

HIT Policy Committee Transcript November 6, 2013

Attendance

Members present:

- Christine Bechtel
- Neil Calman
- Arthur Davidson
- Paul Egerman
- Judith Faulkner
- Scott Gottlieb
- Gayle Harrell
- Charles Kennedy
- David Lansky
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Robert Tagalicod
- Paul Tang
- Devin Mann

Members absent:

- Madhulika Agarwal
- David Bates
- Patrick Conway
- Thomas Greig
- David Kotz
- Aury Nagy
- Joshua Sharfstein
- Alicia Staley

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'm going to take roll, and you'll notice a few new members, which we'll introduce after roll call. Paul Tang?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Bates? Christine Bechtel? Neil Calman?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Art Davidson?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Judy Faulkner? Scott Gottlieb?

Scott Gottlieb, MD – Resident Fellow & Practicing Physician – American Enterprise Institute

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Gayle Harrell? Charles Kennedy?

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Kotz? David Lansky?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Devin Mann? Deven McGraw?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Aury Nagy? Marc Probst? Troy Seagondollar? I know both Troy and Marc are here.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

I'm sorry, I was muted. Yes, this is Troy.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare

Marc Probst is here –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Josh Sharfstein? Alicia Staley? Patrick Conway? Thomas Greig? Rob Tagalicod? Mad Agarwal? Okay. So as you may have heard, we have three new members of the Policy Committee, and I'd like to introduce them now. So we have Dr. David Kotz, he will be our new privacy and security representative. He'll be replacing Latanya Sweeney. And he currently is a professor at Dartmouth College. We also have Dr. Devin Mann. He will be our new research representative; he is replacing Connie Delaney. He is a professor at Boston Medical – I'm sorry at Boston University and he is a physician at Boston Medical Center. And finally we have Troy Seagondollar who will be our new labor representative and he is replacing Scott White. He is a regional nursing technology liaison for Kaiser Permanente.

So, we want to welcome all three of our new committee members, this is their first meeting and then we'll get to meet them in person, hopefully, at the December meeting. So welcome to all three of you, we're very excited to have you as members of our committee. And with that I', going to turn it over to our new Acting National Coordinator, Dr. Jacob Reider.

Jacob Reider, MD – Acting National Coordinator – Office of the National Coordinator

Thank you Michelle. I'm going to keep these remarks reasonably short so that we can get on and be efficient with our meeting. Thought I would just introduce myself for a moment to those who don't know me. I am a family physician, have been at ONC for about two years and have been involved with Health IT for roughly 20 years, mostly behind the scenes. I am a self-described health IT nerd and I'm an extroverted health IT nerd. But as many know that health IT nerds by definition are introverts and the joke, as some may have heard is how do you tell an introverted health IT nerd from an extroverted one and the answer is the extrovert looks at your shoes when they talk to you. So that's who I am, I like to think of myself as a facilitator. So you may see me driving a little bit less than my predecessor, but rest assured if there's driving that needs to be done, I will certainly push folks along, because I think this is important work that we need to, as some would say, keep our foot on the gas pedal here. So that's about all from me, it's a pleasure to be doing this and I'm really honored to be serving as your Acting National Coordinator and the Chair of the Health IT Policy Committee and look forward to working with all of you and, of course, seeing you face-to-face or shoe-to-shoe at our next meeting. So, I'll pass it on to Paul for the review of our agenda.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you Jacob and welcome. So, we have a fairly full agenda this time and you can count on a very full agenda next month at our face-to-face in Washington. We're going to start off with the data update from both CMS and ONC; so, Rob Tagalicod and Rob Anthony are going to be telling us about what's been happening in the Meaningful Use Program. ONC will follow with Jennifer King and Steve Posnack on the activities related to ONC and certification and further data analysis. Next will be Larry Wolf and Mark Probst from the Certification & Adoption Workgroup. They had a hearing update, which was called care planning. It did cover advanced directive and they're going to be reporting out on that the recommendations of which will be fed into the Meaningful Use Workgroup for Stage 3 discussion. They're also in the process of working on voluntary certification and hope to have draft recommendations at the February HIT Policy Committee and final recommendations in March, that's sort of the calendar for that.

