, just recognizes, first off, that HHS maintains a very large infrastructure to manage the variety of programs that they're involved in across the healthcare delivery value chain. So everywhere from healthcare payment, delivery, public health, product regulation, you know, I think, as everyone knows, it's a very broad portfolio.

And the idea here is that some of these infrastructure components and the associated services can be opened up for public use in a way that would catalyze and enhance development of market-based HIE products and services. And really, this is consistent with the open data initiatives that are underway across the government, and really, the recommendation, the broad recommendation here is to try to think as aggressively as possible about how to incorporate those open data principles in every activity that HHS is involved in. So we'll dive into that in the recommendations. Sorry. Next slide.

So we had two broad categories that encompass a lot of things. One is that – is a recommendation for CMS, and I guess this is more HHS at large, to the extent that there are other things that we haven't identified here, or that public health has covered here, so it's broader than just CMS, is the opportunity to repurpose existing data and business infrastructure to facilitate the market development of HIE capabilities.

So one area would be to open up to the greatest extent possible existing databases, like NPES, the meaningful use attestation database, MPI databases, to make data available to the market for a provider directory creation, for example. And this was a topic that the Information Exchange Workgroup had discussed about a year or a year and a half ago when we were coming up with our provider directory recommendations, and there was a strong sense in the workgroup at the time that that data, though it isn't necessarily, you know, being collected for the purposes of provider directory creation, so it's not necessarily, you know, perfectly aligned with what a provider directory to enable direct transactions, for example, would be looking for, it could provide a great feed that the market could build on to create such directories in a better, faster, cheaper way than perhaps would happen right now.

The second opportunity area is to build on the credentialing of patients and providers that – to support validation needs for HIE activities. So to the extent that there is credentialing and validation that happens for patients who participate in Medicare or Medicaid, for example, or to providers who similarly participate in Medicare and Medicaid, to be able to use that process and leverage it for things that are difficult for the market to accomplish right now.

So for example, provisioning patients with DIRECT addresses could be a part of that credentialing process that would greatly enhance the patient's – a patient's ability to be able to take advantage of the – you know, the growing and richer infrastructure that's being created based on the DIRECT protocols. And that's just, you know, one example.

And then finally, a particular area with public health that came up in the workgroup was to enable patient access to immunization information that's contained in public health immunization registries. There are four or five states right now that ONC has been working with, I think very successfully, to have them open up the immunization registries to patient access, but certainly figuring out ways to get that more broadly adopted across the country would – even though it's a very particular area, to the extent that patients get more activated and more engaged in the information that's available to them, I think it was the sense of the workgroup that all of that would – you know, the greater patient activation and engagement will contribute to interoperability more focused on patient needs. So any lever we can pull there is an important lever to be able to pull.

And then finally, the alignment of FDA programs with the meaningful use framework, there's a lot of things to cover there, and I think that the appendix, we detail some of those. But to categorize it in general, there is the device interoperability work that's going on, and that's both for diagnostic types of devices and medical devices that would typically be in a provider organization, but also want to make sure that we recognize that there's a lot of devices, like home monitoring types of devices, glucose meters and what have you, scales, those kinds of things that would happen, that are more patient controlled, and we want to, you know, have greater thought given to the device interoperability at that level as well.

The second area of alignment would be structured product labeling standards, to the extent that there are those kinds of labeling standards, like NDC, for example, that occur within the NDA, the ability to map those cleanly to the more codified approaches that are being taken in the – on the HITECH side, like RxNorm, would – you know, would be a great step forward as we think about this. And then event reporting standards right now, having those mapped to SNOMED, for example, would, you know, be another example of the kind of alignment that would greatly enhance interoperability.

So that's – that concludes our formal recommendations, and I'd be happy to take any questions or comments from the committee.

**Paul Tang – Palo Alto Medical Foundation**

Thank you, Nicky – Micky. Sorry. These are really very, very strong recommendations, so well-thought-out, in a very compressed timeframe, so thank you for conducting all those calls and coming up with this set of recommendations. So I'll remind the group that these are – what we're going to ask for is approval of these comments or edits thereof as a response to ONC/CMS's RFI. So these are not recommendations from the Policy Committee. It's approving the comments to the RFI. Okay? So Gayle?

**Gayle Harrell – Florida State Legislator**

Yes. Thank you very much. This is certainly extremely comprehensive, and I want to say you guys have worked very, very hard on this. There must have been a whole lot of phone calls. The one thing that I find lacking, however, is that when you're talking about providers ineligible for meaningful use, you left out a key group, and that are – that is mental health providers. And I think that is very significant, because it's – we're seeing – when you integrate so many of your medications, your mental health medications in particular, with your – you know, your physical health medications, you have significant problems frequently. And I was just hoping that maybe you might want to take a look, and it's probably too late to include this in it, but I think that's a key group that we need to truly address.

And, you know, this legislation does not allow payment, incentive payments, to mental health providers. But I think when we talk about interoperability, we do need to really target and discuss – and there are specific privacy and security – privacy concerns with that group anyway. So – but we need to make sure that we address that issue.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. I don't think it's too late, Gayle, and I agree with you. It was inadvertent that they're not on that list.

**Paul Tang – Palo Alto Medical Foundation**

So what can happen is Micky can make some edits. I think it's going to cross both the ineligible and also the state variation categories.

**Gayle Harrell – Florida State Legislator**

Absolutely.

**Paul Tang – Palo Alto Medical Foundation**

Thanks. I think Rob was next.

**Robert Anthony – Centers for Medicare and Medicaid Services**

Yeah. I just wanted to – thank you, Gayle. I actually wanted to validate that, because we've been hearing in different fora the same thing about integrating the mental health piece, so I just wanted to check that off. At the risk of committing CMS resources, but these – it was very comprehensive. I think the next step really is there's an eHealth steering committee at CMS that gets several of the key folks around the table regarding payment policies, because it does affect – even though it says HHS, I can checklist off the number of payment policies, and whether we go through a regulatory or non-regulatory or sub-regulatory or whatever other means in order to get to the HIE outcomes that this is implying. So I'd just like to make that as a comment and as an offer, and then I think we need to come back together.

And Micky, you've done a great job, so thank you very much.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Marc? We've got Marc.

**Marc Probst – Intermountain Healthcare**

Again, great job. My comment's on page 4, and it's on the payment policy recommendations. It just seems to me that if the – if the – if there were adequate mechanisms in place for HIE to happen, there wouldn't be a need for supplemental payments to encourage HIE. The benefits itself are tremendous. So, I mean, a concern – we have a lot of payment mechanisms and things for putting into play. I don't know. That was just my comment, that I thought that – I don't know that that's required, if we'd actually just get the infrastructure in place and allow it to occur.

**Paul Tang – Palo Alto Medical Foundation**

Judy, Chris, and Terry.

**Judith Faulkner – Epic Systems Corporation**

One of the things that would really help, and I don't know if this is something that we can do through here, but the patient access to immunization information, there are many different ways that immunization is being stored across the US, so that the vendors can't write one system for immunization. It has to be state specific. Terry just told me that the different – that the CDC gives the states flexibility, and I wonder if that is actually not helpful, but it would be more helpful if there were standards.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Chris?

**Christopher Boone – Avalere Health**

My question is similar to Gayle's. I was wondering, where does the urgent care clinics or retail clinics fall? Are they eligible for meaningful use as well? Or are they considered as part of the HIE strategy?

[Background voices]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Although – yeah. Well, nurse practitioners oftentimes.

**Christopher Boone – Avalere Health**

Medicaid?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, so it'd be under Medicaid. Yeah.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

So yes and no.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Sort of.

**Paul Tang – Palo Alto Medical Foundation**

Sort of. Yeah. Terry, please?

**Terry Cullen – Department of Veterans Affairs**

I have a few comments, but one is overarching. First off, this is great, and I really want to be thankful for it. But I want to follow up on what Marc said. I think there's a more basic issue that we need to get to, which is when I'm in the ER and I'm requesting records, I get a fax back. So I'm wondering just how we move to, you know, e-readers. There's something we're missing in workflow.

And while I think all these incentives are really important, I don't know why I still get a fax. And the expectation is I get a fax and it's 20 pages and that's fine, just last weekend. So I – so I think we need to do all this, but there's some other step, and I wish I was prescient enough to know what it is.

And my other thing is, and this is really related to CMS and the health insurance exchanges. I, and I've been saying this for a while, I think this is a very unique opportunity. I want to engage in a health insurance exchange on the patients. Can I do my privacy and security and my DIRECT address at the same time I'm engaging in that? And I don't need another system, and you guys are the lynchpins? So –

[Background voices]

[Laughter]

[Crosstalk]

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

So what I can say is that for the health insurance exchanges, now the marketplace, is yes, because we've been looking, at least incrementally – well, this is about a year ago now – on the – just on the standards, just on the admin send standards. And so I think we're already asking the question. So I'd like to just validate that, because I think from CMS's point of view, that has taken the back burner because we're setting up the system, but at the same time, it's coming quickly to the front burner now. And I think our engagement with this particular committee and that workgroup is going to be important.

**Terry Cullen – Department of Veterans Affairs**

Well, the one thing I would say is I think we really have this unique opportunity, and obviously, we want to – we don't want to do anything to derail your delivery of the health insurance exchanges. But there is a huge federal investment going on right now in that, and I think we should leverage it. And –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

There's also a lot of state activity and investment and planning on this. Josh, do you want to comment on the marketplace IT and interactions with information exchange infrastructure?

**Joshua Sharfstein – Department of Health & Mental Hygiene, Maryland**

Sure. So Maryland is a state-based exchange, and we have a, you know, pretty mature HIE also. And we've looked at what we – you know, everything is, as I try to explain, version 1.0, 2.0, 3.0. But we're aiming for 1.0 to use the provider directory out of the HIE to allow people to be able to check which plans people are in when they go shopping for insurance. So we actually put in our original grant to ... and got funded for CLIF, which is the HIE to set that up. And so far, that's on track, so we'll see. We think that'll be hopefully part of the 1.0 rollout. Over time, there'll be a whole bunch of other things that – you know, we'll be able to engage on. And then we do have the HIE very involved in a lot of the delivery reform activities, and a little bit related to the insurance exchange, but probably the biggest direct hit is the provider directory for the first rollout.

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

In Massachusetts, we also are going to be using the HIX and Medicaid enrollment process to try to issue DIRECT addresses, for example, to patients. That's underway as a part of the next phase of the statewide HIE rollout there.

**Paul Tang – Palo Alto Medical Foundation**

While you have the mic, Josh, you want to – did you have a question?

**Joshua Sharfstein – Department of Health & Mental Hygiene, Maryland**

No, I was just going to say that I think that the point on aligning payment incentives across all payers, really driving interest in exchange, is really exemplified in Maryland, where, you know, probably not coincidentally, we have the only hospital rate setting system, which does align a log of payment policies, and a very developed HIT, so that the readmission policies, for example, that are set into hospital payment, have driven an enormous of interest and use. And we just had a – in one of our health delivery reform workgroups a presentation for the HIE team saying that they're doing all sorts of reports for hospitals. They're so interested in figuring out where they stand as quickly as possible on some of the new incentives. And it is just – there's just a huge amount of activity.

We also have now I think 10,000 primary care provider notifications about patients when they hit the ER, get admitted, per month, going out. So there's just a huge amount of interest, and it's not question its' being driven partly at least because of the payment points. I think that the point in the report here is very good.

And I would also echo – Judy says about the immunization, I see it from the other side, that we have an immunization registry. We purchased one that we thought was the most common national one for this kind of purpose, and it's been a nightmare of trying to align the individual EMRs to get it in. And so each one is sort of like trench warfare. You have to go and figure out what the connection is. So, you know, from our perspective, a single standard would be much more helpful.

**Paul Tang – Palo Alto Medical Foundation**

Farzad?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Micky, you mentioned on the slide 9 infrastructure, leveraging the infrastructure at CMS for credentialing providers and credentialing patients. Could you give a little more of a flavor of what are the existing opportunities there?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Maybe not, but to the extent that there is, you know, an enrollment process for – you know, for a patient, for example, as they enroll in any of the programs. I mean, so patients I think we've talked about a little bit, with HIX, Medicaid, Medicare, to the extent that there is a validation process that happens there, the idea would be to leverage that. And then similarly, to the extent that providers become enrolled as Medicaid or Medicare providers, to the – you know, trying to leverage to the greatest extent possible the validation process as it happens there as well, and the credentialing process, recognizing that they may not be enough for HIE activities.

And certainly in Massachusetts, as we're looking at that, we're thinking that, you know, it may be that the HIE activity is going to require an additional layer of validation on that, but at least there's a foundation that you can start with.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I think it was actually Carl Dvorak who said as part of meaningful use attestation maybe we should collect providers' DIRECT addresses, and kind of creating a quick and dirty national provider directory. Obviously, there's a little bit of a mismatch between that and what's, for example, in the – you know, DIRECT addresses don't need to be tied to an individual. It can be organizational. And multiple individuals may share a DIRECT address in an institutional setting and so forth. But I think that's the kind of thing you're talking about.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yes. Exactly. And, you know, and as I said, and as you're suggesting, it's not going to be perfectly aligned, but the – I think the idea is that to the extent that that information can be made available, and the design principles behind it are made available, so that those who are using it will recognize the limitations of it and then be able to supplement it in whatever ways they feel necessary to tune it to the purposes that they're trying to use it for.

**Paul Tang – Palo Alto Medical Foundation**

All right. Thank you. Christine?

**Christine Bechtel – National Partnership for Women & Families**

Thanks, Paul. Really great work, Micky. Thank you. And I certainly support moving it forward. I had two things. One is I think a question/recommendation, which is we have Blue Button for Medicare and VA. What about Medicaid? How do we open – is that there, done, or are we thinking about it? Farzad or Rob? Rob?

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

I'll say that we're thinking about it. The question is how do we – and I – this is not to preempt the Medicaid folks who are already inquiring how we would do that with the individual states. So I think that's already happening. I don't know what the answers are, so I think maybe in a report back to this committee, I think we'll – we should get back to you regarding the status of that.

**Christine Bechtel – National Partnership for Women & Families**

That would be terrific, and it might be helpful, Micky, to include, you know, some encouragement for both CMS and also in the states to think about how to do Blue Button there.

The other question I have is – and this may be a function of a shortage of my technical knowledge, but when I think about, you know, Blue Button availability for Medicare and Med – or VA, and then also, you know, in Stage 2 of meaningful use, the only way I think that, Farzad, we get to your, you know, what you have described as consumer mediated exchange, is if the other end can do something with it. You know, like it's not enough to just get it to my hands. How do we make it easy or have we yet made it easy for providers to upload what they need? So we've got view, download, and transmit, but then there's this sort of piece around like how do they upload and use it?

And I think that's either a recommendation that we need to make here, Micky, that I would suggest, or if we've – you know, I don't think we've figured that out yet.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

So let me put this RFI a little bit into context, and I think this answers somewhat Terry's question as well. We're doing a bunch of stuff on the – through this committee, through the standards work that we're doing, and so forth, in terms of dealing with the policy and technical issues to foster exchange more broadly, and then the specific use cases, as you're bring up. For example, we will – we are actually looking at the consumer mediated exchange and saying, well, what else do we need to do, whether it's, you know, a watermark or, you know, the certificates for the patient bundle versus the provider bundle, interoperability issues, to be able to get that piece to work.

This RFI really said, yes, yes, yes. We need the technical pieces. Yes, we need policies. But what we also need is a business case for it to be more profitable to share information than to hoard it. And what can we do on that side through our payment policies, through our other policies, to make it create the context within which there will be a business case for information to be – to be shared. And, you know, making sure the technology is there is really key, but it's not sufficient. And that's what this RFI was saying, that we have a commitment and an intention, a policy intent, to make it never unprofitable to share patient information. That's the – that's the context for the RFI.

And then to say, well, are there opportunities from a policy point of view as well, for example, this infrastructure, to accelerate that?

**Christine Bechtel – National Partnership for Women & Families**

And so that's very helpful context. I think maybe I'm overthinking it, but I think about the challenge that HIE's have had sometimes where they'll have one big health system that doesn't want to play, and doesn't want to share data, and I think about the challenge that consumers face where, gee, you know, I really want to shift away from this provider, but my goodness, you know, I've been with them and I have complex care, and they've got all my data. How do I move?

So if we begin to get data in patients' hands, but also, you know, the ability for systems to upload it, it becomes – then consumers could actually, right, become a market driver, because you've got to make sure I'm happy. Otherwise, health system, the one that doesn't want to play in the HIE, guess what? They don't need to negotiate anymore, because the consumers can take their data and give it to the HIE. So – thanks.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

And then just to answer your other question on the – on the Medicaid side, it is a state by state issue, and there's some states that actually have already moved forward. I'm going to be – the Cajun Code Fest in Louisiana next month is going to be all about the access to the – I think it's going to be all about access to Medicaid Blue Button. So I think there's some exciting movement, but it's state by state by state.

**Christine Bechtel – National Partnership for Women & Families**

Go Louisiana, leading the way.

**Paul Tang – Palo Alto Medical Foundation**

All right. Final question, and – okay, two short questions, please. Art?

**Arthur Davidson – Denver Public Health**

Yeah. First is a comment. I agree with this – thank you, Micky, for the great work. The first is I agree with the – it is a burden for the state health departments to manage these immunization registries, given all the variation you can see in the EHRs. And it seems to me that adding the burden of – although I agree in principle with the concept that a patient should be able to retrieve their information, adding that burden to those registries is not necessarily going to make their life any easier. And we have a method, the view, download, and transmit, through their provider, that should be a way to receive their immunization data. So I'm just wondering whether that's the right way for us to approach it.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. Art, on that specific point, in the appendix, I mean, I covered this at a very high level for the presentation. In the appendix, we do note that it's unclear right now whether direct patient access or access through a tethered portal, for example, tethered to their provider's EHR, is the best way of getting that immunization information. So we kind of left that open ...

**Arthur Davidson – Denver Public Health**

Great. Thank you. So then my question is, on slide 6, under laboratories, you have a point here about provide safe harbor from certain CLIA requirements if providers are compliant with meaningful use and using certified technology. I didn't quite get what you were trying to say there. Is it – are we trying to get laboratories to get more involved here? The commercial labs? And how does that play out? I didn't quite understand that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Sure. So I see that someone is moving forward to the detailed recommendations. Oh, if you skip forward, actually, to the detailed recommendations in the appendix, and I know we're running out of time, but the idea here is that there is a very specific CLIA requirement that we talked about in the workgroup about reviewing the requirement on – that's a burden on the lab, to review the way that the lab results are presented within an EHR. And there were certain requirements about what a new – what constitutes a new EHR, what constitutes a new install, and how – you know, and so therefore, where they would have to perform that review.

And to the extent that that is a burden on a commercial lab, to have to do that over and over again for what may be essentially the same EHR that happens to be deployed in multiple settings, the idea would be that if they're willing to be aligned with providers who we know are going to have to do the structured lab requirements for meaningful use, and all the CQMs and everything else that requires proper management of labs, and means that they are motivated to make sure the labs are coming in, and technologies that are certified for meaningful use so they've, you know, got the ability to handle LOINC and other things, that that would be one way that we could, you know, sort of wave the regulatory wand to give an inducement to commercial labs to try to be more focused on those who are aligned with HITECH.

**Arthur Davidson – Denver Public Health**

Thank you, Micky.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Paul Tang – Palo Alto Medical Foundation**

David?

**David Lansky – Pacific Business Group on Health**

I wanted to support Christine's comment. The problem with the one big player who doesn't want to be involved is a real one. There's a registrant who worked with me, did some modeling around that, and we were able to show that that does very substantially affect the value of the – of the exchange. And in certain markets, there is, you know, one really dominant player, and it seems to me that probably in that sort of situation, we have to use a regulatory sort of approach.

**Paul Tang – Palo Alto Medical Foundation**

Great. Thank you. Let me first list some of the things I heard in terms of some edits, and see whether both the committee and Micky agree. One was the inclusion of mental health in the non-included MU as well as state variation. Another was to take advantage of the insurance exchange as part of I guess infrastructure. A third is the need for single immunization standards. But the question that Art raised is should it – and I think that's something we have to decide, should the patient access, direct access, even be as part of the comments? Inclusion of the Blue Button as part of the consideration for patients.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Medicaid.