Next Micky Tripathi and Deven McGraw are going to be talking about – giving us an update on the – from the Information Exchange Workgroup. This is a revision on data portability. They had first given us some recommendations on August 7 and this is revised after discussing with Doug Fridsma. Quality Measures Workgroup headed by Helen Burstin and Terry Cullen are going to update us on some of their draft recommendations in collaboration with the Accountable Care Workgroup, in response to the Policy Committee request to provide recommendations related to deeming, so quality measures that would be suitable for the deeming program. They're going to be giving us some draft recommendations for the Policy Committee feedback and have final at our next face-to-face meeting.

Then Deven McGraw and Paul Egerman from the Privacy & Security Tiger Team are going to talk to us again about data intermediaries, there are challenges related to privacy and security and they're going to be telling us about their deliberations as part of their update today. They'll also be talking to us on the Accounting for Disclosure Hearing; I believe that's on next month's agenda. Any other changes to the agenda? And we'll end with public comment and adjourn by 2 p.m. Eastern time. The next meeting, by the way, is face-to-face, as I said in Washington, DC. The hotel's been selected; it's the Crystal City Marriott near Reagan National Airport. And following that, that's on December 4, following that on December 5 will be the Accountable Care Hearing. Any questions there? If not, you also had distributed to you draft minutes from the last meeting, I'd entertain a motion for approval.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So moved, Neil.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Second.

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

Charles, second.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Any further discussion or corrections? All in favor of approving the minutes?

Multiple Speakers

Aye.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And any opposed or abstain? All right, well thank you very much. So we'll start out with our first agenda item, assuming the fire drill hasn't occurred yet, it'll be with CMS updates with Rob Tagalicod and Rob Anthony.

Robert Tagalicod – Director, Office of eHealth Standards & Services – Centers for Medicare & Medicaid Services

Great. Thank you Paul. This is Robert Tagalicod and before we get into the data update, I'd like to preface our presentation with a welcome back to the entire committee from CMS, our administrator, Marilyn Tavenner and our team from my office, the Office of eHealth Standards and Services. Welcome back from our brief hiatus and we're looking forward to re-engaging this committee on the work that we have for fiscal year 2014. And we have a lot of work, by statute that is happening this year. And so again, it's shared work and we are looking forward to working with you. We also want to congratulate formally Jacob Reider on taking on the role of Acting National Coordinator for HIT as we start this fiscal year. And we will work together to, to use Jacob's word, drive where we need to drive and pause where we need to, in order to look back retrospectively on the successes that we had in the past and build upon those successes going forward.

So both ONC and CMS have really recommitted ourselves to working collaboratively as we look ahead to implement Stage 2 this year, that is focused on interoperability and preparing the process for Stage 3 rulemaking that is focused again on outcomes. And CMS again continues to be the primary lead for rulemaking for Medicare and Medicaid EHR Incentive Programs and ONC again is the lead for the EHR certification per statute. But again, I'd like to reemphasize we both go hand-in-hand and we will work together to build, with your help, upon the foundations of Stages 1, and this year on Stage 2 as we plan for Stage 3. So for CMS, there is a lot of work also beyond meaningful use under the rubric of eHealth. And so more specifically we are managing this year on behalf of Health and Human Services and the Secretary as you know ICD-10 and a slew of things under administrative simplification that includes Health Plan ID and the like.

So in coordination with ONC and the Office of Civil Rights as well, and in my role as CMS's senior agency official for privacy, privacy and information security continues to be in the forefront of our thinking as we standardize all sorts of electronic data interchange, and I would argue both HIPAA and non-HIPAA. So in order to ensure success of many of these transformative eHealth initiatives, we are engaged with not only this committee, but with other FACA committees such as the National Committee for Vital and Health Statistics, or NCVHS, and that's our FACA at CMS. And on behalf of the Secretary, many of you already know and some of you participate, like you Paul, this committee also advises the Secretary on standards and operating rules related to electronic data interchange and transactions. And there are several things we both shared, this committee and NCVHS on – and transforming the electronic health landscape and I look forward to even closer collaborations. And again, the collaboration between ONC and CMS, and this is not to preclude all our other federal partners and state partners as well.

We will continue to leverage both the health Policy Committee and NCVHS to engage more specifically providers and consumers, health plans, payers, clearinghouses and a slew of stakeholders to help inform our eHealth initiatives. And I want to re-double our efforts; clearly CMS had the meeting with introduction via ONC to consumer forums and consumer stakeholders and now looking at Blue Button. So before the shutdown, we had a great meeting in the Great Hall and it is our recommitment and again, Blue Button is a strategy – is one tactic in order to engage consumers with their healthcare through electronic means. So we will work again closely together regarding this initiative, as well as addressing more specifically health disparities as we go forward. So we again look forward to fiscal year 2014. There is again a lot of work to do. We do want to hear from you and there will – we will be creating different workshops and fora in order to listen more carefully and better, as we try to be successful in managing all these initiatives. So without any further ado, I'd like to turn it over to our Rob Anthony.

Robert Anthony – Health Insurance Specialist – Centers for Medicare & Medicaid

Thanks Rob. Do we have – up, there we go. So I know that there's a lot of business in front of the committee, so we will just go very quickly through an update. As always, a fuller slide deck with some of the more detailed information is going to be available on our website, the website you can see in the bottom of these slides, the cms.gov/EHR Incentive Programs website. So if we go to the next slide. The first thing we'll go through is the registration and payment data. Next slide. Of course all of this is as of the end of September. We'll take a look at some of the October figures in just a moment, but as of the end of September we have almost 425,000 active registrations. That's – as we'll see later, a pretty significant number of both hospitals and eligible professionals. Next slide.

We've been including this slide for a while now to draw attention to where we're really seeing the transition of Medicaid providers from AIU, adopt, implement, upgrade to actual meaningful use. And as you can see, we're continuing to see an uptick. As with everything, we are at that time of year where we're sort of in a little bit of a lull, it is the calm before the storm for most of our numbers. So you can see the month of September, there were about 2000 AIU payments for EPs through Medicaid. There were about 1300 meaningful use payments. Altogether we're at about 23,000 meaningful users under the Medicaid program. Of course everybody under Medicare is a meaningful user. We will, I think, continue to see an upward trend of these numbers, and of course as we move into December, and especially January and February, we're going to see a dramatic uptick of these numbers, if the trend that we've seen from previous years holds true. Next slide.

So as of the end of September, we had a little over \$16.5 billion paid out program to date. Obviously if you take a look at 2011, 2012 and 2013, we'll be paying out much more as we head into January, February and beyond, as more returning providers come back and do a full calendar year of attestation. We are right in the middle of processing hospitals for their fiscal year 2013. And of course attestation is still open for hospitals until the end of this month, November, and we are seeing a number of hospitals continue to come in. We do have some information on some of the returning hospitals a little later in the slide deck, but we are still obviously waiting for the bulk of those hospitals to come in. Again the trend typically is that they come in the last couple of weeks of that available attestation date. We have asked the question a couple of times and by a couple of committee members about whether attestation was open during the shutdown and all of the systems were active during the shutdown and a number of hospitals did come in during that time and attest for the 2013 year. So everything on the HITECH end continued at pace. Next slide.

So as of the end of September, we have over 325,000 unique providers who have actually been paid through the program. That is a combination of both AIU and meaningful use. Next slide. So this is a look at the registered and paid for eligible hospitals and eligible professionals. At this point in time, we have over 91 percent of all eligible hospitals registered for the program. Next slide. And we have over 82 percent of all eligible hospitals actually paid for the program. That is a combination of Medicare and Medicaid, very often for many of these hospitals both, but that does represent a unique number of hospitals, so over 82 percent of all eligible hospitals. Next slide.

You see that we have a similarly large capture of the total number of eligible professionals registered. That ever-shrinking little piece of the pie that is blue is indicative of the number of EPs who have not registered. We are at almost at 80 percent of all eligible professionals actually registered for the program. We do anticipate that as we're moving into 2014, into the final year of participation that we're going to capture more of that. Next slide. And then of course at this point in time. We have a little over 60 percent of all eligible professionals actually paid under the program. And again that's under both AIU and meaningful use and of course the Medicare Advantage Organizations as well. But you can see that breakdown represented here. Next slide. So this is a breakdown of Medicare EPs by specialty, and I won't go through this. We seem to have stabilized at the figure of about 61 percent of all Medicare EPs are non-primary care, and you can see the breakdown of the specialties that are represented under meaningful use at this point in time. Next slide.