**Paul Tang – Palo Alto Medical Foundation**

And Medicaid. Blue Button and Medicaid. Any other things that I missed in terms of edits that came up?

**Christine Bechtel – National Partnership for Women & Families**

Piece for exchange. I don't know if that's –

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

Okay. Where would we put that?

**MacKenzie Robertson – Office of the National Coordinator**

Sorry. We can't hear you. If you could speak into the mic.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Sorry. The single – the issue with a large player who does not want to be involved in an exchange. I think we could just – I think it's clearly an issue, and many of these recommendations are aimed at changing the incentive structure for that large player to want to play versus not want to play. But I think to be really helpful, the recommendations, or the comments back on the RFI, should be quite specific to certain policies, certain regulations, and so forth. And I think absent that, it's – you know, it's just part of the – what we're trying to solve.

**Paul Tang – Palo Alto Medical Foundation**

It actually could come under this – make it part of the payment policies that HIE is part of – being qualified as let's say an ACO. What does the group think about the direct – the patient – direct patient access to immunization? Do we want to include or not include? And Judy had her hand up.

[Laughter]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

And just to clarify, Judy, this is where there are state immunization registries. It's not the vendors. It's where there are state immunization registries that already under law collect immunization information for parents to be able to directly access the kids' immunization history from the state registry, rather than have to be intermediated by the provider in accessing the immunization registry, as four states are doing.

**Judith Faulkner – Epic Systems Corporation**

I think it's a good idea. I don't think it solves the problem of if all the states have different ways of doing their registries, the EHR vendors or the portal supplying – the EHR vendors who supply portals or the portal supply vendors have the same exact challenge. It doesn't solve the challenge problem.

**Paul Tang – Palo Alto Medical Foundation**

Our point is that if we solve – we have to solve the standard problem anyway. That would make the other things flow, and maybe not distract the public health department.

**Judith Faulkner – Epic Systems Corporation**

Oh, I absolutely agree with you, that clearly, patients should have access to it, both directions.

**Paul Tang – Palo Alto Medical Foundation**

Gayle?

**Gayle Harrell – Florida State Legislator**

I just want to add to Art's comments. I think that that can become very problematic to state, and very expensive to states, to have to set up the validation and authentication process, to allow individuals to come into their public health records. I don't know that this committee has the ability to mandate or make recommendations that states do that kind of thing. I think this is beyond the purview of this committee.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, but we're making comments – it is an important point, which is I think why we need to have some kind of agreement on whether to include that or not, because presumably that's a –

**Gayle Harrell – Florida State Legislator**

My thought would be not to include it, because you can get it through your physician records, and to have that – to go down that whole road into requiring states to do something without the finances and ability to do it is very problematic.

**Paul Tang – Palo Alto Medical Foundation**

Let me get a sentiment of the group. Now that – go ahead, Josh.

[Crosstalk]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Josh, as our health department representative on the Policy Committee.

**Joshua Sharfstein – Department of Health & Mental Hygiene, Maryland**

Right. Well, while I'm sympathetic to the idea that it may – that it obviously imposes some technical challenge, the value is enormous. It's enormous not only to individual patients, because they may be in places where they need access to their records that they can't figure out how to get into their physician, you know, portal. And if there was one simple way for the state that people could get in, you know, you're at school, you need to get your kid in school, you don't know this particular portal, but there's a way to do it, and the parent can give consent. You could get it right there. I think it's enormously valuable there.

And then I also think from a public health perspective of, you know, being able to, you know, do immunization clinics and give people their records, you know, being able to do it out of one system is probably going to be much more efficient. So I think – I think it's – I certain would – I'm happy to put the asterisks of, you know, feasibility, but as a goal, I think it – particularly for something that is so frequently utilized as an immunization registry, I think there'd be enormous value in having simple access to it.

**Paul Tang – Palo Alto Medical Foundation**

Art and Gayle, are you okay with the – to go forward with an asterisk?

[Crosstalk]

**Arthur Davidson – Denver Public Health**

So I totally agree with – but for an immunization clinic, that's going to happen by the provider giving the immunization. They're going to have access. In our state, that's the way that works, that you can get access. So I think that's – that could be a model for that. I just think that the – the idea is great. It's just that the state health departments are under a lot of pressure right now. That's the first thing.

The second thing is that in Stage 3 we say that immunization data is going to flow to the record from the registry. So we're now – are we going to be able to use that flow well for the patient? I'm totally in favor of patients getting access. It's just that I'm concerned about the cost to states to make that happen. The feasibility is the issue. That's the asterisk.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

So the committee is in agreement about the single standard for state immunization so that information can flow. And let me just do sentiment on terms of either not having it or having it with an asterisk. Not have – not including it in the – all those in favor of not having it – the direct patient access included in the comments? Okay. So that means – all in favor with the asterisk? Okay. So – all right. So that's the way – did you get that, Micky?

**Micky Tripathi – Massachusetts eHealth Collaborative**

I couldn't see the hands.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

There was – it was unanimous, I think, in terms of getting – adding an asterisk and explaining that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Paul Tang – Palo Alto Medical Foundation**

The challenges.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Very good.

**Paul Tang – Palo Alto Medical Foundation**

Let' see. Are we ready – any further discussion? Are we ready to vote on accepting these comments? Okay. All in favor – oh –

**Gayle Harrell – Florida State Legislator**

Where does that asterisk go, though? Should it also say that we recommend that a single standard for the country is ...?

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

We already said that.

**Gayle Harrell – Florida State Legislator**

That is in there? Okay.

[Crosstalk]

**Terry Cullen – Department of Veterans Affairs**

Unasterisked.

**Paul Tang – Palo Alto Medical Foundation**

Unasterisked.

[Crosstalk]

**Gayle Harrell – Florida State Legislator**

Unasterisked. Okay.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

An unambiguous, you know, recommendation. Okay. All in favor of the asterisk – the qual – the comments as presented by the IE workgroup with the – with the additions of – that we mentioned, and an asterisk about the direct patient access. All in favor?

**Several**

Aye.

**Paul Tang – Palo Alto Medical Foundation**

Any opposed or abstain? Okay. Well, thanks again, Micky and the whole IE workgroup in making these very, very –

[Applause]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Okay. We're –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Will you get applause, Deven?

[Laughter]

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

Deven and Paul always get applause. It's – we might as well applaud while – as they walk up, particularly for being patient with us, because we are behind. But the good news is the privacy and security tiger team are so good –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

– at telegraphing the thing that they're discussing. So we heard – of the three scenarios, we covered scenario one in pretty good detail in previous conversation.

**Deven McGraw – Center for Democracy & Technology**

Yeah. Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So we probably can go over that pretty quickly and move on to scenarios two and three.

**Deven McGraw – Center for Democracy & Technology**

Yeah. So we'll definitely streamline the presentation. This is – you know, we began to give you pieces of this in an earlier presentation. And we actually tried to do that purposefully, so we're not trying to hit you over the head all at once with all of this stuff, because we know it can be complicated.

Just a recognition here of the members of the tiger team. We did work fairly hard and for a fairly long amount of time on these recommendations on query, and I want to give a special shout out to my co-chair here, who is the reason why we're actually able to report recommendations today at this meeting, as opposed to six months from now, because these – all of our issues, I think, at some level, could be talked about and talked about and talked about forever.

So we are talking about query and response. So query for a patient record, and then the duty of the data holder to then respond in turn. And we know that this is actually already happening in healthcare, so we really focused on what are the new challenges and questions that are raised when you automate this process. And we're also fortunate that we already have some law in this area already. We're not – it's not the Wild West. HIPAA and other laws at the state level and federal level regulate when most healthcare providers are allowed to disclose identifiable protected health information, including in response to a query for records.

But keep in mind that these rules permit but don't require in most circumstances that this information be disclosed. And as a result, if there are uncertainties with respect to liability, whether one can disclose, whether one can't disclose, you know, the path of least resistance from a liability standpoint on the privacy side would be not to disclose.

And so we saw a high degree of value in going through a few query scenarios and coming up with recommended approaches that we think would be reasonable for providers on both ends of that transaction to adopt as a policy matter in order to try to clarify what's a best practice for moving forward when you do query?

We did three scenarios, as Paul explained. The scenario one is the – probably the easiest, but it's the foundation on which we built the others. It's what's called a targeted query for direct treatment, and HIPAA is the controlling law. There are no other additional laws in play. We'll talk in a second about what we mean by a targeted query. I'll tell you. Why keep you in suspense? Targeted query is where you know where the patient's record is. I need to find Dr. Cullen, because I know my patient has been seen by Dr. Cullen, and I know she has some records that I want.

Scenario two, same exact scenario. You know who the end point is, but in scenario two, additional law applies beyond HIPAA, and mostly that involves the need to get the patient's consent before the information can be disclosed.

And then in scenario three is the scenario where you don't in fact know where the patient's record is, and you need to find it.

So we can skip through the explanation on scenario one because we went through it. So what are some of the sort of existing obligations that providers on both ends of this transaction have when a query comes in? Well, the data holder has to have – the data holder who's the disclosing entity for HIPAA, that's where all the liability rests, right? You can't disclose that unless you are permitted to under say, since this is treatment, you're disclosing it for treatment. So what do you need to know in order to respond to a query of information for treatment purposes?

Well, you need some reasonable assurance that the entity, you know, who's asking is an entity that's treating the patient. You need some reasonable assurance that there is in fact a treatment relationship that exists there. You have to – you make a decision about whether to release the data. Again, under HIPAA, if it's treatment, you don't necessarily need the patient's consent to do so. And then if you are responding, of course, you need to send the right data back, and you need to properly address it, and you need to send it in a way that's secure. That's the HIPAA security rule.

The requester, then, if you sort of look at what the data holder needs to be assured that they're doing the right thing, well, the requester has to present some identity credentials, and they have to have some way of presenting that they're in or about to enter a treatment relationship with the patient, and they have to send enough information or – to the data holder to be able to match the right record to the right patient. If it's John Smith's record, is it the John Smith at Oak Street, or is it John Smith at Salem Street? Is it the – etcetera.

So we tried to go through each of these elements of – that could create uncertainty.

#### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

It's important to note what is not there is a requirement for specific affirmative consent.

#### **Deven McGraw – Center for Democracy & Technology**

That's correct, because that's scenario two. So we really are assuming in scenario one that you have a HIPAA control – a situation where HIPAA is the law that you need to follow. And again, for those of you who don't read HIPAA every day, if it's for treatment purposes, you do – you are not required to get the consent of the patient in order to disclose identifiable health information for that purpose.

So what would support reasonable reliance by the data holder that the requester is in fact who they say they are on identity? And for each of these questions, there's no one way to do this, but there are a range of possible options where if the data holder took that action, it would seem reasonable that they could rely on that. One would be the use of a DIRECT certificate, that the query comes through a DIRECT certificate. And again, if it's issued at an entity level, you can have an expectation that the identity has ID proofed and authenticated the individual participants, because the law already requires that.

Let's say you're all members in a trusted network. The data holder can rely on the documents that they've signed and rely on that relationship. What if the requester is known to the data holder? They have a preexisting referral relationship. They know who's on the other end of that transaction. They can take comfort in that. None of these is 100 percent foolproof, right? But it is reasonable to rely on all these options. And that's not to say that there aren't others that one could add there, but those were the ones that we thought were existing vehicles that folks could rely on in a query – in a digital query response environment.

What would support reasonable reliance that the request has or will have a direct treatment relationship with the patient? And in this particular scenario, that creates the legal authority to be able to access the record. Well, there's a range of responses for this one as well. The data holder has knowledge of or a history of transacting business with the requester, and has come to trust that when she queries for patients, she's on the up and up. Again, we've already solved the – we've already started that the identity issue has to be resolved in a reasonable way. Here, if you have an existing business relationship with somebody and you've come to trust them, it should be reasonable that you can rely on that.

Are you in a network where you can actually confirm that, where you can actually do a look-up and see if that patient is being seen by another provider? This is a possibility, not always – not always a capability in some circumstances, but where it exists, it's reasonable to rely on it. Again, you're using a network that you trust, and you have – there are penalties associated with falsely attesting that you have a direct treatment relationship with the patient.

In some cases, even if patient consent is not required, let's say the treating – the treating provider is sitting with the patient and says, you know, you want to let them know that you're okay with this – with this transaction occurring? You know, even if it's verbal? Maybe it's just a written, you know, please share my data with this healthcare provider. It's reasonable to rely on that, too, unless you have contrary information in your own records that suggests that in fact the patient wouldn't want the information to be disclosed in that circumstance.

This, we want to make very clear here that we're not setting up a situation where we're saying consent is required in the circumstance. What we're saying is that you have it, it's reasonable to rely on that as assurance that there's a treatment relationship in place with that patient.

And then, you know, perhaps you already know that the treatment relationship exists, again, because the patient has talked about it previously, or there's some other indications that you have that can enable you to trust that this treatment relationship exists. This is a real spectrum. Again, it's not all of it 100 percent foolproof, but all of it feeling very reasonable to us as ways that entities can rely on it.

So then we asked the question of does it really matter if the data holder is making a human decision to disclose, or if the data holder's response is automated in some way? For example, being set by the data holder or being automatic by participation, such as in a network. And what we said here is yes, it does matter. We do think that the – that data holders may make the decision to automate how they respond to queries, and that they should actually have policies to govern when automatic response is appropriate, just as they likely do today in terms of how they respond to queries that come in through fax or by mail or by phone.

And such policies should ideally be sort of linked to the degree of assurance that they have about questions one and two, or am I sure that I know this person is who they say they are? How confident am I that there is a treatment relationship? It's sort of a risk-based assessment in some way, but not really that different from the decision-making that occurs on a daily basis today in non-automated environments. You can automate the algorithms, for lack of a better word, or maybe that is the right word, that you customarily in order to make decisions about releasing data.

So then we asked a second question. So to what extent does automation trigger the previous recommendations that we made that you all adopted on meaningful choice by patients, and we have some backup slides to remind folks about what those recommendations said. And just to shorthand what they were, they were very much – what was important was whether the data holders still had the capacity to make decisions about when to release the records.

So what we said for this question was if the data holder maintains the ability to make decisions on when to disclose a patient's information, they can choose to automate those decisions, such as by following the similar policies that they use within their records departments – assuming they have a records department – records department today to release that information. But if you don't have that discretion over your record release policies in ways that you do today on a non-automated circumstance, then we really think our previous recommendations on meaningful choice in circumstances where data holders don't have that decision-making capacity anymore would apply in this circumstance.

So then we asked yet another question. The matching issue. You know, clearly if the query's coming in, you need to be able to match the information to the right record. And so what – how much identifying information about the patient should be part of the query? Well, you know, here from a policy standpoint, we didn't want requesters to over-disclose information about the patient, so ideally, no more, but then again, you don't want under-disclosure so that the match can't happen, right?

So there is this sort of sweet spot of disclosing information to the point where you have some reasonable assurance or a high enough degree of confidence that this is the right record, and of course, you start with the demographics. And here, we really felt like the recommendations that we as a tiger team had previously made on the issue of patient matching accuracy and that the Policy Committee had endorsed several years ago were worth reiterating. And this is actually just a summary of what was in here, but a recognition that this is an issue that is about data quality, that is about consistent representation of data, so that – so that there's address match, so that that kind of – even automated matching might be able to occur – that this is an issue that both providers and health information exchanges need to focus on in terms of improving matching accuracy.

And there's also a role for ONC to play in disseminating best practices about what types of algorithms work in the matching context. We did at that point, and it's not on these slides, but it certainly is in our previous letter, we did talk about the issue of a unique identifier. And what we said was that it's not a panacea, and that all of this – these other issues would also have to be focused on, because at no point does anybody ever match with just two data points, name and number. You're still going to need for these other elements to be there and that – and we sort of wanted to resurface those recommendations as part of this constellation of recommendations.

Another question we asked, again, all relate – all under scenario one, right? But the good news is we built a foundation that much more easy to talk about scenario two. What's the obligation on the data holder to respond to a query? And the last thing we wanted to have happen is the response of silence. We do not think silence is an appropriate response to a query. We think that data holders should have a duty to respond in a timely manner by either providing the information that's been requested or some sort of standard response that indicates that the content that is requested is not available or cannot be exchanged. And this is the approach that's taken in the DURSA. The DURSA is the Data Use and Reciprocal Support Agreement that supports eHealth exchange.

Here's another one that we didn't get a lot of time to discuss in our last Policy Committee meeting, and that is should there be a requirement to account for and log the query and the response, and then to share that log with the patient upon request? And we said as a policy matter the answer to this should be yes. The data holder should log both the query from an outside organization and the response regardless of its content. So even if the response is no, it's not available, that should be logged.

And that this – and similarly, the requester should also log the query. We had quite a bit of conversation about whether this should be a reciprocal obligation, and the agreement of the tiger team was that yes, it should be, and that this should be available to the patient upon request. This is something that we hope that the Standards Committee will take a look at in terms of sort of building the technical capability for this to occur. In terms of sort of having some members of the Standards Committee on the tiger team, the sense was that for this query and response type of transaction, that that would be possible. Now timing I don't know, but it would be possible.

You want to add anything to scenario two? I'm breezing right through this, Paul. Thank you.

So in terms of scenario two, this is – to be clear, it's exactly the same. It's still targeted. You know your end point. But in this case, you have additional law that you need to abide by, and typically, this is a law that requires the patient's consent before the PHI can be disclosed. Many of these laws apply at the state level, but also from a federal context, federal substance abuse treatment laws require patient consent for disclosure of identifiable information. Similarly, if you're covered by the education rules, FERPA, you need the patient's consent to disclose information as well.

So without re-debating whether those laws were right or wrong or whether they create problems or don't create problems, they still exist, and the reality is that providers ideally need a technical capability to be able to comply with them. And in this particular case, we're talking about the ability to communicate the need for consent, to communicate what needs to be completed in terms of the information that's required to obtain from the patient, and then to have that sent back and all of it to be recorded.

And so the form, though, of this consent might be different depending on what state you're in and what the particular requirements are. So it's a little bit difficult to do a one size fits all here. So we said that as a best practice, and to be able to assist providers in complying with law that may apply to them here, that there ought to be a technical way to facilitate this back and forth communication about what consents are required, to getting the patient – to getting that consent obtained, and to passing it back.

And, you know, and this is just a couple of examples of the sort of communication that we're talking about here. So data holders might have to tell a querying entity, hey, you know, I'd love to give you this data, but guess what? We can't – I cannot do it in my state because I need to get a patient's authorization before I can share this data. Here's either the authorization I need you to fill out, or here's the information I need you to get from the patient, and I need the patient to sign it, and either I'll take an electronic signature or I can't, based on my own legal obligations. And then that can be communicated back.

And as another example, let's say it is data that's subject to the federal substance abuse treatment laws. The other piece of information that needs to be able to be communicated is that the data is actually subject to this additional obligation, because this particular set of federal laws attach to the data and affect subsequent re-disclosure by anybody down the chain, and you need to be able to communicate that the data is part of that.

So ideally, this could happen in – with some automation and technical capacity, but it's going to be a challenge, because from what we hear, the standards are not – are not necessarily quite mature, but the laws at least today are there, and if we really want to talk about eliminating friction and at least being able to facilitate in the environment that we need to operate in today, we need to be able to do that. And so we have a clear directive here to the Standards Committee to give further thought to a technical way of getting this done.

And we wanted to make sure that the Standards Committee understand that we're – we actually think that the use of sort of a service for this, like a consent management service, is certainly an option for providers to use, assuming that it meets their legal needs on both ends.

We – even though it is not our business to change these laws, we did want to reiterate the concerns that we initially articulated in our 2010 letter on consent, which is that this is – we recognize that this is a very complicated area, and that providers are very concerned, and some patients, too, about the constraints, the friction, as Micky said, in terms of sort of sharing laws in the face of more stringent rules on certain types of data. We had a lot of discussion about mental health data and the need to be able to share that, but that's the type of data that's subject to more stringent laws, frequently.

On the other hand, there is a concern on the part of some privacy advocates and patients that people won't go in for treatment if they can't get additional guarantees about confidentiality protections on this data, and this is always a critical tension that is – that sort of underlies the discussions around all of these laws, one would have to assume, before they're even enacted. So this is not easy stuff.

We also want to ideally be able to facilitate compliance with these laws, because the last thing we want to have happen is that people decline to share this data because it's complicated because of additional laws. But the circumstance that we're in today requires us to sort of deal with the environment that we're in while we continue to sort of pressure on whether this is the right environment for us in terms of going forward.

Scenario three. You don't know where the patient's records are. How do you find them? So the – so this is really about initial query to find the locations of the patient's record, and the next bullet says it may require the use of a service. I don't see how you do this without a service, frankly, you know, a record locator service, a master patient index, a data element access service, if you look at the way the PCAST report framed it. You have to find out where the patient's record is.

And so the first question that we came to was one of whether patient's should have meaningful choice about whether or not they're even included in this – in a record that permits queries from external providers. And the clear response from the tiger team was yes. This sort of fits into the scenarios that we came up with in our – in our original considerations of this consent issue. So there should be choice.

The issue that we could not get to, in part because we ran out of time, but that we would be happy to continue to deliberate on, and we – if the Policy Committee wants us to, or we would just at least like to get your impressions, is whether queries should be – need to be limited in some way. You have to do it by geography, for example, as opposed to being able to query anyone in the nation. This is assuming that we actually have aggregator services that are nationwide as opposed to the circumstance we have today, which is where these exist, they're limited to the providers who are participating. If you think of CommonWell and the network that they're trying to put together, that will not necessarily be limited by geographic boundaries. Similarly, with Epic's Care Anywhere service.

The Social Security Administration representative on our call acknowledged that they – right now, the queries for – I assume it's e – the eHealth Exchange that they're part of, where they query records to do social security disability determinations, that they – that they can't sort of do a broadcast query, that there are some limits to sort of where they're querying, so there's not this sort of broadcast out there kind of query.

And you could sort of see a circumstance where if you place some limits on the query, you sort of limit the opportunities for mischief, right? You require people to do some thinking ahead of time about where the records might be based on the fact that most people get care locally, geographic homes for most of the patients that you see on a regular basis.

On the other hand, you place geographic limits, and you create a circumstance where if the patient shows up in an ER and you have no idea where they live, but you do know their name, or you have an address and it doesn't – it turns out that it's an old one, you might not be able to find them if you're – if you're not allowed to query in multiple places.

So we just couldn't – we didn't have a lot of time to get to this, and it's a little bit of a meaty issue. We would be happy to go back and continue to chew on it, unless the Policy Committee feels strongly that they can just answer it, and we'd be okay with that, too. Paul, anything you want to add?

**Paul Eggerman – Businessman/Entrepreneur**

Good job.

**Paul Tang – Palo Alto Medical Foundation**

All right. Thanks once again for dealing with these tough issues with very clear recommendations and rationale. Farzad?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

First of all, fantastic. I mean, you know, in a way I feel like there's been bits and pieces of this, and we've done work on this, but there continues to be questions out there in terms of what are the rules of the road on privacy and security for different kinds of query, and I think you have taken a big step forward in answering those questions from the standpoint of the federal advisory committee, and it's really to be commended.

In a – last year, in March, we provided in a policy information notice to our state HIE grantees many of the same elements here that have been processed by the privacy and security tiger team. One thing – one difference that I noticed was that in determining whether a treatment relationship exists, we had specifically said that an attestation or artifacts, like ADT trail, whether a prescription was written, and so forth, such as are used by some health information exchanges – I think Regenstrief is one – can serve as establishing that connection. I noticed that was absent here. Is that deliberate or not?

**Deven McGraw – Center for Democracy & Technology**

I think we just worded it differently, Farzad.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Okay.

**Deven McGraw – Center for Democracy & Technology**

Yeah. We – now I have to find –

**Paul Egerman – Businessman/Entrepreneur**

I think there's someplace that says if it's a known relationship.

**Deven McGraw – Center for Democracy & Technology**

Yeah.

**Paul Egerman – Businessman/Entrepreneur**

And so instead of an artifact, a known relationship would be if you had ever –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Evidence that –

**Deven McGraw – Center for Democracy & Technology**

No, here's –

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

Yeah.

**Deven McGraw – Center for Democracy & Technology**

Yeah. That's part of it. Here's the other way we worded. We said capability to confirm within the network IDS. So in – we can add those as examples, but we didn't – you know, it's sort of you're in this network, and you can – they can give you indicia, like the medication list, or list of who's prescribed the medication, that suggests to you strongly, and you can rely on that.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

ADT messages.

**Deven McGraw – Center for Democracy & Technology**

Right. Right. I mean, you know, it – we didn't actually have pure unadulterated attestation on this list. We – I would say that each of our elements here has a sort of other component to it, which is that you have knowledge of who this is. As Paul said, you're in a network that you trust, where you have penalties for false attestation, as opposed to something that comes in and says, I have a treatment relationship with your patient, and you don't have any other indicia.

[Crosstalk]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

No, I think we meant a patient attestation –

**Deven McGraw – Center for Democracy & Technology**

Oh.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– which is similar to the patient consent.

**Deven McGraw – Center for Democracy & Technology**

That's similar to patient consent.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah.

**Deven McGraw – Center for Democracy & Technology**

Exactly. We just worded it differently.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Thanks. Judy?

**Judith Faulkner – Epic Systems Corporation**

Two things. The first is on page – well, in slide 17, the sensitive data – by the way, I thought it was excellent. Thank you. Those – the rules for sensitive data were originally developed in a paper world, and I'm not sure how the EHR vendor is compliant or whether we are able here to help the EHR vendors be compliant.

So here's an example. Some of the rules that I have read in the state say that anything done in a separable mental health environment – it could be a mental health facility, it could be a mental health wing of a multi-specialty group – but anything done in a separable mental health environment does not get shared.

Well, when the EHR vendors have integrated systems, if the mental health professionals put in an allergy, put in a med that isn't a mental health med, then what does that mean? Because is that not shared? Or is there a way that the vendors can understand which diagnosis – like with HIV, it's easy. It's a limited set of information. But if it's all mental health, we're told a mental health drug may be used for mental health, but it may not be used for mental health. So do we – how do we – I think how do we help the vendors be compliant? Because the vendors don't know how to – don't know how to do this.

**Paul Tang – Palo Alto Medical Foundation**

Is this the slide you're referring to, Judy? This is 17. I'm not sure this is the right one.

**Judith Faulkner – Epic Systems Corporation**

I can't hear you. What, Paul?

**Paul Tang – Palo Alto Medical Foundation**

Is this the slide you're referring to?

**Judith Faulkner – Epic Systems Corporation**

Well, it may be –

**Deven McGraw – Center for Democracy & Technology**

I think it's the whole scenario, too, really.

**Judith Faulkner – Epic Systems Corporation**

It's the whole scenario. Yeah.

**Deven McGraw – Center for Democracy & Technology**

Yeah.

**Judith Faulkner – Epic Systems Corporation**

And it's not that vendors don't want to be compliant. I think that there's a big problem with understanding how to do it, given that nowadays information is entered in any place, and it may apply to many different things.

**Deven McGraw – Center for Democracy & Technology**

Right. Well, and I think – I think there's also an issue of sort of what does the law specifically say, and it's probably – and for mental health data in particular, where it's that – the source of that law is at the state level, it might be slightly different. Many of the state laws have exempt – exceptions for medications, so that the other mental health data may be covered, such as a diagnosis, or, of course, HIPAA does have restrictions on psychotherapy notes and the ability to share that. But medication data can still be shared.

And I think a lot of times there is a knowledge out there that there is a mental health law in the state, and not a lot of clear guidance on how it's being interpreted. And of course, what I might tell you that the law means is not necessarily how the regulators in that state might interpret it. So I do think it's a challenge. I – you know, I'm not quite sure how to deal with that. You know, one of the IE workgroup's earlier recommendations was to – you know, to try to continue to take a look at the state variation and to try to be helpful to try to, you know, sort of identify areas where, you know, if states were able to work together to sort of try to figure this out, it might – it would certainly be helpful.

We certainly don't have the authority to tell states to change their laws, nor does ONC. But this issue keeps cropping up and cropping up and cropping up and cropping up, and yet, you know, there isn't – you are hearing periodically of some states deciding to change their laws and adopting sort of federal law as their sole health privacy rule, but other states take exactly the opposite approach, which is to continue to respond to the needs of their constituents and say, we're going to – we're going to enact even more protections on this data than we had before it was digitized.

So, you know, other than to say, you know, certainly examination, you know, talking to the regulators at the state level and examining what's in the law, and particularly asking states in contiguous borders where the – where there's a lot of sort of cross-border movement of patients, to try to just sit down together and figure out a consistent way of interpreting this, doesn't help a national vendor, though, because ultimately, you know, a solution that works across the board would obviously be more desirable from an implementation standpoint.

**Judith Faulkner – Epic Systems Corporation**

And then – and so I –

[Crosstalk]

**Deven McGraw – Center for Democracy & Technology**

We'll be helpful in whatever way we can, but I'm –

**Judith Faulkner – Epic Systems Corporation**

Yeah.

**Deven McGraw – Center for Democracy & Technology**

– sort of struggling with what more we could possibly say on this issue.

**Judith Faulkner – Epic Systems Corporation**

Right. I think the vendors are struggling very much. The other thing I didn't understand was on slide 11, if the data holders don't have discretion over record release policies, could you tell me – I always thought that the data holder would have control. I can't imagine a scenario in which they don't, and I wondered if you could tell me that.

**Paul Egerman – Businessman/Entrepreneur**

Well, this scenario, again, you're thinking about a situation where it's an automated query response. And so the basic issue is if you have some automation process, basically, as long as in that process the data holder is able to implement some set of rules, not just respond to everybody, then –

**Judith Faulkner – Epic Systems Corporation**

That's what the first bullet says, if the data holder has rules, then you can automate it.

**Paul Egerman – Businessman/Entrepreneur**

Right.

**Deven McGraw – Center for Democracy & Technology**

Yeah.

**Judith Faulkner – Epic Systems Corporation**

The second one seems to say if the data holders don't have rules, and I don't understand that one.

**Deven McGraw – Center for Democracy & Technology**

It's – well, if the data holders don't have the capability of exercising their rules. So in other words –

**Judith Faulkner – Epic Systems Corporation**

Well, are you saying there that if they have rules but they can't automate those rules? Perhaps you should change the –

**Deven McGraw – Center for Democracy & Technology**

Be happy to clarify in that way.

[Crosstalk]

**Judith Faulkner – Epic Systems Corporation**

Yeah. Okay.

**Deven McGraw – Center for Democracy & Technology**

That is what we meant.

**Judith Faulkner – Epic Systems Corporation**

Okay.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Just a clarification on that. Let's take the example of a consortium or any data sharing network that has agreements, binding agreements on each other that say if you want to be part of this network, you've got to respond to every query with – not with just saying that I can't share it with you, but you've actually got share the information. You've got to be all in. Would that fall under category two?

**Deven McGraw – Center for Democracy & Technology**

So assuming that there is – that they – that the conditions for release that they're all agreeing to are not ones that they would feel would be the very rules that they would make for themselves in terms of discretion to automate, they're sort of being forced into kind of a take it or leave it circumstance, I think we would say, again, our – that there would be meaningful choice that would apply in that circumstance, again, because going back to our very original framework about the patient not being surprised and rely – and trusting the data holder to make decisions on their behalf in circumstances where they don't control the records, we've always sort of framed it as the data holder should be able to make the decision, and they can automate those decisions, and they can choose to get an agreement that automates those decisions across sort of multiple providers.

But that – they – that has to be sort of consistent with the way that they would decide to release records anyway, right? Otherwise, if it's sort of – you know.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

You may want to – if you're editing the second bullet there, you may want to incorporate that concept, that that includes areas where participation agreements essentially have an all or none, you know, binding the hands of the provider in terms of what they – discretion they have over the policies.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Gayle?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Which is not uncommon.

**Gayle Harrell – Florida State Legislator**

Thank you, Paul, and again, being part of the tiger team, I can say this is a whole lot of hard work, and I want to thank Deven and Paul in particular for all your hard work in keeping everybody on task during those very lengthy meetings, very lengthy meetings.

[Crosstalk]

[Laughter]

**Gayle Harrell – Florida State Legislator**

Keeping me on task, and shutting me up occasionally.

[Laughter]

**Gayle Harrell – Florida State Legislator**

But I do want to make a comment on the data – on the issue that Judy's bringing up. And when we're talking about whether it's mental health, but I also want to remind people, it's not just mental health issues. It's also things like HIV, STDs, abortion issues. It's not just mental health that are – that are – you know, that are part of the problem.

And this goes back to the whole discussion on the PCAST report, and data segmentation. And I think, you know, that whole issue and how we go about doing that maybe needs further conversation on the data segmentation elements, and how you would do that.

**Paul Egerman – Businessman/Entrepreneur**

So Gayle, to show you how much I enjoyed keeping everybody on task, it's – the data segmentation issue is a very interesting issue, but that's actually not what we're trying to address with these recommendations. You know, we're trying to address sort of like the rules of the road as to when –

**Gayle Harrell – Florida State Legislator**

Correct.

**Paul Egerman – Businessman/Entrepreneur**

– we have to do meaningful choice. You know, what constitutes a – you know, information about treatment. And the basic assumption is when you provide – when – if you're the data holder and you respond, you're going to respond in a way that is legal. Yeah. That corresponds with whatever the laws are. And so if you cannot do that electronically, then you have to do that manually, or then you don't respond. But, you know, that's the basic assumption. But again, we're not trying to figure out how segmentation is going to work.

**Gayle Harrell – Florida State Legislator**

Correct. And I want to clarify that, but I think that's a conversation – that does not apply right now, but that is something that perhaps needs some conversation. These rules – this is for when you're not using a data segmentation model, and you're simply saying – establishing the rules of the road. When you have those kinds of elements, then that personal intervention comes in, when you're dealing – and that's a problem for vendors. I totally understand – a huge problem for vendors. But it's not going to go away, because states are not going to change their laws without absolute federal direction, and I can tell you they're not going to like it one bit, because you have communities who feel very strongly about these issues.

**Paul Egerman – Businessman/Entrepreneur**

And, I mean, I agree that part is a problem. It's a problem if you're a vendor, just finding out what the laws are in a state.

**Gayle Harrell – Florida State Legislator**

Absolutely.

**Paul Egerman – Businessman/Entrepreneur**

And HIPAA is nice, because it's sort of like all in one place, but you go to any other state, and there's like 250 different laws on privacy. And no – and there's not a single person who can tell you how it really works.

[Background voices]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– suggest – these recommendations don't cover the granular data segmentation issue, but it may be something that in the – is addressed in the future, in terms of the implications that it would have for –

**Paul Egerman – Businessman/Entrepreneur**

That's correct.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– meaningful choice and so forth, right?

**Paul Egerman – Businessman/Entrepreneur**

That's correct.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Okay. Terry?

**Terry Cullen – Department of Veterans Affairs**

I have – well, I wanted to comment on this, so I'm going to take this opportunity. The problem is that – I don't even think it's a state problem. I think it's a federal problem. We don't know how to implement this electronically. So Paul and Deven, first off, this is amazing work. I'm always blown away that you guys take a very complicated subject and make it understandable to me, so I really appreciate it.

But I do think we need to be cognizant and respectful of where the industry is and what the industry can do, and, you know, VA is working on data segmentation. It's a huge issue. We make a little inroad, and then we kind of jump back a little. So I – my concern is not that the recommendations aren't appropriate, but the implementation of them is going to lag. And I think we just need to be – we're cognizant and acknowledge that as we go forward.

**Deven McGraw – Center for Democracy & Technology**

Yeah.

**Terry Cullen – Department of Veterans Affairs**

And then I had some very –

[Background voices]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Terry, are there specific – because the recommendations don't address – that's the whole point. They don't address data segmentation –

**Terry Cullen – Department of Veterans Affairs**

No, they –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– other than the one point about re-disclosure under CFR part 2.

**Deven McGraw – Center for Democracy & Technology**

Well, yeah, and all we said was that the communication of – that that requirement needs to kind of ideally go with the data, to put – it puts people on notice. It doesn't create some sort of automatic execution that it won't get re-disclosed down the road.

**Terry Cullen – Department of Veterans Affairs**

No, but it talks about my ability to do this with best practices. And further –

[Crosstalk]

**Deven McGraw – Center for Democracy & Technology**

Yeah, but we –

[Crosstalk]

**Terry Cullen – Department of Veterans Affairs**

– 20 –

**Deven McGraw – Center for Democracy & Technology**

We stopped at the level of acknowledging that the consent passage would have to go back and forth. And we stopped at that level. So you've got the consent in your hand. What are you – or you don't have the consent in your hand. You can't get it. The patient says no, or the patient can't be – can't be reached, and there's no emergency exception. What can you then disclose absent that data? If you don't have a way in your electronic record to be able to take out data you're not authorized to disclose, you may have to default to mechanisms we use today, like fax or paper.

And that then triggers the question of whether we should be developing automated capabilities that enable the parsing of that data at a finer level so that it can be disclosed. But we only engage this at the level of when you need consent, at a minimum, you have to be able to communicate that you need it, what it looks like, and that – and then to get it back and to be able to record that. So that's sort of the – almost like a first level set of questions that have to be answered.

We think – I mean, part of the reason why we didn't address the segmentation issue is because NCVHS has addressed it. We touched on it after the hearing that we had on technical capabilities, and said, this stuff's not mature yet. It needs to be further tested, piloted. You know, there's not been silence on this.

**Terry Cullen – Department of Veterans Affairs**

So maybe the –

**Deven McGraw – Center for Democracy & Technology**

But we deliberately did not take it on in this set of recommendations.

**Terry Cullen – Department of Veterans Affairs**

But – so maybe what's concerning is the word technical, which is open to lots of interpretations on –

**Paul Tang – Palo Alto Medical Foundation**

Terry, where are you looking? Where are you looking?

**Terry Cullen – Department of Veterans Affairs**

Nineteen.

**Paul Tang – Palo Alto Medical Foundation**

Can we go to the slide?

**Terry Cullen – Department of Veterans Affairs**

Should have a technical way –

**Paul Tang – Palo Alto Medical Foundation**

Nineteen.

**Terry Cullen – Department of Veterans Affairs**

– to communicate applicable consent –

[Crosstalk]

**Terry Cullen – Department of Veterans Affairs**

– authorization, needs, or requirements, and maintain a record. So maybe it's technical, because technical to me means I'm putting it electronically somehow in my system.

**Paul Tang – Palo Alto Medical Foundation**

Go back one. Slide 19.

**Deven McGraw – Center for Democracy & Technology**

So we did think it would be great if there were some technical support –

**Terry Cullen – Department of Veterans Affairs**

Oh, I agree.

**Deven McGraw – Center for Democracy & Technology**

– but just for exchanging the consent piece.

[Crosstalk]

**Terry Cullen – Department of Veterans Affairs**

Okay.

**Deven McGraw – Center for Democracy & Technology**

And so, you know, again, the Standards Committee is the one that has – ones that have to figure out the technical path forward, if there is a technical path forward. But what we specifically said is a technical way to communicate applicable consent and authorization needs and requirements. So again, technical capacity, building in some technical capacity on that first level set of questions about, you know, wow, this needs consent. Oh, okay. Well, what do you have to have? All right. I got it filled out. Here it is. I need to record it. Right? How great would it be not to have that all take place on paper, if possible?

**Terry Cullen – Department of Veterans Affairs**

Okay.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I just actually wanted to ask – I think Judy has her hand up. I want to ask you, Judy, when there are – I mean, I saw this in action, I think it was MetroHealth querying Cleveland Clinic, where they got ... Epic, and they got a consent – they got a requirement that, oh, this is the consent form you need to sign. So is this feasibly – you know, technically infeasible now to communicate what the consent form is or so forth?