So this is sort of where we are today. We've got about 83 percent of all eligible hospitals have received an EHR incentive payment, that's more than eight out of 10 eligible hospitals that have made a financial commitment. We've got about 56 percent of all Medicare EPs are meaningful users; about 73 percent of all Medicaid EPs have received an EHR incentive payment. Obviously many – a lot of that is for AIU, but we're continuing to see this figure below go up, and we've got 16 percent of Medicaid EPs now who are meaningful users. When last we spoke, that figure was at 12 percent and it is continuing to go up. So we have over, as I said, 60 percent or 3 out of every 5 Medicare and Medicaid EPs have made a commitment to an EHR and of course, over 325,000 EPs that have actually received an incentive payment. Next slide.

So this of course are draft estimates for October, again October a traditionally slower month for us. Things begin to pick up a little bit in November as we get more of the hospitals in and as some of the 90-day people, the first year people begin to participate towards the end of the year. And we really start to pick up in December and, of course, skyrocket in January and February. So, we do see some lower numbers here, it's consistent with what we've seen in the last couple of months, looking like about 2500 Medicare EPs, about 3000 Medicaid EPs. And we were not able to pull together a number for Medicare and Medicaid hospitals because what we have right now is a combination of returning hospitals who are doing their second or third year attestation. And also those hospitals that are coming in new for fiscal year 2013.

We'll have a firmer figure on that once we are able to run all the reports, but we were not able to kind of scrub this for unique hospitals at this point, so, weren't able to provide a number. But obviously we do have some of those hospitals coming in, and that's what I want to discuss. If we go to the next slide, we won't look at all of the attestation performance data, although again, if you want to see that, the full deck will be posted to our website, the EHR Incentive Program's website. But I did want to take a look, if we go to the next slide, what we're beginning to see for hospitals that are returning. So this is a breakdown of core objective performance of first, second and third year performance returning hospitals. So essentially how the same hospitals perform across the various years of meaningful use. So this doesn't represent 2011, 2012, and 2013 as much as it represents the first-90 days, the second full year and the third full year at meaningful use for hospitals. At this point in time, we have – this represents a little over 250 hospitals that have returned in their third year. So by no means a complete picture of data, it's just that were beginning to look at these returning providers to see how they stack up against previous years. And as you can see, we're seeing consistently the same high levels for performance across core objectives, in some places even higher. Certainly for most of these we are seeing a higher threshold of performance than we saw in the second full year. So as this is – meaningful use is becoming incorporated as part of workflow, we're seeing some improvement. But you can see that we are well above the required thresholds on all of these, even where we see some slight drops in electronic copy of health information or electronic copy of discharge instructions. Next slide.

The same holds true for menu objectives, now of course this isn't a – this doesn't indicate which menu objectives people chose, but we'll be looking at that as we get more data in. This just looks at just performance across the menu objectives when people did report on those and we again see some consistently high-performance in some places, a little bit higher than before. The last three of these are the public health reporting objectives for immunization registries, reportable lab results, syndromic surveillance and there is a little bit of a spike in immunization registries. It's an offset to some of what we're seeing with reportable lab results with public health agencies. Syndromic surveillance seems to have stabilized. However, overall there's always some fluctuation in these last three areas based on what's available, what the different public health agencies will accept as submission, the standards that they're on so those fluctuations probably mean a little bit less than the other measures would be. Next slide.

So I just wanted to peak a little bit of interest and talk about some things we might talk about at our next Policy Committee meeting. One of the things that we wanted to do in addition to giving a data update is to talk about some of the 2014 resources that we will be – or already having available for Stage I and Stage 2. There's a fair amount of anxiety I think publicly about being able to meet some of the objectives and CMS is trying to conduct some education and outreach to make sure people have those resources available and we would love to get the Policy Committee's feedback or input into that.

We also wanted to talk a little bit about some of the lessons learned with small and rural hospitals. We conducted some informal discussions with small and rural hospitals about some of the challenges facing them, some of the resources that they would find particularly helpful. We are, of course, concerned as we move into 2014 to make sure that we are making resources available for small and rural providers who face particular challenges in trying to implement meaningful use and many of those are resource related, so we wanted to talk a little about what we've been hearing and what we'll be planning on doing. Next slide.

As always with questions if anybody has anything I'm more than happy to address outside of things. For the fuller report, it will be on our website. And if anybody on the Policy Committee has any questions, I'd be more than happy to answer them.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you Robert and Rob. Let's see, we'll spend a couple of minutes on questions – we'll have some time at the end of both presentations, but is there any pressing question right at the moment? Nothing – let's go on to ONC's update.