**Judith Faulkner – Epic Systems Corporation**

It's technically feasible, but you would have to use it for every patient, basically, and for every patient, because we can't tell when someone – let's say there are 20 million patients a day going on, and from that, many millions of medications and diagnoses, problem lists, and other things. The systems can't tell which ones of them are going to be dealing with reproductive issues, dealing with any other issue. And so we would have \_\_\_ consent on everything.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

But this – let's put the segmentation aside.

**Judith Faulkner – Epic Systems Corporation**

No, I'm not saying segmentation. I'm just saying consent. To be able to do it safely, you would need consent for everything.

**Paul Egerman – Businessman/Entrepreneur**

Yeah. So I'm hearing – if I'm hearing you right, Judy, you're saying you don't have a technical way to know when it's required.

**Judith Faulkner – Epic Systems Corporation**

Exactly. That's it.

**Paul Egerman – Businessman/Entrepreneur**

In other words, you can't look at the medications list or something and say, I have – this is a mental health patient, you know. That's where you're running into some difficulty.

**Judith Faulkner – Epic Systems Corporation**

Right. The only other way I could think of is if somehow every provider had to mark this diagnosis or this whatever is to be kept separate or – I'm not talking about segmentation. It's just to be – require consent. That is a possible thing, and that could be done. But other than that, you would have to really get consent for everything. Marc, you're on the development side. What's your –

**Marc Probst – Intermountain Healthcare**

No, I agree. It kind of goes back to the data segmentation discussion that we're having, but I don't know how we would differentiate.

**Terry Cullen – Department of Veterans Affairs**

I had two other non-controversial comments, hopefully. One is I –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

By the way, Terry, I will – I will give credit to – the Interop Showcase attends the VA and SAMHSA, demonstrating actual implementation of that data segmentation. So we certainly should – I think to say that you should comply with applicable laws is pretty, you know, pretty defensible, I think, as far as the Tiger Team to say you need to comply with it. And ideally, there should be a technical way of accomplishing that.

**Paul Egerman – Businessman/Entrepreneur**

And sometimes it's a little bit easier with substance abuse, because the person – patient may be enrolled in a substance abuse program. So there's a clear way to sort of like categorize those people.

**Judith Faulkner – Epic Systems Corporation**

Sometimes.

**Paul Egerman – Businessman/Entrepreneur**

Sometimes. And also, just an observation, is because of this, some healthcare organizations might choose to go ahead and do the consents on everybody. They may say, well, that's good privacy, and, you know, that's – we'll just go ahead and do it.

**Terry Cullen – Department of Veterans Affairs**

So I do want to acknowledge the VA as trying to be a leader in this space. We have been successful, but we are not in production. So as we all know, there's a difference to go from very limited data tagging for attributes, for security, to a large standardized way to do that from an enterprise perspective. We need to go there, and we will.

So I have two very concrete questions. One is on slide 9, I just – I'm worried that the 2D is pretty – I think you were trying to be vague, but I'm wondering if it's too vague. Some official communication of patient consent as does not conflict. So I don't know whether it would be helpful to re-clarify that.

And then the other one is just on slide 13. As you know, we engage in lots of data matching, and our internal review on this was a sense of concern, not that there shouldn't be a standard format, but the move to that would require everybody to do a lot of potential rework, and there's maybe some difficulty in that transition, because if you don't collect a middle name, and you're going to say you need to match on a middle name, now you've got to go back and get a middle name.

**Deven McGraw – Center for Democracy & Technology**

Yeah. We're not – I mean, we put those recommendations out, calling for standardized representations of data, in February of 2011.

**Terry Cullen – Department of Veterans Affairs**

Right.

**Deven McGraw – Center for Democracy & Technology**

And then it was really up to the Standards Committee to sort of take that and decide what needed to be required from a certified EHR technology. So we were not willing to engage that issue more completely, absent just sort of resurfacing what we had already agreed to. And in terms of your other comment, we did deliberately leave it vague, and here's the reason why. We said, this is a circumstance where consent is not required. All you're doing is using it as an indication that a treatment relationship exists. And for that reason, it doesn't have to have a particular form. It doesn't have to – you know, it could be just a patient's voice over the phone. Like I said, none of this is 100 percent foolproof, but it's just one other element where you can be assured that a treatment relationship exists. And we were not going to wrap that up in a bunch of technical requirements, because it's not in response to a circumstance where consent is required.

**Terry Cullen – Department of Veterans Affairs**

Okay. So Deven, let me go back to the data matching, though. We are aware that February 2011 – so is there work on that between now and – between then and now, or is –

[Crosstalk]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I actually think we should take a look at what was in Stage 2, Terry, on the – in the header of the consolidated CDA, where there were defined demographic elements that could I think serve as a – as a foundation for much of this. So around date of birth, around gender, language actually, name, address. There were standards as part of the Stage 2 requirements that I think largely covered these already.

**Terry Cullen – Department of Veterans Affairs**

Because I think this is really important, and the more we can do to move it along, the better.

**Paul Tang – Palo Alto Medical Foundation**

Okay. And Neil, are you –

**Neil Calman – The Institute for Family Health**

I am. I just had a question about the – again, we're on slide 9, but where you say, or will have a direct treatment relationship, to me, that's a little bit more complicated.

[Crosstalk]

**Deven McGraw – Center for Democracy & Technology**

Well, so that's indicative of a patient who's made an appointment but hasn't actually come into the office yet. So in other – this was – frankly, this was the whole reason why original HIPAA rules, which said you had to get consent even for treatment, you know, for – to share treatment data about a patient, got scrapped, because nobody could prepare for a patient coming into their office because they didn't have a way to – you know, it would have been complicated to get the patient to consent in advance, as opposed to, you know, I'm either – I've either treated this patient already or I will be, because she's coming in in a week, and I want to get – and my – I've instructed my nurse to pull her records in advance.

**Neil Calman – The Institute for Family Health**

So just two quick scenarios. I mean, one is on the referral, at the time you make a referral, you're not sure whether the patients are actually going to go. A large number of people don't. We send this information off, and it sort of goes to somebody that the patient never sees. But another recent situation that just came up was around OB, where patients designate a place where they expect to deliver. All the records get sent there at a certain point, and, you know, the patients never arrive.

And these records are now in another institution that's created sort of a place for them, and the issue about that, and also the re – the potential re-disclosure, those are just – you know, these are the complexities that we've been facing now, and so I'm really glad you put that in, is what I'm really trying to say, because I think what we're trying to do is get the data to move, not to lock it up. And I think it's really important that it – that we make it clear that an anticipated relationship is a reason why it can move without consent.

**Deven McGraw – Center for Democracy & Technology**

Yep. Great.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So the question you had for us is do – would we like you to do the additional work on the – limiting the non-targeted queries. I think it is important. It is a big area. It's going to become more important, and having some guidance on that would be useful. So I think – does the group agree that –

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

Okay. So would you like us to approve anything up to that point, or would you like to come back?

[Crosstalk]

**Deven McGraw – Center for Democracy & Technology**

Yeah. No. We would like – we would love for you to approve it up to that point. And I've noted the areas for additional clarification on the automated response.

**Paul Tang – Palo Alto Medical Foundation**

Correct. Okay. Any further discussion on that? So all in favor of approving up to the non-targeted – limiting the scope of the non-targeted?

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

The question they had was on 23. Yeah.

[Background voices]

**Deven McGraw – Center for Democracy & Technology**

Yeah. So all the way up to slide 23. So not slide 23, but everything that comes before.

**Paul Tang – Palo Alto Medical Foundation**

Up to 22, then.

**Deven McGraw – Center for Democracy & Technology**

Yeah. Thank you, Paul. Up to 22.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

For those who can't do the math.

**Deven McGraw – Center for Democracy & Technology**

... the non-lawyerly language.

**Paul Tang – Palo Alto Medical Foundation**

Up to but not including. Okay. So all in favor?

**Several**

Aye.

**Paul Tang – Palo Alto Medical Foundation**

And any opposed or abstain? Great. Well, thank you very much for this wonderful work.

[Applause]

**Paul Tang – Palo Alto Medical Foundation**

Okay. Would MacKenzie – since we have two times for public comment, MacKenzie, is it okay if we just have the one at the end of the day?

**MacKenzie Robertson – Office of the National Coordinator**

I prefer to keep the two on there, if we just do a brief one.

**Paul Tang – Palo Alto Medical Foundation**

Are there any public comments?

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

Operator, if you can please open the lines for public comments, and if there's anyone in the room, if you could please come to the table. Again, it'll be limited to three minutes, and I will be ending you after three minutes. Thanks.

**Alan Merritt – Altarum Institute**

If you'd like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-6006 and press star 1, or if you're listening via your telephone, you may press star 1 at this time to be entered into the queue.

**MacKenzie Robertson – Office of the National Coordinator**

And we do have a public comment in the room. Go ahead.

**Daryl Roberts – American Nurses Association**

Hi. This is Daryl Roberts. I'm a senior policy fellow at the American Nurses Association. I will keep this short. I'm as hungry as everybody else.

First of all, I want to say a great deal of work, and a lot of great outcomes from the tiger team. I had the privilege of writing my master's work on HIPAA, and know for a fact how painful it is. So you guys did a great job.

In response to some of the discussions that took place today, it is very unlikely that CommonWell is going to go away. In fact, it appears that CommonWell will flourish, regardless of its business or non-business model. ANA believes that reporting on their work is a first good step – a first – a good first step for today, but going forward, the ANA recommends that the Office of the National Coordinator open conversations directly with the constituents and representatives of CommonWell, as well as continuing discussions with vendors not affiliated with CommonWell to ensure complementarity among ONC, CommonWell, non-affiliated vendors, clinicians' needs, consumers' and patients' needs together.

While inviting CommonWell to the table might appear to give tacit validation to their existence, absent or limited communication among these players could have an equally deleterious effect, particularly in light of the valuable and comprehensive recommendations from the Information Exchange Workgroup and from the Tiger Team. Complementarity between the ONC's work and these several players is an essential element of any future success for any exchange of health information at a national level. Thank you for the opportunity to speak.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you. And I believe we only have one public comment from Carol Bickford on the phone.

**Carol Bickford – American Nurses Association**

Carol Bickford, American Nurses Association. I invite the ONC to explore opportunities to enhance publication of the REC lessons learned through conversation with the Health Exchange IT repository that is being populated by ... it's the Health IT Exchange. Helga Rippen is the primary contact for your conversation. Thank you.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you very much. And I'm showing no more public comments, so Paul, if we want to break for lunch, perhaps we can delay the start of meaningful use a little bit.

**Paul Tang – Palo Alto Medical Foundation**

Right. What – do people think we can do it 35 or 40?

**MacKenzie Robertson – Office of the National Coordinator**

Lunch is here, for those that already preordered. So I'm not sure how many of you that was, but it's already waiting.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So let's reconvene at 1:20, please. Thank you.

[Break from 03:09:46 to 03:48:28]

**MacKenzie Robertson – Office of the National Coordinator**

And I believe we're open. Okay. Welcome back from lunch, everybody. We're going to go directly into the meaningful use workgroup update with Paul Tang, George Hripcsak, who's on the phone, and Christine Bechtel. So I will turn the agenda to Paul.

**Paul Tang – Palo Alto Medical Foundation**

Great. Thank you, MacKenzie. And so we have a one-two punch here. We have the Meaningful Use Stage 3 recommendations, or at least some explorations of new concepts we want to put before you, and then we're going to go into recommendations having to do with clinical documentation. For the meaningful use Stage 3, we have Christine Bechtel, who led the subgroup dealing with consolidation, and will be explaining to the – explaining that to you briefly.

And George Hripcsak is on the phone, yes, George?

**George Hripcsak – Columbia University**

Yes, indeed.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Great. Okay. I want to first give thanks to Michelle Nelson, who's sitting there on the floor, because she's our partner in crime in helping us with the Meaningful Use Workgroup, which is a heavy lift. So thank you, Michelle. And thanks to all of the folks on the workgroup who are listed before you. This is really a hard-working group, and we tackled some of the key issues having to do with meaningful use. And in this – in today's presentation, we're going to explain some – we're going to describe some new approaches to Stage 3

**MacKenzie Robertson – Office of the National Coordinator**

Sorry, Paul. Before you continue, I just want to note that the hands that – the handouts that are printed for the committee members are slightly different, but there aren't any substantial changes. So if you're following exactly, they're going to be a little bit different.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Thanks. You'll all recall that in – this famous diagram where we talked about some of the main objectives for stages one, two, and three. That doesn't mean it stops at Stage 3, but those are the first three we're tackling. And in stage one and two, we concentrated on getting data into the EHR, in Stage 2, getting it to the places where the patient goes, and care coordination, and Stage 3 we think of as a tipping point, here we're shifting from getting functionality into the EHR and getting data to move around, and now working on the improving outcomes, which was the main goal for the EHR incentive program in the first place. So because of this tipping point, we also are at a tipping point where we're thinking of alternative ways to move the program along.

Just a review of the original principles we had for all the stages, not just Stage 3, but one, the EHR incentive program was to support the new models of care that's much more team-based, it's outcomes-oriented, and clearly in the – in the new payment paradigm, where we have accountable care organizations dealing with population management. We're tracking the national health priorities as set by the administration and the Secretary. So those were goals for the whole EHR incentive program.

The third piece is that because – it's that the criteria and the objectives have to have broad applicability, because it becomes a floor for the entire country. That means it has to understand the differences between primary care and specialty care, the different needs that patients have throughout the country, and the different areas we have in the country, rural, urban, densely populated areas and sparsely populated areas, for example.

And we didn't want – this – and Farzad talked to us about individual accountability, social mores, and then falling back on regulation where those first two don't work. So likewise, we don't want to be doing things that the market is already doing. And so – and we also want to be pushing in areas where the standards are mature enough for let's say interoperability to occur, some of the feasibility concepts that we discussed earlier this morning.

Look, in this tipping – in this inflection point in Stage 3, we looked at the experience we have with Stage 1 and some of the experience that we're gathering from Stage 2, and what are its implications for Stage 3? Well, one, as Rob Anthony informs us about every time, is how well the program is doing in really creating this inflection point in EHR and PHR adoption and use. So that means that we are building up a critical mass. When three-quarters of the hospitals are basically meaningfully using this technology, and over a third of providers are, that's a critical mass that's being built. So we can – we can see that data is being captured and stored in computers, and that can be made available.

Second, that the mandatory floor is creating the network effect that we wanted. And so we do have a rising tide that's floating boats. We have the setup for patient engagement, because we have this information in electronic form. We have the setup for health information exchange for the same reason. But we still have to make progress to get it to move around appropriately.

Third is, as Rob reminded us again, the threshold – once people implement the function, they blow right through our thresholds. We had thresholds of 10 and 30 and 50 percent, and they're operating in the 90s-plus percent. So once the functionality is in the record and they are using it, they use it full force.

The next point is that they consistently use it even across the years. You saw that with Rob's report this morning as well. So we're holding the gains. So the gains that people have from Stage 1 and now we're seeing even in Stage 2 are persisting. So these are all very encouraging. That's what we hoped for, and they're very encouraging. And we're trying to take it – take these facts into account as we think about Stage 3.

On the other hand, we've also heard about how the reporting requirements are hard. There's considerable cost, there's considerable burden in reporting even what you're doing. And so we want to streamline and simplify the reporting requirements so that we can reduce the burden of complying with this program. We see that we're recognizing some of the benefits. We see that the people are taking advantage of these things at the 90-plus percent. They're maintaining the gains. Let's back off on the reporting cost of doing so.

The other piece is if you look at it, because of this floor, and the floor is rising, it's been sort of a forced march. Both the vendors have to put in certain functionality, and the providers have to use that functionality. Now that – that's a good thing, we hope, because we've put a lot of thought into what are these requirements and objectives, but it also makes less resources available for both vendors and providers to innovate, or to address their local priorities, because we're sort of setting this forced march for national priorities.

So recognizing that, one of the approaches we're trying to take with Stage 3 is to rely more on the market pull. Both the RFI about the policy levers and some of the comments Farzad has made, is this the time for handing off some of the functionality we're putting into EHRs to having the market pull based on payment, based on measuring quality, measuring outcomes, have that pull to use instead of pushing? And so that's one of the approaches we wanted to discuss with you. In other words, we want to reward good behavior.

Additional goals, there's still some work to be done, and we all talk about it, including this morning, in the areas of interoperability, for example, in patient engagement, in reducing disparities. And sometimes no one organization will do it – will want to assume all the costs of getting the data to another organization. So you sort of want to level the playing field and make everybody do it for everybody to buy in. That's at play in, for example, interoperability and health information exchange.

So we talked about the burden – reporting burden, and we talked about folks accomplishing a lot and maintaining their gains. We thought it was a time then to consolidate some of the meaningful use objectives. So to reduce the total number of things you have to report on and fulfill as sort of a recognition of where we are in this pathway, this trajectory. So we're going to talk about consolidating meaningful use objectives.

And the other thing we're going to talk about in terms of the rewarding good behavior side is to create an alternate pathway. So it's optional, but for folks who are already achieving a high level of performance or a high level of improvement, they should – or we're proposing that they be deemed in satisfaction of some subset, not all, but some subset of the meaningful use functionality, assuming that in order to get there, they had to be effectively using these tools.

Okay. So the first thing we're going to do is talk about the consolidation work that is reducing – sort of subsuming some MU requirements under others, and then we're going to talk about the deeming, and then we'll open it up for discussion. So Christine's going to lead the consolidation discussion.

### **Christine Bechtel – National Partnership for Women & Families**

Great. Thanks, Paul. So first, let me say an enormous thanks to the subgroup that worked on this, which put a lot of hours into it, and to Michelle and all the ONC folks who supported us in that. And also, I want to thank Steve Waldren, who was really helpful in using his clinical and technical knowledge to look at these with some fresh eyes. So we really appreciate his help.

So we want – another way to say what Paul might – or what Paul just described might be advancement through eliminating some of the kind of check the box, standard of care, you know, things that we think by this point in the game really should be the de facto way that we're using electronic records. And so we wanted to really simplify things, but advance them at the same time.

So in summary, what we did is we started by looking at all 43 objectives that were originally proposed in the Stage 3 RFC, and we were able to consolidate them into 25, which is I think a pretty big deal. We made a couple of assumptions here. One is we worked with the criteria as they were proposed. We didn't go through and try to change ones based on feedback or public comment at all. We know that that's part of the process for the full workgroup to continue doing. So these are based on what was originally proposed.

And the second was that we assumed that all of the criteria would be included in some form or fashion in certification. So the functionality would continue to be available, but we didn't have to always focus on micromanaging its use. So what we wanted to do was really focus on advanced uses of data. Anything that is a recording kind of objective raised a red flag for us, whether it was new or – new to Stage 3 or existing. We wanted to think more about, well, how could you use that data, which would require that it be recorded?

We also assumed, and I think Paul mentioned this, that we're really giving credit for objectives that frankly should be standard of practice, because they were part of Stage 1, or they were core in Stage 2, and now that we have the use data and the threshold data for – in terms of performance from CMS, that was really helpful. So we looked at that.

And so we really focused on what is it that needs to be used here? So we did three types of consolidation or advancement. Number one would be – and I'm going to give you some examples of each of these. We advanced a concept within another objective. Second would be, you know, we identified areas where there was just duplication, and we said, all right, let's merge. And then the third was that, again, that standard of practice. It's been demonstrated to have been in use, and we think it'll continue because it's valuable.

So the first – I'm going to have to go to paper, because it is really hard to see, even though I did get new glasses. So the first example of the types of consolidation that we did is this kind of merging within a concept, right? So one example of that was recording preferred means for communication from patients.

So we did two things. One is we really incorporated it into the three patient-facing kinds of information that were already in meaningful use. So patient education materials then became delivered per their communication preference. Reminders deliver per communication preference, and same with clinical summary.

And then what we did was we said, okay, well, to do that from a certification perspective, we need to probably treat it sort of like we do demographics, where we create the ability to record those preferences in a certification – through a certification mechanism. So the blue boxes mean that it's gone to a certification only piece, but we don't have to require recording.

So the second kind of advancements that we did was around duplicative concepts. So immunization intervention, which was down in the public health category, which you may recall, if you know, if you haven't memorized the 401B numbers, 401B was implementation of an immunization recommendation system. Others might call that decision support. And yet the decision support objective, number 113, also had immunizations recommend – or mentioned there. So we just said let's merge these. They're really the same thing.

Another example of that was structured lab results, which they're already included in the care summary. They're included in view/download/transmit. We don't need to include them separately and just require people to show that they're recording them.

And then finally, the demonstrated use idea. So a good example of this is patient lists and dashboards. It was a menu option in Stage 1. It is core in Stage 2. We've already seen what happens with thresholds among those who select it. But probably more importantly, you have to have this for population management and quality measurement. And we couldn't really see a particularly useful way to measure it anyway. How do you measure whether you looked at a screen? I mean, that just doesn't make any sense. It's not meaningful for anybody.

And so we can rely on the fact that there are enough external drivers that are going to use – that are going to, you know, mean this requirement would be in use, or this function would be in use, that we felt like it doesn't need to be required separately, but it does need to be maintained as a certification criteria, because the idea of a dashboard is new to Stage 3

So CPOE would be another example of this. CPOE for medication orders was core in Stage 1, and the performance on it was 83 percent. So it's continuing through in Stage 2. So really, do we need to do that again for Stage 3? We thought not, but in addition to that, you really need to do CPOE in order to provide medications within the care summary. You need to have it, you know, in VD – for VDT, and then also of course for e-prescribing and the formulary and generic substitutions objective, which does get maintained. So you can't do those three things unless you're doing CPOE for medication orders, so why are we requiring it separately? Okay.

And so at a glance, here is what we did. So the green are the individual criteria that would be maintained. The blue are the certification only criteria. So there's 18 things that we've identified that would go to certification only. And you can see an example here. This is kind of the big picture overview of where everything landed. So I just mentioned CPOE. You can see that there's a certification criteria. It's pretty much landed under the e-prescribing formulary generic substitution piece. You can see test tracking, for example. You can't do test tracking on laboratory results without doing CPOE for labs. And then you can see what's now under view/download/transmit and care summary in the middle, etcetera.

We do have some remaining work that we need to do after getting your feedback, of course. We want to make sure that we haven't kind of, you know, created any inadvertent loopholes in requiring that these items be part of the care summary or part of view/download/transmit, and that means that we need to make sure that those fields are actually required in some way to be part of VDT and care summary. And – but we also want to make sure that the care summary and view/download continue to be helpful to providers and patients. So we need to look at are there ways that we still require the data, it's available for a care summary, but we allow that care summary to be customizable so that providers can really make it meaningful as they share it with one another?

But I think at the end of the day, being able to identify so many objectives, going from 43 to 25 I think was a really hard exercise, and really a worthwhile one. Paul?

#### **Paul Tang – Palo Alto Medical Foundation**

Good. Thanks, Christine. So we'll proceed on to discussing the deeming work, and then we'll have plenty of time, I believe, for questions and comments. And what we're looking for from you is whether these are in the right direction, because as Christine mentioned, we have a lot of work to reconcile the request for comments input with all of the individual objectives.

Okay. So moving on to deeming, so our assumptions, we hold that – as we hold these truths to be self-evident: one, that in today's world, with the amount of data on a patient, with the amount of knowledge you have to have in order to try to be that – part of that person's professional health team, you cannot be a good performer without effective use of HIT in this or any other industry. So that is an assumption. The other thing we gave credit for is significant improvement, because we wanted to give some way for people to demonstrate that they are doing really well by their patients using these tools.

So therefore, if that's true, then let's let up in terms of the requirements so that we can allow – so we can promote innovation, so that we can reduce the burden of complying with this – with these regulations, and that essentially that we can reward good performance, because that was the end game.

So our proposal is that we deem that high performers – we'll have to try to figure out what that level is – or significant improvers would be in satisfaction of a subset, some way that we can sort of tie, oh, doing well in this kind of area probably means you took advantage of these functions, some subset of the meaningful objectives as an optional pathway. So the old-fashioned way of complying with the now 25 proposed objectives would still be there, but as an optional pathway, you could through high performance, which is the end game, deem satisfaction of some of the requirements.

So what's an example? So these are only examples, and we're open to your feedback, but here's an example of deeming criteria for eligible providers. So you would have to demonstrate high in the – let's just for the purpose of stake in the ground say, well, it's not 50 percent. That's only halfway there. It's not 90 percent, because that's really hard. So 70 percent is our straw person there to set. If you're in the 70th percentile or better, or you improve performance – now you don't want to punish people who are already doing well, so we used the halfway to the goalpost kind of a method, which is as a straw person, saying 20 percent reducing the gap between where you are, where you were last year, and the full performance goal, then you are a significant improver.

Okay. So select two from a couple of domains that are on the national quality strategy. One is prevention. You take some prevention of high priority diseases, pick two from there, and the other is control, not just process measures, but control of some high priority chronic health conditions, like heart disease, like diabetes, like asthma, heart failure. So there's some high priority conditions that cause high morbidity, high mortality, high cost, control – do a really good job controlling them with the knowledge we currently have. So you have to score at the whatever it is, 70th percentile, for all four measures in those two domains.

Examples for eligible hospitals, two from safety and two from care coordination. So safety, there are things that we don't – either should never happen at all or we want to happen at a minimal level, like C. difficile infection, or central line bloodstream infections, or meth-resistant staph aureus infections. These are things that we want to minimize, and so if you're at the 70th percentile or better, that would be a high performer.

Care coordination, as you know, we have very limited measures so far. Some examples we could call upon are HCAHPS, the questions that say how well did you understand your discharge instructions? How well did you know what you're supposed to do next? Those kinds of things. Maybe use the readmission measure as an example of you must have had care coordination if you're going to do well on readmission, for example. So two safety and two care coordination criteria.

In addition, which is one of our focal areas for Stage 3, is healthcare disparities. We're asking you, for those measures you have selected, to report them by disparity variables. So there's no performance measure associated. There's lots of issues, you know, with respect to your patient population, etcetera. So it's not performance measure. It is – but it's putting in front of your ... as we've always wanted to do, your performance against the disparity variables.

An example for what kinds of MU objectives would you be deemed in satisfaction of if you prove yourself to be a high performer or significant improver. So the ones on your left, you probably – you – we already captured computerized physician order entry, as Christine explained, but you probably – almost certainly use clinical decision support in order to either improve or do well. You're electronically prescribing. You're tracking your tests. You're communicating with your patients. You're educating them. These are the things we think are necessary for you to do well managing your patients' health, or co-managing your patients' health, along with them.

A couple, you see an asterisk and italics below, are pending performance on Stage 2 So if people are doing well with VDT in Stage 2, then that could be something eligible for deeming as well. Similarly, if they're taking advantage of secure patient messaging, which we think is critical for performing well, that could be part of the deeming. So we're making that conditional on the performance reports that come in on Stage 2.

There's a lot on the right side that remain, and maybe there is more work that we could do to try to pull some of these from the right side to the deem side to up the incentive for going in the deeming program, because the deeming program emphasizes good performance, and that's what the whole program is doing, so you want to load that as much as possible.

Additional considerations, part of it is – one question is double jeopardy. Gosh, if I have a one year reporting period, I won't know whether I had to do the other pathway until the very end. Well, that makes sense. So as a proposal, we say, well, let's make the performance reporting period part of a year. Let's say six months. So it's up to you whether you want to wait, make it the last six months, but it probably would be in your best interest to make it earlier than that and have a six month reporting period to prove whether you're scoring well or not.

The other part is yes, we are – we continue to be limited by the number of particularly outcomes related quality measures in the specialty area, and we acknowledge that. CMS is trying to push more in the pipeline, NQF is trying to push more. So anyway, we do need more of those, but until then, if in your specialty you cannot find four performance measures to quality for this program, there's still the original pathway. So it doesn't exclude anybody, just because we don't have measures, but it continues to put pressure on all of us to get better measures out there.

So that's the consolidation and the deeming. So – and the combination, we're trying to reward good behavior, reduce the burden, and put these tools into place, and let the pull, the market pull, the desire to produce good outcomes pull people along. And we hope that that's a direction that you like. So we're open to comments on is it the direction or individual comments. These are examples we've given you, but we're open to your feedback.

**Christine Bechtel – National Partnership for Women & Families**

Do you want to ask George if he has –

**Paul Tang – Palo Alto Medical Foundation**

Yes, George?

**George Hripcsak – Columbia University**

First of all, excellent presentation. Thank you, Paul, and thank you, Christine, for a wonderful – for leading that group and then giving the presentation. Let me just say, I think that this is an excellent program in general, because everyone is always thinking about how to achieve our goals while making things as flexible and efficient as possible for the stakeholders involved, and I really like the idea of saying, what are the things that only meaningful use can accomplish? Focus on those, realizing that everyone's already gone through the first two stages, and so now by Stage 3, to reduce the reporting requirements where we're able to.

The things that you've seen today, you know, that'll change the exact definitions as we go through and respond to the comments that we got from the previous RFC, but, I mean, what we're showing you here today is really the concept. Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Gayle?

**Gayle Harrell – Florida State Legislator**

Yes. Thank you. I think this is a great idea. The simpler we can make it, the better, the less burdensome on our practitioners, the better. So I think the deeming is a wonderful aspect of it, and the consolidation both. I think this is the direction that we need to be going at a faster pace. Are you considering using PQRS standards or anything like that, if you qualify under other programs, that you could also be deemed a meaningful user?

**Paul Tang – Palo Alto Medical Foundation**

It's an interesting question. We didn't address that question per se. Might as well put out a comment. One of the – right now, that would be PQRS deeming for meaningful use.

**Gayle Harrell – Florida State Legislator**

Correct.

**Paul Tang – Palo Alto Medical Foundation**

Because meaningful use is spending a lot of time, and there's expertise around this looking at what can the EHR bring to the table for quality measures, it may make sense to have it go the other way around. In other words, the – being deemed in the EHR program with e-measures –

**Gayle Harrell – Florida State Legislator**

Right.

**Paul Tang – Palo Alto Medical Foundation**

– de novo e-measures, would be a really good pathway to qualifying for PQRS. I mean, that's just a suggestion, a sentiment.

**Christine Bechtel – National Partnership for Women & Families**

Well, I would agree with that, but I'd also point out, Paul, I think that all of the measures on the list are PQRS measures. So to do it in that other direction –

**Gayle Harrell – Florida State Legislator**

Correct.

**Christine Bechtel – National Partnership for Women & Families**

– would be – it would be the same thing.

**Paul Tang – Palo Alto Medical Foundation**

The path would be the same, but I made sort of a philosophical comment, because we're so vested in understanding how to get the data and the measures out of the EHR that that might make sense to go in the other direction in the future.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Just let me follow up, though, on Gayle's point. Particularly on the specialist side, there may be – all the measures are PQRS measures, but all PQRS measures are not meaningful use measures. So if a – we should consider if a specialist is performing well on their PQRS measures, if they're in the top percentile there, or showing improvement there –

**Gayle Harrell – Florida State Legislator**

Yes.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– whether there are meaningful use functional measures, not just the quality measures, but functional measures that they could be deemed out of. That's something that we could consider, if that's Gayle's –

**Gayle Harrell – Florida State Legislator**

I think that's absolutely a way we need to go. The simpler we can make it – if you can qualify for this and qualify for that, or at least partially qualify under either one, it makes it much easier. It's less burden on the practitioner, and allows them, especially in the specialty areas, to qualify.

**Paul Tang – Palo Alto Medical Foundation**

Chris?

**Christopher Boone – Avalere Health**

Yes, sir. I want to speak on behalf of my experience at the American Heart Association. And traditionally, as the – patient registries have functioned in this quality measurement space, and they've done a lot of these things that you guys are – have highlighted here, which I think is great. But I'm more curious about the technical support that's offered to the providers as we move this direction, which is what they did as being a part of a patient registry program with one of the professional societies. But then I also want to challenge you to think about the role of these patient registries going forth, and what are your thoughts about that?

**Paul Tang – Palo Alto Medical Foundation**

The role of a – I didn't hear the last –

[Crosstalk]

**Christopher Boone – Avalere Health**

Registries generally. Yeah.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

So as part of the Budget Reconciliation Act, actually, there was a piece about how PQRS would deem reporting to professional registries. Was there discussion, or how would you think about – we have reporting to professional registries as an optional menu item for Stage 2 meaningful use. Your thoughts on whether reporting to or participating in a professional registry could be deemed equivalent to some of the functional measures?

**Paul Tang – Palo Alto Medical Foundation**

In some sense, it's almost a consolidation. So we could use – I think it's a consolidation approach versus a deeming, because performance is what you get deemed for. Participating in registry could be one of those ways you demonstrate you're using reports, for example, out of the EHR, etcetera.

**Christine Bechtel – National Partnership for Women & Families**

I would agree with that. I think, too, it would be helpful, given the public comment on registry, CR5, that's out now on registries and PQRS, it would be very helpful to see the public feedback on that, because I know not all registries are quite the same, and the data isn't always fed back. So I think there are some other, larger issues, and I would agree with Paul.

**Paul Tang – Palo Alto Medical Foundation**

Rob?

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

Just as an FYI, and I think it's for your consideration, I think at HIMSS '13, CCSQ, Clinical Quality Standards and – Center for Clinical Standards and Quality, presented as part of the eHealth Initiative within CMS the alignment of all quality programs, and the drive towards you report – you come in once and you report once for a slew of quality and pay for performance initiatives.

So I think that those need to be seen in context. And yes, to Gayle, your point, the simpler, the better, but I think we need to see what the effects are regarding that. So it's more complex, but again, PQRS is a good starting place, but I'd like to – you need to be aware of that kind of alignment, so that whether – however we deem, it accounts for all those other initiatives to make it simpler.

**Paul Tang – Palo Alto Medical Foundation**

Good point.

**Christine Bechtel – National Partnership for Women & Families**

Rob, are those slides available for us to look at, number one? And number two, are all those performance programs as well?

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

Yes. In fact, and I can even give you the contact person. It's Kate Goodrich, who is on top of it. So I'll forward you those.

**Christine Bechtel – National Partnership for Women & Families**

Great.

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

When I mean you, I mean you.

**Paul Tang – Palo Alto Medical Foundation**

Good. Thank you. Marc?

**Marc Probst – Intermountain Healthcare**

Yeah. So both of these are great, both the consolidation and the deeming. I was wondering, in your discussions, when you talked about deeming, was there any concern that without a lot of good thought around deeming this could be skewed to one kind of provider group over another? You know, if deeming isn't appropriately defined.

**Paul Tang – Palo Alto Medical Foundation**

Yes. We always – we always look at the challenge of applying it across all specialties. What we tried to do is follow the national quality – the national priorities. Whether it's Million Hearts or Partnership for Patients, what are those things where we've already – the Secretary's already decided, these are things we're going to work on? We thought we would align with those. As you know, that was one of our original principles. So it may not be all-encompassing, but we tried to – that was the way we tried to prioritize.

**Marc Probst – Intermountain Healthcare**

Okay. Because obviously, I mean, EPs play one way, EHs play another way, and depending on how these are defined, it – we just have to be careful we don't skew it to one group or another. But I think this is excellent work, and really support it, so thanks.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Other comments? Terry?

**Terry Cullen – Department of Veterans Affairs**

Well, you know we review these internally in the VA, so I have a few comments that may be a little nitpicky. Slide 18, there was concern that none of the other measures besides obesity are included in the recommended core set right now, and that there might – you might want to consider a correlation between these measures and the recommended core measures.

Slide 19, and I think this is probably the more important one, is that none of these measures are on the finalized measures for 2014, so given that they may need to show an increase in performance, you may have a difficult situation there, and perhaps you want to include some of the existing 2014 measures so that people are not –

**Christine Bechtel – National Partnership for Women & Families**

2014, meaning meaningful use or –

**Terry Cullen – Department of Veterans Affairs**

Yeah. Yes. Meaningful use.

**Christine Bechtel – National Partnership for Women & Families**

Okay.

**Terry Cullen – Department of Veterans Affairs**

So these would all be new, and you're asking people to show improvement, and so it might be hard to do that.

**Paul Tang – Palo Alto Medical Foundation**

Right. Good point. Neil?

**Neil Calman – The Institute for Family Health**

So is there a way to enlarge this list on slide 18?

**Paul Tang – Palo Alto Medical Foundation**

What is slide 18?

**Neil Calman – The Institute for Family Health**

Which is the deeming EPs.

**Paul Tang – Palo Alto Medical Foundation**

Deeming for EPs. Okay.

**Neil Calman – The Institute for Family Health**

I'm thinking about Gayle's comment about specialists, and, you know, the comments that we made in our prior meeting about specialists, that this is the opportunity to broaden the scope and to get people in different specialties really thinking about what's important to an orthopedists, and where can – how can they start using the tools in sort of orthopedic practice? So I feel like we're being too prescriptive here, that we actually need to open this up and give people an opportunity to innovate in this space, and actually think about ways of using the tools we've given them to do things that are important in their specialty.

And, you know, I don't know how CMS goes about then at that point taking that information for a broad range of stuff. So maybe one way is to make the list a lot longer. Maybe another way is to figure out a way that people can propose and then follow up with measurement and stuff in a particular specialty area. But I think we're missing a big opportunity here to get outside of our top ten list and start including people in other specialties for whom this top ten list is not that relevant.

**Paul Tang – Palo Alto Medical Foundation**

So this did – we did try to do that, and as you know, one, there's a more limited set of measures for specialists, but two, the criteria we used here for deeming are outcome measures. So you notice, for example, in the second category, it's control, not process measures. So we have both a limited number of measures for specialty areas, and even more limited set that demonstrate control.

So it's sort of a statement, and that's why we made the statement this is an optional program, and if we want to create drivers for new measures to become available, this perhaps could be part of the driving force to make new measures available, so you can deem in your specialty.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

It's part of identifying some of the gaps in the measures.

**Neil Calman – The Institute for Family Health**

You know, I guess maybe this is too far out of the box, but just the fact that we don't have a measure for something shouldn't keep people who are involved in a particular field from really trying to innovate, using the tools that we've been pushing them to use for the last two years. You know, it's kind of like we're all into this like if there's not a measure for it, you know, we can't really do it. But the measures are being – the measures are being developed from people who are innovating in a field, and I'm thinking, you know, think about oncology, and think about, you know, orthopedics. Think about some of the real high cost specialties and things. And to be able to go back – and remember, we had those – the specialty hearing – that must be two years ago now – where people were really doing some incredibly creative things in their specialty area.

And I – we've yet to sort of find a formal way of recognizing that in our meaningful use program. I just think it's something that we could continue to – we should continue to discuss.

**Christine Bechtel – National Partnership for Women & Families**

So Neil, we did discuss that at length, in both subgroups, actually, and I – and Paul's exactly right. The challenge is, you know, this is supposed to be about performance and giving you credit for doing lots of other things. But the one area where I think there is an opportunity to do exactly what you're describing is the question that we put in the Stage 3 RFC around creating kind of a third pathway for quality measurement.

So I think if we – if we like the consolidated idea, what it would look like is that, you know, a specialty society or a specialist could do the consolidated little approach, and then instead of having to report quality measures, though, they could do this innovation pathway, where they create a measure and they tell CMS the specs, and what happened when they implemented it, and did they perform or not doesn't matter, but it's a way to start to fill the gaps that Paul described.

So I think that's an essential point. I just think it's more closely tied to the consolidated approach and the innovation pathway in the RFC than it is to the deeming approach.

**Neil Calman – The Institute for Family Health**

Okay.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

So we're trying to add –

**Neil Calman – The Institute for Family Health**

That's fair enough. I mean, I think it could go in that – in that subgroup as well, as long as – but is that called out here somewhere that I missed?

**Paul Tang – Palo Alto Medical Foundation**

No.

**Neil Calman – The Institute for Family Health**

Or is that for future discussion?