Jennifer King – Research & Evaluation Branch Chief – Office of the National Coordinator for Health Information Technology

Okay, great, good morning everyone. Steve and I are here to talk about new data on 2014 edition EHR certification progress. The last time we met in September, we gave an overview of where we were at that point and today we want to give an update on where we are now. And then also answer some questions that came up at the last meeting about how different provider segments are doing, so taking a look at progress by characteristics, hospitals and EPP's as well. So we can go ahead and get started on slide two. We first start off looking at progress among the hospitals. So, as of October there were nine vendors with an inpatient product certified to the 2014 EHR edition that met the base EHR definition. So these nine vendors account for 81 percent of hospitals who attested Stage 1 Meaningful Use. An additional 3 percent of hospitals were covered by a vendor that had a – some sort of 2014 edition product certified, but not one that met the full, base EHR definition at this point. So just wanted to note that we're looking at this at the vendor level, so we don't necessarily know that if a hospital has a vendor with the 2014 edition product, that's not necessarily the same product that that hospital used to attest in 2011. And we don't really have visibility at this point into implementation timelines or product rollout timelines, but this gives us some sense that over eight in 10 hospitals are using a vendor that has a 2014 edition product certified for a base EHR at this point in time.

So going on to the next slide we take a look at how this progress looks across the different hospital types and you can see that the smaller hospitals and the critical access hospitals are a little bit less likely to have a vendor that has a 2014 edition product at this point. So for example, 23 percent of critical access hospitals are using a vendor that only has the 2011 edition product compared to about 12 percent or 11 percent of medium and larger hospitals. And on slide four we take a look at sort of the overall pie of hospitals that have currently attested to Stage 1. You can see here again that 81 percent of them are covered by a vendor with a 2014 base edition product, 3 percent with a 2014 edition product that's not yet a base definition and then the 16 percent who do not have the 2014 edition product yet. And we've listed there in those boxes the specific vendors that account for at least 1 percent of the market share and that fall into each of those categories, so the ones that are already certified to 2014 and then the ones that aren't.

And then moving on to the next slide, here we start digging into the same data on the professional side. So here we see a little bit lower progress at this point, 21 vendors have an ambulatory product certified to the 2014 edition that meets the base EHR definition. And this accounts for about six in 10 professionals that have attested to Stage 1, so 58 percent of professionals that have attested are covered by a vendor with a 2014 base product. And an additional about 10 percent are covered by a vendor that has some product certified to 2014, but not yet the base EHR product. And then on the next slide we take a look at this to understand whether or not there are any gaps emerging by rural or urban location and we don't really see any at this point, so we see sort of equal progress among those geographic areas. Providers in both rural and urban areas are about as likely to be on a product with a 2014 edition EHR.

And on the next slide we take a look at it by professional specialty. So this first – the top of the graph there shows physicians broken down by specialty groups, and there's not a lot of variation there, with the one exception being the radiology, pathology, anesthesiology category, which is a little bit less likely to have a vendor with a certified 2014 edition product. But across primary care and other specialties, we don't see much of a difference. And then in the other professional categories, so the non-physicians which make up about 10 percent of all EPs who have attested at this point, we do see that some of them are doing significantly worse at this point in terms of having a 2014 edition product available. The next slide shows the very small level detail of professional by each specialty group. So this is sort of here for people's reference if there's a particular specialty that folks are interested in and it also lists the actual numbers of attestations in each specialty, so you can get a sense of the magnitude of the size of the groups that we're talking about here.

And then finally the next two slides again just break out the overall group of professionals who have attested to Stage 1 by their current vendor status, listing the vendors who have at least 1 percent of market share in each category. So this slide here shows the vendors that have not yet gotten a 2014 edition product certified either at all or to the base definition. And then on slide 10, has the names of the vendors that have gotten the 2014 base edition product certified at this point. And – included on the final set of slides is sort of the usual progress in terms of overall progress to meaningful use by provider characteristics, but I think Rob covered sort of the highlights there and in the interest of time, we don't need to go over those in detail, we can pause here for questions or discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you Jennifer. Is Steve going to be continuing or –

Jennifer King – Research & Evaluation Branch Chief – Office of the National Coordinator for Health Information Technology

Umm –

Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator

I'm here for moral support.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, good. Thanks. Well actually this is very interesting data Jennifer, thank you very much. Let me open it up to the committee for questions of either the CMS folks or ONC.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Paul this is Michelle. I want to remind the folks that weren't on when we initially started; we're using the raise hand feature, which you can find the icon at the top of the webinar. So if you have a question at any point, if you could just use that and we'll put you in the queue.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you. I don't see any hands raised. Are there any questions from folks who are not on the web, maybe just on the phone? Okay. Well it looks like we had a very clear information presented by both – by all three of the presenters. And I think we'll take some time to digest this, but it's very, very helpful, appreciate it. Final opportunity for any questions, then we'll move on. Okay thank you very much Robert, Rob and Jennifer and Steve for moral support. We're next going to go to the Certification/Adoption Workgroup and get an update on the Care Planning Hearing from Larry Wolf and Mark Probst.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So hi, it's Larry. I seem to have just lost my airport Internet connection. So I will be walking through the slides, but I won't see what you guys are seeing, so hopefully we can stay coordinated. So let's start, we have the slide number one has certification and adoption workgroup members, so there are a lot of folks involved with this, we actually have multiple slides, so, other workgroups that were part of this. So just to get some thanks out there, we had a pretty big group. Let's go on to slide two. We also had involvement of the Meaningful Use Workgroup and we had the Consumer Technology Workgroup, so, let's go on to slide four, the hearing agenda.

So we had a very full hearing, it was a virtual hearing, but I think it was very well done and a lot of people were very engaged. And then we had a little bit of a follow-up the following Friday, as additional material came in from one of the attorneys. The topic here is – has various settings. The overall heading for the hearing was on care planning, also advanced care planning, and within that we look at advanced directives, POLST and MOLST, physician orders for life sustaining treatment and medical orders for life sustaining treatment and many of the issues involved with this. As you can imagine, this is a pretty hot topic and we had something I think unique, certainly for this workgroup, and maybe unique across the workgroups. We actually had a presentation from a senator's office, Senator Mark Warner's office presented some materials and we also had a letter from some of the members of Congress, and I'll talk about those in a little bit.

We had – we wanted to look at a variety of scenarios here, so we were looking at sort of what were the legal issues around advanced directives, around care planning and how this worked. We wanted to look at state perspective on what the states are doing and we had several states presenting where they are. We also heard from several hospitals and providers. We heard some from some implementers that have specifically taken action to embed health IT advanced directives in their health IT work. And we also heard from some patients, not that we didn't hear patient themes throughout this whole thing. And there was some public comment.

So going on to the next slide, on slide five, so I think the highlights here were the congressional initiatives. It was sort of interesting to see where this is in Congress, not to say that many of these are expected to pass imminently, but just that there is discussion in the Congress on these topics. And I think we heard an important message from all of the presenters that this was as much about the important conversations, maybe more about having important conversations than it was the formal ways in which those conversations get recorded and documented and brought forward. And the primary value in that was to clarify how individuals want their health managed, both with issues relating to life-challenging, life-threatening, end-of-life care and also the quality-of-life issues; so interesting and hard conversations there.

And also appointments of individuals who will act on their behalf when they're not able to make their own decisions and getting clarity around who that individual is also seemed to be a really valuable thing for people to do. And then the artifacts, the ways in which those conversation then get brought forward into the electronic technologies. We learned about some important documents for this and we also learned about a variety of registries that are in use that actually represent innovation in the marketplace and opportunities that we might incorporate in what we do with meaningful use.

So, moving on to slide six, so Mark Warner has introduced some legislation called The Care Planning Act of 2013 to create a Medicare and Medicaid benefit to support patient-centered care planning. And the intention here is that this would allow for a formal plan to be created to reimburse professionals for their time, there would be a voluntary process and discussion and that it would also include some education for the professionals. We had a letter – so moving on to slide seven; we had a letter of support from the House. Several House members drafted a letter that indicated their support for advanced patient and family-centered care planning as part of the Stage 3 Meaningful Use and then a few specifics about what they wanted to include in that. And – in both, there was strong encouragement that these are important topics that the Senator and these representatives felt ought to be getting our attention and we should be moving forward on.