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

The innovation pathway is part of the RFC, as Christine said. So it is one of the things the Meaningful Use Workgroup put out there was – that's yet another alternative, really. The idea that was floated is in lieu of one of the CQMs, that – the core CQMs, you could propose something you've already done, measured, and here's your response, and then describe – it's like a mini-application to NQF. So describe why did you do this, what's the numerator, denominator, how did you test it, etcetera, and get credit for that.

And what happens is that starts greasing the skids for the pipeline, and it makes it a candidate, potentially. And that organization doesn't necessarily have to be the measure developer that furthers it along, but somebody else could pick that up.

So we're trying to raise the ante for what good could come out of organizations donating some of the things that they're already measuring. And NQF I know is working on areas of how do we identify these gaps, how do we fill these, acting in a – sort of a convener/catalyst role. Farzad?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I just wanted to, on the measure side, and it clearly makes sense to have outcome measures where we're saying Stage 3 it about outcomes. If you already reached the outcomes, then you're deemed from the functional measures. But there may be measures that fall short of total outcomes, but are still closer to outcomes than the functional measures are.

So if, for example, we have an area for care coordination, and we currently have, you know, send discharge summaries, which is pure process, with referrals, say, you know, or send the patient information with referrals. And then you have a measure which is closing the referral loop. Maybe the closing the referral loop is a better measure, and if you're doing a really good job of closing the referral loop, then maybe the – you know, the transition of care requirement may be one that you can be deemed out of.

Another one may be around medication safety. If you're doing a really killer job of managing your patients on Coumadin, then, you know, you probably are doing an okay with some of the – you know, the functional measures around CPOE, CDS, drug-drug, and so forth, right? So on med safety. If you're doing a really great job on patient experience, then maybe, you know, you – the functional requirements around patient education – handing them patient education materials is not an outcome, but it's more of an outcome than the functional measures are.

So I see the point about, you know, wanting to wherever possible rely on true outcome measures, but we should I think be open to deeming for quality measures that really relate to that functionality, but are better than the functional measures, if that makes sense.

**Paul Tang – Palo Alto Medical Foundation**

No, I think it makes total sense. I think we are actually exploring the whole patient experience, because one of the outcomes is if the patient understands what to do and does it, that's a prerequisite for like management of Coumadin, for example, or the management of the INR, really. And I think we – that – those are candidates for us. We just didn't want to lower the bar so much that we get back down into the process.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Because then deeming sort of becomes –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So no, those are good examples. In fact, we proposed HCAHPS as one of the examples.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah. And I would tie the deeming to specific functional measures that relate to that measure, rather than a broad – you know, broad on both sides, broad on quality, broad on deeming, because we lose the communication message that says – the whole meaningful use program is about the outcomes.

**Paul Tang – Palo Alto Medical Foundation**

Right. No, we – well, that's how that list got developed, the one on the left, is we tried to make a meaningful connection between doing well on the things we proposed, prevention and control, and what it would take to do that. Judy?

**Judith Faulkner – Epic Systems Corporation**

Well, the greatest benefit to society is what we can do for our kids to get them off to a healthy start. So I think this is good, and I get that – I don't know if there's more things, when you – when you really look at this list, if there's some more things you can think of for pediatrics, since it is a large segment of the society. And also, you do have obesity there. I don't know if that is meant to include childhood obesity, but if so, that would be really good.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, we certainly can go back and look at peds. And BMI, yeah, is applied to kids as well. It's just a different scale. Gayle?

**Gayle Harrell – Florida State Legislator**

Yeah. Just one more comment, and I couldn't agree more with what Neil has to say, and the process of really being innovative and creative. And one of the things I'd like to suggest is, you know, in developing some of the categories around which you could deem – you could be deemed a meaningful user is perhaps reaching out to some of the specialty societies and asked them to come up with very specific recommendations as to what – and have them put together a package that they would say, if we accomplish this, we can be deemed meaningful users.

I think then you're really going to get buy-in from specialists, and you're going to get many more people participating.

**David Bates – Brigham and Women's Hospital**

Paul?

**Paul Tang – Palo Alto Medical Foundation**

Yes, David?

**David Bates – Brigham and Women's Hospital**

I was going to agree with Gayle and Neil. I think there's a channel here we could try to flush out. Going back to your comment about the meaningful use RFI for the third way, to invite specialists, either through their societies or other mechanisms, to propose very small and precise subsets of measures which are – which would lend themselves to deeming. And I think our challenge, or CMS's challenge, if they were to put together a request process, would be to define some criteria for what measures would qualify, building on what you've presented today, so that they be outcomes oriented, and respecting Farzad's caveat about that, that they leverage the IT infrastructure and they somehow demonstrate or are intrinsically taking advantage of information flow and management, that they span some larger part of the continuum of care than just a very small point of contact, a transactional approach.

I think one other goal we have is to continue to encourage the vendors to develop more flexible systems for reporting quality measures and driving improvement from those measurement tools, as Neil has talked about, and to the extent – whatever measures are proposed in this channel would also be ones that, going back to something Gayle said earlier, can help the vendors move towards more flexible reporting platforms. That's a plus. That is, rather than the hardwired approach we've had trouble with.

And lastly, that they enable standardization, because the good quality measures that emerge from a CMS point of view, I would think, and certainly the private payers, we want there to be the opportunity for those measures to be widely used for recognition and payment programs and for general public interest improvement goals, so if the ophthalmologist or the orthopedist or whoever come up with some good measures for this that would support the deeming approach, we would also want them to ultimately be usable for these public purposes, not just of narrow interest to them locally.

So if we could lay out some of those criteria or help CMS to do that, maybe then we could open up the process in the ways that Gayle and Neil had suggested.

#### **Paul Tang – Palo Alto Medical Foundation**

Good points. I think what we're trying to do is raise the incentives, so that more people participate. So for example, I know NQF has certainly made a call for measures to the specialty societies. I suspect CMS has as well. And they don't like rush in. But if we can pile on more and more reasons why it's really a good idea for the country to have these outcomes-oriented or surrogate outcomes measures across the board, maybe they'll start flowing, and I think that would be to the benefit of everyone. Certainly CMS would benefit in the value-based purchasing programs, we just need these kinds of measures. So we just add to the incentives, I think, and that's what our goal is. Farzad?

#### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Is there – you mentioned HCAHPS surveys, and that's an interesting one, because the data resides outside of the meaningful use reporting. So it would be saying, if you are functioning – performing really well on another quality reporting system that we would deem you on meaningful use, if we take that as a precedent, there could potentially be other areas where if you're in an ACO that is demonstrating cost savings and improving quality, then maybe you're – you know, you're – if you're a patient-centered medical home level three and you are, you know, whatever – so is this – how big a door are – is the workgroup thinking of opening here on the – on the deeming side?

Is it contained within, you know, quality measure reported electronically through an EHR deems you for some of the functional measures, or is it, you know, a little more complicated, but outside reporting systems as well?

#### **Paul Tang – Palo Alto Medical Foundation**

We didn't – that's a good question. We didn't think so much outside. When we mentioned CAPS, we mentioned the same – we had previously talked about PROs, patient-reported outcomes, and we thought of this as not just an EHR incentive program, but an HIT. So we were thinking of the patient portals and PHRs as being a conduit to get data from patients, but actually in a refreshable way, in an ongoing way.

You can imagine all kinds of PROs, including experience, that would be useful for the providers. So we weren't – we weren't opening quite that door. It probably would be a scope question as well. But – so we were thinking in the context of things that were accessible through the ... program.

#### **Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah. I will just caution, then maybe Rob might want to speak to this as well, there are certain expectations in terms of program integrity that the funds use for the health IT incentive program be spent on health IT, and not merely duplicate or be redundant with quality – other quality incentive programs, and so forth. So we just have to be – you know, I could just imagine testifying before Congress and saying, so, you know, you paid X number of billions of dollars for people, and do you even know that they're actually using the systems in such a way? So we have to – there's a balance there that we have to be careful with.

#### **Christine Bechtel – National Partnership for Women & Families**

So Farzad, I'll take a – I understand the balance completely. I think the one area that, though, may be worth exploring, is the HIT CAPS module. So it is – there are some challenges. It is obviously HIT specific. It would absolutely deem for view/download. And I would think that it would actually be a lot more valuable to the provider to know whether or not the – you know, the display of information is even helpful to patients.

You know, the CAPS question asks those things, but you could hold them accountable only for performance on what is really directly connected to meaningful use, which is are you offering online access, for example. There are some challenges which are I think that CAPS is specified at the group and not the individual level, but if – you know, I think if there's some willingness to support some work and staff time by ONC to help us do the mapping, it would be a very worthwhile piece, though the other issue with that is the infrastructure, that it does cost externally to put that in place. So we would have to think that through.

**George Hripcsak – Columbia University**

Paul?

**Paul Tang – Palo Alto Medical Foundation**

Yes, George.

**George Hripcsak – Columbia University**

In answer to Farzad, I think we can be fairly expansive, though, because I believe that we're paying for the objectives we do keep, for those areas of gap, which would be patient engagement, HIE, and other areas we decide. And all we're doing is saying, since you've already achieved these other ones in stages one and two, we're not going to make you report them for state three, so it's an efficiency thing, but you're actually paying for the achievement of the gap goals that are not duplicative of the other quality efforts around the – around the country.

**Paul Tang – Palo Alto Medical Foundation**

Thanks. Rob?

**Robert Tagalicod – Centers for Medicare & Medicaid Services**

So to ensure there's no, what is it, unintended consequence, and it does go back to the program integrity piece, I mean, right now, CMS has been asked to do the prepayment audits, and that all – that's – there's another discussion on what that does regarding people coming into the program. But it's just as an FYI, we're looking at that, we're seeing what level and what balance do we need, and what kind of threshold that OIG, GAO, or whoever is asking.

So again, it's one of those question marks. I don't know yet, because we are beginning to embark in that piece, because we made a business decision. The business decision was post payment or post attestation. So just as a – we'll report back as to what the operational effect will be.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. Terry?

**Terry Cullen – Department of Veterans Affairs**

I was going to follow up on what David said and everybody else in terms of the deem – expanding the options. And I think one way to do it so you don't make CMS totally crazy, since Rob is my new best friend, is to – is to really publish what the constraints are within those recommendations. And I think that that's going to take a little more work in terms of what would qualify, because you don't want – I don't think you want to put out a panoply of options, you can send in anything as a potential measure.

I also think – I'm also wondering more long-term, if there's a way to really strategically involve the boards, because in family medicine, at least, you're reporting on measures that you're choosing every year for your update. And so whether there's a way to – I don't want to shift burden to the boards, but there may be a way for people to, once again, align what their personal incentives are, which are not just money, but performance, and it's related to their board certification.

And I think the last thing is – and I don't know what to do with this, and I just thought of it when Farzad was talking, is really, this is a HIT program. We want to look at outcomes and how HIT helps it. So I'm wondering if there's some innovation part related to the HIT part of this. And I don't know what to do with that, but I'm just throwing that out there.

**Paul Tang – Palo Alto Medical Foundation**

Well, thanks for reminding us about the boards. Early on in our meaningful use discussions, we did – actually even heard from ABIM, or INRE, the overall-arching board, in the context of maintenance and certification. So I think you're right. That's another kind of alignment that could be done. And their main certification often involves improving your practice, literally improving your practice.

So to piggyback – to make these – one deem the other, I'm not sure which, but would be – would be wonderful. I mean, that's another kind of alignment.

**Christine Bechtel – National Partnership for Women & Families**

Which I agree with. I would just say I think we have to pay attention to the timing issue, because the certification is ten years with like a five year refresh, and that won't work, I think, for some of these areas.

**Paul Tang – Palo Alto Medical Foundation**

Other questions? Chris?

**Christopher Boone – Avalere Health**

I don't want to sound like a broken record, but I do want to advocate for the collaboration with professional societies. And it's going to back to the whole registry thing. I don't think that we want the program to seem as though it's competitive with a lot of the initiatives that are being launched by professional societies in the registry space. You know, it's just piggybacking off of what Farzad mentioned earlier in regards to the request for comment from CMS in regards to building PQRS registries.

But I also think it's equally important that you understand the purpose behind the registries that are established by many of the professional societies, where they're using much of that evidence to generate or create the very measures that we're asking them to submit, right? And so in addition to that, you have other research aspects to consider, such as the clinical guideline development, and many of the content these providers would be – would be adhering to. And so I'm saying this more as a comment, more so than a question, but I just think we want to keep that in mind.

**Paul Tang – Palo Alto Medical Foundation**

Sure. Art?

**Arthur Davidson – Denver Public Health**

Yeah. I think Chris just actually took most of what I was going to say, because I think that the discussion here today is focused on filling a gap for the specialists, allowing them to find a way to play in this deeming process, and using HIT as a method. So indeed, the specialties, many of them may have registries. I think the challenge for us would be to kind of push the registry value that, you know, it's not just about prevention, not about control, but about learning how to do those things better in those specialties.

And I think one of the areas we might try to push them even to do more might be to incorporate some of the patient-reported outcomes in the reporting to the registries, so that there is – there's added value there, not just from a specialty creating its own registry, but we're now finding out what are the outcomes for patients, and how did that affect the way that the registry is used?

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

Good. Any more questions, discussion?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I think in general there's been a lot of nodding heads in the room in terms of looking for opportunities to streamline, simplify, and provide alternatives in meaningful use, moving ahead. I would actually urge you to be even bolder, and think – within the constraints around the consolidation, for example, is there even more that we could do on there? And the deeming, with an eye towards making sure that, you know, when Rob and I get – you know, have to testify, that we can provide a clear justification for why this is appropriate deeming of that, but tying them, and thinking about more quality measures that really do substitute for functional measures.

But thank you so much for this little bit of a rethink. In the time that we have, we – Marilyn Tavenner announced at HIMSS that we're not going to be doing an MPRM, a rule-making, for stage three in 2013. I think that gives us a little chance for a breather, for a little room for more reflection, instead of kind of what was seen as a headlong rush into, okay, now what's Stage 3 going to look like, before we've really looked at Stage 2.

So I think you for the work of the Meaningful Use Workgroup, and I think it was – it's the right idea for us to take a little – a little pause and a little reflection as we move ahead.

### **Paul Tang – Palo Alto Medical Foundation**

Okay. So I'm taking that as an endorsement of this direction. Your counsel is to be bolder. And so we're going to go back for the next three months and go into details, take all – reconcile all the comments from the RFC and put that into place, and potentially work even more objectives – consolidate more objectives, and come up with other deeming – both qualification and what gets deemed, as long as they're linked. And so you'll have a even stronger story to tell the next time you're on Capitol Hill.

Very good. Okay. Thank you, every one. And we'll transition over to another top. Is this queued up? Great. Which is the clinical documentation hearing. This was a hearing that was jointly between the Meaningful Use Workgroup and the Certification Adoption, and you see the members of both groups listed before you. It's – the hearing itself was held on Valentine's Day, and we heard – Amy had actually – had already written a paper on this subject, and it was really a good paper, and that was presented to the group as sort of a ground-setting testimony.

And then we had four panels, one looking at the clinical documentation from the perspective of clinicians, a second looking at care coordination across the healthcare team, a third on secondary uses, and the fourth dealing with legal purposes.

So summary of the hearing. One, it was clear that clinical documentation is important. It has many primary and secondary users. The primary are those involved in direct care of the individual. The secondary are everything from public health to research to quality improvement, and yes, to billing and legal requirements.

And it turns out, as this group knows, that the preoccupation with the billing uses and the need – the legal requirement, so if it's not documented, it wasn't – it wasn't done, gets in the way of the clinical uses, ironically, of the record. And that's made a little bit – it's sort of exacerbated a bit, because with the conversion from paper to computers, we now have a lot of productivity tools to move text into this document. That causes a risk of overuse or inappropriate use of some of these productivity tools, which may impact the accuracy or the information and make it more difficult, with the volume of text that's in the document, make it difficult to find the information. So those are both the clinical challenges we have, as well as the potential challenge in the billing area.

Now unfortunately, although anecdotes are there about poor documentation and the problems associated with some of the documentation, there were – there were little to no quantitative evidence about how big a problem this is, how big an impact there is on accuracy, how prevalent is the impact. So – and there was also no clear method that said, well, here's the way we solved it, no clear best practice. So that meant the recommendation we have from some of the panelists is I wouldn't go into prescribing you should do this or you shouldn't do this at this point in time.

The next part is there's not necessarily a correlation, or at least a strong correlation, between the quality of the documentation and the quality of care. So that's one point. There are various ways of getting text into the record or dealing with the free text that's there. Getting text in, voice recognition continues to make improvements over the years, but it's – it works for some and it doesn't work for some, so it's not – it's not the panacea. And you clearly have to proof your work almost contemporaneously.

Second, natural language, similarly, is making progress over time. There's still the issue of negation and the various ways that humans both utter the negation and decode negation from the text, and that poses challenges to the automated ways. But it's making progress.

So trying to get – there's probably no best way to get it in, is sort of the upshot, and so a hybrid may be the way that it's done. One, you need the free text to record the things about a human being, about a human patient that just really actually does belong in the record, and sometimes is no longer there, and yet try to get some of the important coded information out. So maybe it's some kind of combination between voice recognition to have an easier way to get the text in, natural language process to have – processing, to help get the coded information that's so – that's so necessary to drive decision support out, and some limited guideline-based structured templates. Probably we're not doing this right match in most cases, and we get the kind of clinical documentation that becomes a challenge for us.

One of the presentations we had was from the Open Notes group, and you probably know that there's a group of providers that shared the progress notes with their patients, and on survey data, to the – they had very favorable results, both from the provider side and the patient side. And our thought was that, one, this certainly could help engage the patients. Two, it could help improve the accuracy by information that the patient notices that was – is missing or inaccurate. And three, could also deal with the fraud question, which is one of the instigators of the hearing in the first place. So that might be an avenue to something that could potentially help all – with a number of these problems.

What happened in the legal panel was interesting. One of the lawyers talked about a client that he had, you know, in – I think a was a malpractice case, but – so the plaintiff showed the defendant what information was in the record, and the claim by the defendant was, well, I never saw that, which is quite possibly true. In other words, what is the legal medical record – what is the medical record when you have a computer system that has rich sort of data in the database, but what actually was seen or what was viewed by the individual, which is actually more important from a litigation point of view?

But – so it struck us that there really isn't a good definition or a way to render the information that is in the database of the EHR in a way that's relevant to either care or to the legal process. So that said, we probably need to have some kind of definition and potentially some kind of certification requirement that says what should the vendor be able to put out that casts an appropriate light on what information was viewed in the context of care?

Another piece that came out is there's a lot of times, and maybe it's ... case, where there's a lot of documentation going on because of some – of a misunderstanding of what really actually needs to be there. So people put an excess amount of documentation, sometimes inappropriate documentation. So there's an opportunity to actually do a better education of what actually needs to be there, and probably not even get to some of the problem to start with.

So it was actually a very rich day of testimony, both about the challenges, but also about some of the possible opportunities.

So there are the recommendations to – that the group is proposing for your consideration. One is that clinical documentation currently is menu. We should move that to core, because there's so much primary and secondary uses of this information. Second, we found no easy pathway to say you should do this or you shouldn't do this. One of our interesting recommendations for your feedback is to come up with a way that addresses a number of the problems.

Remember, one of the problems is there's so much text in an unformatted way that it's hard for the clinician actually to get the real data out, so that's one point. And the second is we don't really know who put it in there. So one of our thoughts is to do something analogous to Microsoft Word's track changes, so if you know, that's a way that people collaborate on the creation of a text document. And it – and the track changes allow you to identify who put what in where at what time. That helps the reader sort of understand the veracity, the context of the information, and the changes made in a copy/pasted section of text.

So if you think about it, this might be a way for us to at the same time help guide the reader to know – to sort of assess the validity of this text, as well as better understand the context and better understand the changes that were made in that text.

Now from a everyday use point of view, the proposal is that it would be just like the accept all change in track changes. So in other words, what is seen in the record is the same thing that's there today. What's transmitted to another organization is the same thing that's transmitted today. It's a clean copy. But at the touch of a button, so to speak, you could reveal the tracked changes. You could see the provenance of the data. You could tell what was copy/pasted en masse into this record. And either it was very appropriate or not, but at least the reader would know, would have a heads up.

Another piece is – had to do with the Open Notes. In other words, to include progress notes in these clinical documents as part of VDT, is another possible approach we could take. And finally, there's just more work to be done. So most of the people in the panel also said, well, really, it's really hard to find the important information in clinical documentation. So we clearly need more research or more innovation of getting meaningfully displayed textual information. Perhaps it's with graphs. Perhaps track changes helps. Anyway, there needs to be far better ways of getting important information to stand out in text.

The number six is actually if there are ways either that ENM coding criteria could be simplified, or that people could be better trained, we could try to reduce the amount of excess text that goes into clinical documents that actually complicates their ability – our ability to find appropriate information.

And finally, going back to the legal medical record, that we propose that HIT Standards Committee review the standards and see if there's a way to prescribe certification criteria so we have a standard way of spitting out what's in the legal medical record, or maybe addressing this notion of what was actually seen in the process of decision-making.

So those were the recommendations and findings we had from that rich day of hearing on clinical documentation. Open to your comments, feedback. Paul Egerman?

**Paul Egerman – Businessman/Entrepreneur**

Thank you, Paul. It's an interesting and important topic. A couple of questions. When you talk about clinical documentation, some places you say clinical documentation, and a few other places you say notes. When you mean clinical documentation, are you really talking about ambulatory progress notes?

**Paul Tang – Palo Alto Medical Foundation**

Okay. So – and I want to mention that Larry Wolf, who's the co-chair of the Certification and Adoption Workgroup, is not – wasn't able to join us today, but is now on the phone. Larry, did you want to say anything before we get started with the questions?

**Larry Wolf – Kindred Healthcare**

So I guess I – I'll start with Paul's question, that the intention was that we'd be looking broadly, that this would be not just for inpatient and not just for outpatient. We'd be broadly looking at documentation. And I think you're right, though, to point out that there may be places where we need to be more specific in trying to distinguish the different kinds of documentation with other things, or progress notes, there's some kind of summary, like a discharge summary, or consult notes, or all the various ways in which documentation comes to be. So we really – we intended this to be pretty broad.

**Paul Tang – Palo Alto Medical Foundation**

If I could just qualify that a little bit, and this may help, is if we looked at the people who are – who are part of the meaningful use program, and so it would be the EPs and the EHs.

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

Oh, yeah, end limit, and so if you had this very broad definition of text, I think you have to consider the situation where the text is not created within the EHR. So it could be created within a separate, for example, radiology information system, and brought over into the EHR system. And in that case, it seems like your recommendations about like track changes don't quite apply, because all of that template stuff to the extent that it occurred, would have occurred in the radiology system. And there may be other examples alike the consultative notes could have come from some other source, some other system, and are brought over, and one wouldn't – not normally, once they're in the EHR system, edit somebody else's consultative note, or edit somebody else's radiology interpretation.

**Paul Tang – Palo Alto Medical Foundation**

That's correct, but you still can copy/paste. And so what we would see in, quote, track changes, is that you did copy the radiology interpretation or cardiologist's consult into your note, which may be totally – so the provenance would be shown, and that may be totally fine, but now the reader knows.

**Paul Egerman – Businessman/Entrepreneur**

Well, but – and my point is then the copy-paste – I mean, the track changes recommendation applies to your ambulatory note. It does not apply to the radiology interpretation or the consultative – the source documents. It only applies to the extent you put it in an ambulatory notes. So it seems like you need to clarify that's what you're talking about with this –

**Larry Wolf – Kindred Healthcare**

So Paul?

**Paul Egerman – Businessman/Entrepreneur**

Yeah.

**Larry Wolf – Kindred Healthcare**

That situation might occur in an inpatient progress note as well. It's very common for inpatient docs to be referencing previously documented information when they write their progress notes.

**Paul Egerman – Businessman/Entrepreneur**

Okay. But I just think you need to clarify that – the other concept is – that I put forward is that if you're going to have this broad concept of text, you might want to have a recommendation that includes something for the Standards Committee to establish a standard to bring in information like consultative reports or radiology interpretations from other systems, so that you can bring the text into the EHR.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. So I think the domain would be information, in this case textual information in the EHR. It could have been imported – in your case, radiologic notes from another system. But once it's in the EHR, then you can copy/paste and edit.

So let's say actually the radiology report had left and it was the right, and you were copy/pasting the report, it would show up in red. And when you changed left to right, that would show up in blue.

**Paul Egerman – Businessman/Entrepreneur**

Yeah. And that's a – and I don't have any problem with that. I'm just suggesting that your recommendation needs to be clear that track changes only relates to progress notes. It doesn't replace – relate to things that come from other sources. And I'm also suggesting that if you really want to get excited about having text in the EHR, you ought to have some standard interface so that these EHR systems can accept, you know, radiology interpretations, consultative reports, and even, you know, information from transcription systems. So there's a vehicle to get the text in, other than physicians just typing.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Larry Wolf – Kindred Healthcare**

Well, so I guess what I'm hearing is a suggestion that while we've said on interfaces we want this all stripped back to just the simple text, that in fact we might be asking for a recommendation to develop standards to allow the structure that created the note to be preserved across interfaces as well.

**Paul Egerman – Businessman/Entrepreneur**

No, that's not what I'm saying. I'm just saying, you need a structure to bring a note in. I don't think you need the –

**Larry Wolf – Kindred Healthcare**

The structure – there are – there's a lot of that that happens today, so maybe I missed hearing what you're asking about, because there's a lot of dictated notes, consult notes that come into EHRs as text that can be managed as text, and it's not a blob. It's not structured like lab, but it's accessible as, you know, characters in a byte stream that you could run through NLP, or you could copy/paste out of – that those things exist today in many EHRs.

**Paul Egerman – Businessman/Entrepreneur**

Okay.

**Paul Tang – Palo Alto Medical Foundation**

Great. Judy?

**Judith Faulkner – Epic Systems Corporation**

Just a request, Paul, that before you would go ahead with this, you contact some of the larger vendors to find out how feasible it is, how much effort it would be, etcetera.

**Paul Tang – Palo Alto Medical Foundation**

Good question, and I forgot to mention, so that question came up during our discussion, and so just amongst the group that was on the call, we produced four or five examples from four or five different vendors, actually, that does do this. So we actually asked that question. How does it ... this recommendation? And so people actually submitted, and so it appears to be not only feasible, it's in some products. So that's –

**Judith Faulkner – Epic Systems Corporation**

Might be in ours, for all our know, but –

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

Terry?

[Crosstalk]

**Larry Wolf – Kindred Healthcare**

I guess maybe a relevant footnote on that is that we also saw a wide variation in how it was done, so we felt it was very important not to be prescriptive in how to do this, but just to describe what we wanted done.

**Paul Tang – Palo Alto Medical Foundation**

Terry?

**Terry Cullen – Department of Veterans Affairs**

First off, I want to thank you for tackling this. In my opinion, this is one of the holy grails that we have, and we don't really know what we're doing with clinical documentation. I have a few points. One is I'm always a little taken aback by the word fraud, and not that that doesn't happen, but I think sometimes notes include mistakes as opposed to fraud. And I would – don't want to be in a situation where we're misconstruing the intent of a provider just because they happen to inadvertently click a button and it got them a higher level of ENM than – so I think we just need to be sensitive to the use of that word, even though I understand there's concerns about it.

Secondly, I think that item five is actually the most – in some ways to me the most important one, because I don't think we have figured this out. We record providers, we record patients, so we have informant wording, and we have historian wording or whatever word you want to use to say who's being recorded there. And I know from the VA perspective, we'd be really interested in working on trying to get at what is the better way to collect and meaningfully display the information.

And then my final comment is related to the standard. I really think these – we do need to have some standards. For instance, I can click, and this goes back to a comment previously, I can click computer records reviewed. How I interpret computer records reviewed may be totally different than the next person that sees this patient, and for me, it may be I looked at the last visit, and they may have looked at the entire record. So I think having some standards there or some constraints around that would save us from this fraud situation and also help move this work forward.

**Paul Tang – Palo Alto Medical Foundation**

So let me just clarify on the fraud. So there's no implication that all inaccuracies are fraudulent. ON the other hand, one of the – one of the charges to the workgroup did come from Congress, and from Farzad, that we need to look at this question, and it certainly is a question. And so we just wanted to make sure that, yes, we're trying to address that as well. Farzad?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Related to that, I like how you put it, that there are productivity tools that have been developed, but that overuse or inappropriate use of the tools can have – create problems with accuracy, both on the clinical side as well as on the billing side. Was there discussion about whether there are some productivity tools that are beyond the pale, that really don't have a true function in terms of anything other than billing?

**Paul Tang – Palo Alto Medical Foundation**

We didn't –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

And whether there could be something – well, again, without prejudging now whether it's regulatory or best practice or education or what else, but something that would – or code of conduct among vendors, something that would provide guidance on – you know what? That – you know, if there's – as you're documenting something that comes up – as an example, I don't even know if this is a real example, something that, you know, a counter that tells you what level you can charge in real time, and highlights one more item that you can do, right? That seems, you know, would seem to many to be beyond the pale, and I don't think it's done commonly, certainly not that I've seen. But was there discussion about that kind of tool?

**Paul Tang – Palo Alto Medical Foundation**

No, we didn't discuss that. I will say that the functionality you just described exists and is advertised as a – as an advantage, so – and that seems to me, that's an example of the – I mean, that's – encourages inappropriate use of documentation. So that's a good thing we could take back, because I think your notion of a conduct – code of conduct, while we couldn't – so we did ask about – we started out with the copy/paste thing. We didn't mention your specific example. And the panelists just didn't want to prescribe any – proscribe anything – no wait, proscribe anything.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

But I think we didn't actually look at what you just mentioned. And as I say, it does exist. It exists in ads, which means they think of it as a benefit of their system. But we could back and look at that, because I think that's an interesting concept. Neil?

**Neil Calman – The Institute for Family Health**

It seems like we have our first anti-certification requirement.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**Neil Calman – The Institute for Family Health**

It's like if your EHR has this, you can't be certified.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Neil Calman – The Institute for Family Health**

As opposed to the other way around. That wouldn't be a bad idea, actually.

**Paul Tang – Palo Alto Medical Foundation**

That wouldn't be bad –

**Neil Calman – The Institute for Family Health**

For some types of functionality that have come under, you know, some significant criticism in terms of the fact that they really don't provide clinical benefit, but provide opportunities for increased abuse.

**Paul Tang – Palo Alto Medical Foundation**

Other comments, questions?

**Terry Cullen – Department of Veterans Affairs**

I just want ... that discussion, though. I think it's really difficult when you come up with a diagnosis of strep pharyngitis, and you look at – and there's a complete review of systems and a complete physical, and it's really because doing that is helping the provider come to that diagnosis, even though you would think that would normally be a level two. And somebody else may look at the chart and go, you're upcoding. And so I think it's a difficult thing.

And what I would argue is that for most of us, if you've ever worked in the private sector, usually next to your desk is what constitutes a level two, three, four, and five encounter. So even though it's not – obviously, Neil, it shouldn't be in the computer, but that's fairly ubiquitous.

**Neil Calman – The Institute for Family Health**

I think there's a difference between that, though, than a system that says, if you document one more body part –

[Crosstalk]

**Terry Cullen – Department of Veterans Affairs**

Document one more thing.

**Neil Calman – The Institute for Family Health**

– you could go a level three as opposed to a level two.

**Terry Cullen – Department of Veterans Affairs**

Right.

**Neil Calman – The Institute for Family Health**

I think there's a –

**Terry Cullen – Department of Veterans Affairs**

Yes. I would agree.

**Neil Calman – The Institute for Family Health**

There's a quantum gap between what – you know, recommending something and doing something for the purposes of encouraging upcoding.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah, the guidance on this is that what should be used in determining the level is what is the medical necessity. That is, what's governing is medical necessity, and this seems by its nature – again, this is – you know, this is – the question is, is there anything that, you know, the group could say is beyond the pale, and the vendors could agree is beyond the pale, and we could – we could move forward on? Or is it all, you know, six of one, half a dozen of the other? Judy, were you –

**Judith Faulkner – Epic Systems Corporation**

Yeah. I think there's different ways for features like that, though. One way is that the physician is checking what I've done, and then it calculates, and then the physicians want to know, I thought it was going to be X instead of Y. It tells them. So there is – just as you were saying earlier, there's ways you can look at it to say it's fraudulent, and there are other ways that you can look at it that says, yes, you got the stuff on your desk, and you want the system to try to help you so you don't have to go looking up the stuff on your desk to see why is it this way instead of that. That's a feedback I've heard from people. I haven't heard people say, oh, we want to upcode. Tell us how. But I have heard people say, we want to be able to enter in what we've done and see what it maps to, and we want to be able to understand why it's producing a certain code.

**Paul Tang – Palo Alto Medical Foundation**

Any other comments, questions? Let me ask – there's three recommendations here I'd like to just get your sentiment on. One is what you saw, number three, which is the whole track changes. Another one is the Open Notes. And the third one has to do with HIT – standards for being able to produce a, quote, legal medical record. I think those are three areas we haven't discussed before, and so these are recommendation I'd be interested to get the Policy Committee's opinion on. Why don't we do this one at a time? So one was the track changes. Please, Paul Egerman.

**Paul Egerman – Businessman/Entrepreneur**

My issue with that is I'm okay with that as long as it's limited to like the progress notes, that – you know, the part that is actually directly entered into the EHR, not – does not include information that gets imported into the EHR from some other source.

**Paul Tang – Palo Alto Medical Foundation**

So when you say doesn't include, you mean you can't change. You don't mean that it should be known that I –

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

No, no. I mean is if you bring in a radiologist's interpretation, you only see that one thing. You don't see any prior versions of that.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Paul Egerman – Businessman/Entrepreneur**

So if the radiologist used a template or cut and paste or something, that's not relevant. You don't have to bring that over. They just bring over the final copy.

**Paul Tang – Palo Alto Medical Foundation**

Oh, yeah. So we don't – that's correct. We don't know what happened in the radiology system, but we would like to know that you copied this blob of text from the consultant report or the radiology report –

**Paul Egerman – Businessman/Entrepreneur**

That's right.

**Paul Tang – Palo Alto Medical Foundation**

– into your note.

**Paul Egerman – Businessman/Entrepreneur**

So it's – so as long as you're saying it only relates to things that are created within the EHR –

**Paul Tang – Palo Alto Medical Foundation**

Okay. I see your point now.

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

I understand that. Any other – do people think this is a good idea for a recommendation? Of course, I mean – okay. Okay. Next point was Open Notes. I probably shouldn't use their proprietary name. It's including progress notes in VDT.

**Terry Cullen – Department of Veterans Affairs**

So VA just started doing this starting in January. I was telling Judy earlier, the one feedback we have is some things that – wording, words that appear to be pejorative, like obesity, can be offensive to people. So we're trying to figure out what to do with that. But by and large, our experience has been really positive. We did do a huge provider education and notification prior to doing it, and we elected to go prospectively from a date. We may actually go back and release everything. But I think the one thing is if it's prospective, I think – I think you're fine. I think if you start going retrospective, there may be more issues.

[Crosstalk]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

This is EHRs should have the functionality.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

It's not – this is not a recommendation on Meaningful Use Stage 3 that VDT include progress notes, which is the behavioral aspect of it. This is more a recommendation on the certification. So for example, this could end up being an optional measure for meaningful use, but you would require the certification capability to include within VDT the progress notes.

**Paul Tang – Palo Alto Medical Foundation**

So I think we at least meant certification, and I think the way we're thinking, and Christine can be the alter ego, is that the consideration is to include it as a behavioral – as a meaningful use objective, so that you are – it is – not only is your EHR capable of doing that, but you actually turned it on.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Again, I would ask that we hold off a little bit on recommendations for what's in Meaningful Use Stage 3, you know, behavioral measures. I think we'll take those as a whole rather than, you know, have a recommendation that speaks to that already in terms of what Meaningful Use Stage 3 would be.

**Paul Tang – Palo Alto Medical Foundation**

Do you want to say anything, Christine?

**Christine Bechtel – National Partnership for Women & Families**

Yeah. Sure. I mean, I think that's fine, because, you know, there's – as long as we're maintaining the functionality component in this, and I think that is what this does, that's great. And then, you know, let's just remember that as we're going back through with the RFC, we can have a more full ... discussion. Because I think Terry raises some good points, and we haven't been particularly specific about the best way to do this. Is it menu? Is it – you know, all those things. Is it separate? Is it included? And I think consolidation changes things. So I think it's worth more discussion. So this would be fine to just be certification, in my opinion.

**Paul Tang – Palo Alto Medical Foundation**

And Terry, is the VA planning to roll this out throughout the system?

**Terry Cullen – Department of Veterans Affairs**

It's rolled out.

**Paul Tang – Palo Alto Medical Foundation**

It's rolled out?

**Terry Cullen – Department of Veterans Affairs**

Yeah. It went as part of Blue Button, so anybody can download notes. Interestingly enough, it isn't as much as you would think. And some of that is because some of our patients – so if you ever read ... you guys know this, and you've had multiple consultations, you have notes that are like – you could have 300 notes from a hospitalization, and they get all those notes. And so what we're also finding, we're trying to figure out how do we help you figure out –

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Terry Cullen – Department of Veterans Affairs**

– how to go through those notes, just the way I need help to go through those notes. But yeah, it's rolled out.

**Paul Tang – Palo Alto Medical Foundation**

And that was my other question. So you trained the providers, which I can certainly understand. Are – is there any way you're helping or training the patients?

**Terry Cullen – Department of Veterans Affairs**

There is information available on the website to help them. But you also get how much megabyte you're downloading prior to download. So we have – we're seeing people go, I want it, then they see the number, and they go, oh, I don't want this. So – or that's what we think they're doing. They're not downloading.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. It's the same experience that they – that they had in the study, Open Notes, which was the provider concern and resistance was really significant, and they did, you know, lots of work. But then when they had the folks who volunteered to ask things like are they – are the patients even reading the notes? Is the system turned on? Because it wasn't a big deal. So it's interesting. And it turns out patients are very resourceful when it comes to figuring things out. But – at least on the – you know, mostly the EP side. But the hospitalization piece is a very interesting one.

**Paul Tang – Palo Alto Medical Foundation**

Paul Egerman?

**Paul Egerman – Businessman/Entrepreneur**

In this recommendation, are we talking about ambulatory progress notes as opposed to inpatient notes, maybe written at the bedside?

**Paul Tang – Palo Alto Medical Foundation**

We didn't distinguish.

[Background voices]

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay. The third piece is the legal medical – yes, Judy?

**Judith Faulkner – Epic Systems Corporation**

Question on that. I wondered whether in fact it will change the physician's writing in such a way that it becomes so conscious of a patient reading it that they're not able to communicate as well for the proper treatment of that patient. Terry, do you have any –

**Terry Cullen – Department of Veterans Affairs**

I think what we're seeing is just people more sensitive to the use of language. So in – my guess is every clinician in this room – well, maybe you're not all like me, but I've clearly written disparaging remarks maybe once or twice in a chart, unintentionally, but where, you know, somebody was belligerent, and I wrote they were belligerent. So I'm not sure I would use that word now in a note. I might, you know, have another word for it. But I actually think it just makes it more sensitive to the fact that we're dealing with somebody that's going to read what we write, and it's probably overall really positive.

**Paul Tang – Palo Alto Medical Foundation**

As Deven will tell you, it's a HIPAA right anyway.

**Deven McGraw – Center for Democracy & Technology**

Although, you know, there's always the ability –

[Laughter]

**Deven McGraw – Center for Democracy & Technology**

You know, if you think that it's going to be harmful to the patient, you do get to hold it back. But that – I don't know that that happens all that often, because that requires you to look through it and scrub it before you give it to the patient. That's a lot of work.

**Terry Cullen – Department of Veterans Affairs**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Because obese is not a harmful to me – at any rate, say – okay. So the legal medical record, whether we have it certification or whether there's a certification requirement, which means there's a definition of what should pop out of the medical record as the legal medical record, and is there a concept of what was used/viewed in the process of that encounter?