So moving on to slide eight, so, beginning to put some structure around this, sort of those various buckets of things that were important conversations in the documentation. So one piece here is who is the person who's doing this? And we got input saying this is not just something you do in the last couple of months or the last few days of your life; this is really a conversation that is part of your ongoing life. It's as important for young people to do this because there often are traumatic events, accidents, sudden illnesses, and sudden emergencies of various kinds, that even someone who's in generally good health suddenly needs to have some structure in place to support them with some tough decisions with potentially end-of-life actions as well. So these might be conversations people would have, not just as patients meaning people who are sick and then maybe not even with health professionals, but maybe important conversations with members of their family and that some of the repository support, people just setting up documentation about their wishes, regardless of their health status.

Clearly involving family is really important because there's have been lots of high-profile examples of the kind of trouble you get into if you don't involve your family. And decisions are being made with people presuming what you would want and often conflicting assumptions, in which case it's very helpful to have a formally designated health care representative of some kind. And to involve healthcare providers so that they're informed as well in this.

A variety of documents, really two major groups of things outside of the EHRs, so advanced directives and advanced care plans as things that are being done in advance of a specific decision being made and themselves not orders but really indications and guidelines. And then POLST and MOLST, which are really meant to be orders that could be done in a way that could be carried from setting to setting, so kind of an interesting innovation there if you will on creating orders that exist outside of a healthcare organization. And then clearly within the healthcare organizations and EHRs, there are various ways in which providers document conversations, I broadly use the heading here for provider notes. There are ways to document those conversations and some of those result in orders that are operational in the system and establish various flags that could indicate someone has, for example a Do Not Resuscitate order, but recognizing that that is really only one tiny piece of the broader conversation to be had here.

We also heard a lot about the value of the artifacts. So, while a lot of us may be used to a digital world and that things these days live as no text on the screen. We heard testimony of the value of having people's handwritten notes, of a mom's really pretty extensive commentary about was important in her life and was important in her living her life. That was a valuable document to the family, the fact that it was in her handwriting, in her words, was very powerful for them, even as a – or of a healing after her passing, but also to really clarify what it was that she intended. And we heard also about the value of audio recordings and video recordings, as well as narrative text. And clearly those of us who focus on standards, there could well be structured elements in here and there's been some work with consolidated CDA to add some additional care planning structure as far as some of the work done this past summer. And the various systems have their own metadata that they use to keep track of all of this.

As I said, we heard about a variety of repositories. So on the systems side, some of the states have already set up statewide repositories to have this information, and there will be some more information about that in subsequent slides. And also some nongovernmental repositories that are set up as things that could be sort of a – consumer focus, consumer-driven repositories that are freestanding of any government organization. Some of these documents wind up in the provider EHRs and there are other applications of various kinds that are looking to capture some or all of this information.

Moving on the slide nine. So, there is an active group, POLST.org, that looks to do advanced care planning very broadly in the country, and there will be some substitute slides about them. And I thought that their information about splitting the advance directive activities and information from the POLST was actually a really good sort of a refresh, who are these documents targeted for and who might be the people that would be using this? So the first piece was sort of an age thing. In our Meaningful Use Stage 1 and Stage 2, the criteria involved the age of the individual. And the suggestions we were hearing is that while that might be important for how we want to calculate our measures that in fact these were useful things for people of all ages. The advance directives are looking at instructions for future treatment and the POLST are medical orders for current treatment. So a very different focus in how these things are directed. The advance directives can appoint a healthcare representative and that seemed to be a really critical role as well.

Joseph M. Heyman, MD – Whittier IPA

Don't you want to advance the slides – oh, got it. Thanks.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm sorry, we should be on slide nine, that correct, that where you guys are?

Joseph M. Heyman, MD – Whittier IPA

Correct, it wasn't until just a second ago. Thanks.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. Also important about what's important to emergency personnel. So it was interesting to see the distinction about advance directives are not specifically actionable by medical personnel whereas POLST and MOLST documents are intended to be actionable by emergency personnel. And clearly they're only actionable if they're made available for those people. And in both cases the documents can guide treatment decisions beyond the specifics the document might cover by laying out by general guidelines.

Let's go on to the next slide. So, on slide 10, this is a summary of state activity and hot pink seems to be the color of POLST, so that's why we have it here on this slide as well, if you go – much out there. So, we have two states with well-established programs, they both have state registries, Oregon and West Virginia, and we heard from West Virginia at the Caring Hearing. We have another 14 states that have registries that have been endorsed by the POLST organization, two of which, Idaho in New York, have active registries and we heard from New York during the hearing. There are an additional 27 states that are doing something to address this area, various stages of program development. And seven states that have no current activity. There are references to the POLST website where this information's available if people wanted to drill into it further about what the states are doing .