**Neil Calman – The Institute for Family Health**

You know, there's a missing piece I think from that, which is what's in the legal medical record, what was available at any given point in time, and then what was accessed. I think there's a third piece in there. You know what I mean?

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**Neil Calman – The Institute for Family Health**

So – because for example, a medication list is changing over time.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Neil Calman – The Institute for Family Health**

So the ability to sort of look at a particular date and say what was in the record as of that date, so that that information is captured historically. And then the third piece is sort of what was accessed at the time.

[Crosstalk]

**Deven McGraw – Center for Democracy & Technology**

This is Deven. It might be helpful to remind the Standards Committee that there was a lot of really good testimony submitted on this topic by the AHIMA and others. Now we didn't have the written testimony from the particular attorney who presented, but at least his remarks will be captured in the transcript.

**Paul Tang – Palo Alto Medical Foundation**

So people in favor of fleshing out this concept, two things. Legal medical record, and sort of what was viewed/available at the time of the encounter. Okay. It looks like – there was a lot of head nods, for those on the web. Okay. Well, thank you for the discussion, and we'll proceed with that. And we'll have to look up – we'll still need to deliberate on Farzad's suggestion about the code of conduct, because we didn't – we didn't talk about that.

Okay. Now I think we're ready for the long-term care coordination update.

[Pause]

**Paul Tang – Palo Alto Medical Foundation**

Go ahead.

**Evelyn Gallego – Office of the National Coordinator**

Good afternoon, everyone. My name is Evelyn Gallego. I am the S&I LCC Initiative coordinator. And I'd like to start by thanking the HIT Policy Committee for the opportunity to brief you today on the work of the LCC workgroup. I also want to acknowledge that this is a more condensed presentation than the one the LCC leads provided to the HIT Standards Committee last week.

Today, I plan to quickly discuss how current and proposed standards for transitions of care and exchange of care plans do not meet policy expectations for Meaningful Use Stage 2 and Meaningful Use Stage 3 for eligible providers and hospitals. I will also provide awareness on the extensive national effort behind these evolving standards and their expected level of maturity by the end of this year.

Based on the public comments received and shared with the HIT Policy Committee regarding proposed recommendations for Meaningful Use Stage 3, there was much discussion around transitions of care and the exchange of care plans. As listed here on the slide, most of the comments centered around the adoption and maturity of existing standards, the lack of standardized definitions for TOC and care plans or plans of care, and the burden of work on providers, should the data not be reusable.

In response, the LCC workgroup has identified three main gaps in achieving Meaningful Use Stage 3 proposed recommendations. I would like to center your attention around the first gap, the lack of care plan definitions, relationships, and ability of the consolidated CDA to represent needed care plan content.

As noted in the LCC workgroup response to the HIT Policy request for comment, the concept of care plan and its component parts are ambiguously defined in meaningful use, and thereby impact the ability for interoperable exchange across the continuum of care for both eligible and ineligible provider groups. This is important when we reflect on the fact that the average Medicare beneficiary sees seven providers in four different organizations per year, and this does not include other members of the care team, such as care managers, social workers, therapists, all of which are not eligible for meaningful use incentives. We recognize that current standards do not support the requirements to exchange a care plan for reasons noted on the slide.

Briefly, let's touch upon the information needs and responsibilities of eligible providers and hospitals for transitions of care. I recognize this is a busy slide. My purpose is to highlight the complexity involved when transitioning a patient from an acute care setting to their final destination. There are multiple sites, multiple provider groups, and not all providers have the tools or the incentives in place to exchange patient information, let alone care plan information, electronically.

Of those transitions highlighted in the previous slide, let's consider that approximately 40 percent of those are for Medicare patients which are discharged to traditional LTPAC settings like a SNF, home health, inpatient rehab facility. These patients tend to be the sickest population and account for approximately 80 percent of Medicare costs. Hence, hospitals play a critical role in conveying the information needed by the recipient of a patient during care transitions.

The LCC workgroup recognizes that meaningful use is focused on eligible provider groups. Given this, it is important to recognize that when an eligible provider transitions a patient to a non-eligible provider or recipient, it then becomes the responsibility of the eligible provider to meet the information needs of that patient.

Quickly go over these. One more. Okay. For this reason, the Massachusetts IMPACT project, a recipient of one of the ONC's State HIE Challenge grants, carried out work to identify the needs of the receivers, or recipients, of patients during transitions of care. They conducted an extensive survey across 46 different organizations where they were able to identify a robust set of data elements needed for transitions of care and care plan exchange. They started with the CCD, part of the consolidated CDA, which has 175 data elements. Following the IMPACT study, an additional 150 data elements were identified specific for transitions of care needs.

As part of their work with the S&I LCC workgroup, which has carried on over the past year, the IMPACT team identified additional data elements needed for longitudinal coordination of care to come up with a new data set of 483 data elements. This is now the total data set to date.

Through this gap analysis, the LCC workgroup concluded that many, approximately 70 percent of the missing data elements within the 483, can be mapped to CDA templates with applied constraints. This leaves approximately 30 percent with no appropriate template.

So where are we today in filling these standards gaps? The LCC workgroup would like us to recognize that much work has been ongoing for the past few years to address standards gaps for TOC and care plans. In addition to the activities of the LCC workgroup, which is a community-led effort, work is also being addressed through other S&I initiatives, including transitions of care and the CMS-led esMD initiative. The HL7 patient care workgroup is also engaged, as well as the IET Patient Care Coordination Technical Committee, and the AHIMA-LTPAC HIT Collaborative. Over the past year, all these groups have been coordinating their efforts to assure alignment and collaboration when dealing with care plan standards.

As I mentioned earlier, the LCC workgroup is a community-led initiative, and unlike other S&I initiatives, is mainly led and funded by multiple public and private sector partners, each of which is committed to supporting the broader community in achieving health information exchange. Today, we have over 200 members participating in the initiative, ranging from vendors, healthcare organizations and associations, and government entities.

Over the past year, the LCC workgroup has achieved much success in setting the foundation for meeting meaningful use proposed needs. This slides depicts the various deliverables or artifacts of the workgroup, each one building from the previous one. Of importance are the last three deliverables: the development of the care plan glossary and subsequent inclusion in the LCC workgroup response to the Meaningful Use Stage 3 RFC, the IMPACT project transition of care high level implementation guide, and the evolving care plan use case, which will set the functional requirements for care plan exchange.

This is a snapshot of the care plan glossary and the proposed standardized definitions for care plan components. These were included in the LCC workgroup response to the HIT Policy Committee's request for comments.

Let's quickly go through these. Okay. This illustrates the five transition data sets which were included in the IMPACT transition of care implementation guide. Even though the LCC workgroup speaks of multiple data sets or multiple transitions across settings, they believe these transitions can be grouped in five data sets with a transfer of care summary being the largest data set, which includes all previous data sets. And this is, as an example, when a patient is fully discharged to post-acute care setting from a hospital, like a SNF, PCP, home health agency.

And this slide is meant to show you that the transfer of care summary is a superset of all the previous subsets.

The IMPACT project is focused on the transfer of care data set. This is what they will go live with next month in Massachusetts as part of the Massachusetts IMPACT Project go live. To ensure that this data set becomes a national standard that can be implemented by vendors across the nation, IMPACT and its project sponsors have contracted with Lantana to develop and ballot HL7 implementation guides for the transfer of care data set, as well as the home health plan of care and the care plan data set.

The home health plan of care work will also be coordinated with the CMS esMD initiative that is currently working towards the development of a digital signature – a digital signature standard. These implementation guides will be balloted through the HL7 structured documents workgroup for the August/September ballot cycle.

There is significant interest and engagement in some key stakeholder groups, including vendors and various provider groups in the LCC workgroup. Several vendors across Massachusetts and New York have expressed commit to pilot these pre-balloted versions of the LCC standards in their products this year. Several national LTPAC providers are exploring incorporating these standards into their products.

This timeline serves to illustrate the various activities and milestones of the LCC workgroup over the course of this year. All activities serve to ensure that consensus driven transitions of care and care plan home health plan of care implementation guides are balloted through HL7, and that significant pilot activities are launched and monitored.

And lastly, here I present the LCC leadership team and support team members, should you have any questions. Thank you for your time today.

**Paul Tang – Palo Alto Medical Foundation**

Thank you. So you identified the gaps. You identified all of the activities that are – logical activities that are going on to fill those gaps. Is there a time – when should we be ready to receive, and I guess how does it fit with Stage 3, which one of our questions, which right now is a 2016 kind of a question?

**Evelyn Gallego – Office of the National Coordinator**

So the standards will be balloted through HL7, the August/September ballot period, and usually if they are accepted and they go through the review cycle, they will be published by HL7 by the December timeframe, usually November/December they'll be published.

**Paul Tang – Palo Alto Medical Foundation**

And that'll close this gap?

**Evelyn Gallego – Office of the National Coordinator**

Sorry?

**Paul Tang – Palo Alto Medical Foundation**

That'll close this gap?

**Evelyn Gallego – Office of the National Coordinator**

That'll close the gap. Yes.

**Paul Tang – Palo Alto Medical Foundation**

So you're saying that we can count on a standard –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Balloted.

**Paul Tang – Palo Alto Medical Foundation**

– balloted transition of care document – care plan, that can be communicated? Both – there's a standard definition of care plan, and it can be communicated?

**Evelyn Gallego – Office of the National Coordinator**

Yes.

[Crosstalk]

**Paul Egerman – Businessman/Entrepreneur**

But we don't have a way of capturing all the information yet.

**Paul Tang – Palo Alto Medical Foundation**

Right.

[Crosstalk]

**Paul Tang – Palo Alto Medical Foundation**

Actually, well –

**Paul Egerman – Businessman/Entrepreneur**

I'm saying once that happens, then we have to develop –

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Paul Egerman – Businessman/Entrepreneur**

– the EHRs have to develop the mechanism of inputting all that information that's got to be transferred, assuming that it's not all going to be in our EHR today.

**Paul Tang – Palo Alto Medical Foundation**

Well, only 175 could even possibly be in there, right?

**Evelyn Gallego – Office of the National Coordinator**

Right. It builds off the consolidated CDA. So it's not that we're reinventing a new document type. It's just building off what's there already. And it does include the additional data elements.

**Neil Calman – The Institute for Family Health**

How much of this reflects the information that's currently transferred on paper or through other mechanisms, and how much of this is really – is new?

**Evelyn Gallego – Office of the National Coordinator**

It reflects what's transferred now on paper. So the IMPACT team, they actually tested the – this data set by paper first, saying – from the receiver end, like they did a survey and they said, if we provide you this information, even paper-based, is it what you need? And that's what they used to then identify the electronic data elements.

**Terry Cullen – Department of Veterans Affairs**

I have one question, then. So – and, you know, I think this is somewhat where we're trying to go. So now it includes patient-defined goals, with all these things with it? So those are all standard now? I'm looking at slide 14.

**Evelyn Gallego – Office of the National Coordinator**

The components?

**Terry Cullen – Department of Veterans Affairs**

Yeah. Well, may –

**Evelyn Gallego – Office of the National Coordinator**

The definitions?

**Terry Cullen – Department of Veterans Affairs**

Yeah. Goals, patient defined goals, prioritization of health concerns, interventions, longevity, function –

[Crosstalk]

**Evelyn Gallego – Office of the National Coordinator**

Yes, it includes patient goals. Yes. So – this one?

**Terry Cullen – Department of Veterans Affairs**

Yeah. But a lot of that isn't standardized, right?

**Evelyn Gallego – Office of the National Coordinator**

It's not standard.

**Terry Cullen – Department of Veterans Affairs**

No.

**Evelyn Gallego – Office of the National Coordinator**

Right? And what – we're working towards – the care plan use case is looking at if we have these – if we can come to an agreement on these components, what are the definitions or the information needed within each one that then can be incorporated in the EHR? There is that understanding that right now, in some provider settings, it – you know, there is patient engagement in updating their goals, and in others, they're not. Our – from a standards perspective, we could say we can recommend that this functionality be available in the EHR system, where the patient is consulted to update their goals, and the goals are also patient-derived goals, but from a process perspective, we can't prescribe that the provider do that.

**Paul Tang – Palo Alto Medical Foundation**

So this might be one of those rare occasions where the standard's ahead of the practice. I mean, I –

**Evelyn Gallego – Office of the National Coordinator**

Yes.

**Paul Tang – Palo Alto Medical Foundation**

The question is, when do you even teach the medical students what to be asking how, and how to capture it, and how it's used?

**Evelyn Gallego – Office of the National Coordinator**

That – and that is a challenge, and from – you know, an S&I – part of my role is to ensure that that's look at it, what a system can do, but we – that's why it's important to have the associations involved, to have provider groups involved, where they come in and they give feedback, but you get that all the time, saying, well, that's not what we do in practice, but it would be ideal. That's what we want to move towards.

**Paul Tang – Palo Alto Medical Foundation**

Art?

**Arthur Davidson – Denver Public Health**

Thank you. So I think I understand that there was a gap in the C-CDA that you're now addressing, and that hopefully by December it'll be solved.

**Evelyn Gallego – Office of the National Coordinator**

Yes.

**Arthur Davidson – Denver Public Health**

And maybe some of these questions are being asked – I didn't quite get – of the 483 elements that you think are important for LCC, how many are now being captured typically in EHRs? And which are the most important ones for us to consider, if it's not there now, as part of certification criteria, at a minimum?

**Evelyn Gallego – Office of the National Coordinator**

Right now, it's – 175 are being captured. So that's what exists right now in the EHR system.

**Arthur Davidson – Denver Public Health**

So we have a long way to go.

**Evelyn Gallego – Office of the National Coordinator**

Yes.

**Arthur Davidson – Denver Public Health**

So you're solving a structural issue, but we're not solving the content?

**Evelyn Gallego – Office of the National Coordinator**

I – and, you know, I would leave – the LCC leads the IMPACT team to – but like my understanding is that there's 175 data elements right now in the CDA, and then there's additional data elements identified, but they're sub-data – so it's like a deep dive of those existing elements. So – and the mapping is – so the mapping that I spoke about in the previous – there is – we'll see that – 70 percent of those 483 map to existing document types within the 175 or the CCD, and 30 percent do not, meaning that there's no data elements, there's no content there for that. So those are new.

**Arthur Davidson – Denver Public Health**

So independent templates – these are 30 percent that just aren't available as content anywhere –

**Evelyn Gallego – Office of the National Coordinator**

Within the electronic health record.

**Arthur Davidson – Denver Public Health**

Within the health record.

**Evelyn Gallego – Office of the National Coordinator**

Yes.

**Arthur Davidson – Denver Public Health**

Okay.

**Paul Tang – Palo Alto Medical Foundation**

Within the CC –

**Evelyn Gallego – Office of the National Coordinator**

CCD.

**Paul Tang – Palo Alto Medical Foundation**

Within the CDA template. Not that it's never been collected in the electronic health record.

**Evelyn Gallego – Office of the National Coordinator**

Right. Right. And some of it could be collected by free text.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I would –

**Arthur Davidson – Denver Public Health**

So is there something that we need to think about in terms of structuring that content? Forgetting about the template, just to do adequate CC – LCC, is there data that we need to be focused on?

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

I guess what I would – just for context, we shouldn't try within – as much as we would like to, within the Health IT Policy Committee, to redo the work that the LCC group has been doing for a couple of years, thinking about what are the most important data elements, and whether they can feasibly be collected, and whether there's structure, and so forth. I understand that – I guess what I'm sensing from this, Evelyn, is that even though this is a shortened version of what you gave the Standards Committee, perhaps there are folks here who would like to dig deeper –

**Evelyn Gallego – Office of the National Coordinator**

Yes.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– into – into understanding more what are these elements? Are they really necessary? You know, and how feasible is it to collect them? What are we talking about? So perhaps we could share the larger set of materials with the Policy Committee, and if there are additional questions, we could have maybe some of the LCC kind of ... clinical leads –

**Evelyn Gallego – Office of the National Coordinator**

Absolutely. Yes.

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

– come in and explain why they think that this set is not only the right thing to do from a standards perspective, but it's the right thing to do from a policy and clinical workflow perspective. Is that fair, Art?

**Arthur Davidson – Denver Public Health**

Yes. Thank you.

**Evelyn Gallego – Office of the National Coordinator**

Thank you.

**Paul Tang – Palo Alto Medical Foundation**

You have another –

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

Yeah. You know, the – now I'll do it.

[Laughter]

**Farzad Mostashari – Office of the National Coordinator – National Coordinator**

The – you know, again, from the Policy Committee perch, the – just the one feedback I would have is to think about what is the largest contributing preventable cause for readmissions, because there's a lot of information that would constitute a perfect handoff, and yet maybe for prioritization purposes, if we focused on what, you know, can prevent those bad outcomes, and readmissions being a good marker of that, may be a way of focusing the lens, if that's not already been done. But, again, I'm sure these are all things that the LCC group has considered.

**Paul Tang – Palo Alto Medical Foundation**

So maybe I can ask, to that question, are the social determinant factors, like have transportation, have caregiver at home, manage – are those all part of the 483?

**Evelyn Gallego – Office of the National Coordinator**

Yes. Yes. So they have social service – it's still – and of course, it doesn't encompass every – 483 is – they looked as much as they could. They include behavioral health. They included social services, and – but there could be more added to them.

**Paul Tang – Palo Alto Medical Foundation**

So I think you're getting questions – Farzad's right. You're getting questions because we're getting informed, we're getting educated. The complement of this – so is there anyone looking at the professional education system and –

**Evelyn Gallego – Office of the National Coordinator**

No, and we – that's something we would love your help on. This is – it's a challenge, because you do have – this is a very committed and passionate group, and these are folks that work on this day in and day out, they're out in the field. So they're looking at it, how will this improve how they deliver care to their population? But they know that at their level they can't make changes to what – you know, to the disciplines.

And it – we would – we would love to have more associations take a look at this, and saying, what could we change from a curriculum perspective? What can we do so once the functionality is available, that you have the providers use it? And, you know, definitely improve the care that they provide to their patients.

**Paul Tang – Palo Alto Medical Foundation**

So an example of needing a pull side. It's – whether it's from the professional associations, the accrediting bodies, the ABIMs, if it's part of MO – maintenance of certification, it'd be nice to have AAMC and the professional societies coming to ask for things from HIT policy. So someone would have to orchestrate that, I think. Other questions for Evelyn? Well, thank you. And you certainly see that we're a hungry group. We want to know more information. And also, really, with the intent of how can we be helpful. But we'll probably have to identify all the players that are needed to make this go well. Thanks, Evelyn.

**Evelyn Gallego – Office of the National Coordinator**

Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So I think that brings us to the end of our formal agenda prior to public comment. Why don't we open up for public comments, please?

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

Operator, can you please open the lines for public comment? And while we're waiting, if there's anybody in the room that would like to give a public comment, if you could please come up to the table.

**Alan Merritt – Altarum Institute**

And if you'd like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-6006 and press star 1, or if you're listening via your telephone, you may press star 1 at this time to be entered into the queue.

**MacKenzie Robertson – Office of the National Coordinator**

And just a reminder that our public comments will be limited to three minutes. Seeing no public comment in the room, are there any public comments on the phone?

**Operator**

We have no comments at this time.

**MacKenzie Robertson – Office of the National Coordinator**

All right. I'll turn it back to you, Paul.

**Paul Tang – Palo Alto Medical Foundation**

Thank you, and thanks to the committee members for your forbearance in a long session. As you saw, it was full of information, full of action items that – because the field is moving that quickly, and we're trying to keep up with ONC.

**Christine Bechtel – National Partnership for Women & Families**

... workgroups reporting to us, too.

**Paul Tang – Palo Alto Medical Foundation**

That's right. That's right.

[Laughter]

**Christine Bechtel – National Partnership for Women & Families**

We'll have to bring sleeping bags to camp out.

[Laughter]

**Paul Tang – Palo Alto Medical Foundation**

All right. Well, thank you, everyone, for everybody's help and efforts, and all the work that goes on in between. So thank you, and see you next month.