And on slide 11, so moving ahead, here's some data from West Virginia to give you a feel of the kind of information that's being stored in these directories. So, we've got a big chunk that are on the advance directive side, everything from living wills, medical power of attorney, a DNR card, and then a smaller chunk that's focused more on the POSLT forms. And a variety of sources that are contributing information. So, the vast majority of this information is being submitted to the registry from hospitals followed by hospice. Interestingly, there's a big bucket of unknown and then non-healthcare settings. So often these groups do community outreach of various kinds and then a variety of lower volume settings, including nursing homes. So a variety of forms being submitted to the states from a variety of locations including some non-clinical settings, but mostly hospitals and hospice and some nursing centers.

So, moving on to New York State and sort of reinforcing this message about these are intended to be medical orders that need not be reissued by a new healthcare provider, but should be reviewed, should be – may be revised. And certainly in this case of electronic systems, may need to be entered into the systems to be active as orders in those systems. And the folks from New York also cleared a point out about the need to support change and maintain current copies of current information.

So moving on to 13, slide 13. We now have a look at the registry that New York is running, this a web-based application that allows individuals to enroll, complete forms and document their decisions, and ways to deal with persons with developmental disabilities where someone else is putting those forms in for them. The systems can produce electronic and hard copy documents and they support a link to the registry so that provider systems can link into that from the EMR. And the goal here is to provide a 24/7 registry to support access at any time .

Moving on the slide 14, so, we heard from one group, MyDirectives, which is a nongovernmental registry that's maintained for individuals to create, store and update their advanced care plans. And similar to the state directories registries, they also allow documents to produce, they supply links to their app so that others can embed that link and access the application. And they also have modular EHR certification and they support Blue Button. So, they're looking very much to be an essential resource that could be used electronically in a variety of ways, and they support audio and video as well as documents scanned and their own forms.

Slide 15, moving on to slide 15, we have a reminder that this is in Meaningful Use Stage 2, and this is a statement of the objectives for Stage 2, really focused on advanced directives for people 65 years or older and done as menu. There's been some discussion in the Meaningful Use Workgroup what Stage 3 would look like, but my understanding is that they were waiting for this hearing and the discussion at the Policy Committee before they got deeply into this for their Stage 3 recommendations.

So moving on to slide 16, some summary of highlights from the hearing. So on the congressional initiatives, sort of the Senate Bill and the House Letter of Support, really looking to move forward with providing care planning for serious illnesses, to generally encourage care planning and the health IT standards to support that. We heard a lot about important conversations, roles and artifacts, that the conversations are really important to clarify intent, that the documents become really powerful anchors for that given what can be a highly emotional situation. Essentially it's a free-form document if you will, the handwritten notes, the videos and the audios. The things that actually, if you will, embody the person when they can't speak for themselves. As well as having a healthcare representative or an agent or a medical power of attorney, somebody who is formally designated to act on your behalf. The importance of the documentation of advanced care plans, advanced directives and POLST or MOLST as separate documents addressing somewhat different needs. And the need really to look at these in combination.

And finally we learned about registries and the value of having a single place to provide access and to manage versions and three examples of places that have those directories up and running.

Finally on slide 17, so some areas for recommendation. So these are not framed as recommendations for the committee to vote on, but really were intended to focus discussion and provide if you will a framework for the Meaningful Use Workgroups to continue this on. So various other – this is broadly about care planning and individual decisions. So while there's been some specific focus on very particular pieces of this around advanced directives in the – excuse me, in Meaningful Use Stage 1 and Stage 2, that this should be done really in the context of care planning. And I know that there's been some S&I Framework activity around care plans that could move from setting to setting. So, this whole notion of what do you do to inform a subsequent care setting about activities done in this care setting and more broadly, what do you do to bring patient information and individual information into the healthcare setting.

This is not just for critically ill people and not just for those 65 and older. So while we may frame some of our measures in terms of this, there was a strong encouragement that we not limit the thinking – limit our thinking that this was only for elderly and those who are critically ill. I think we learned about repositories as an avenue of 24/7 access to latest versions. These are not universally available yet, not all the states are doing this. And while there are some nongovernmental options, it's not like many – not like a vast majority of individuals are using these tools themselves. So I think that there was really a sense that this we've, in some sense, this has moved beyond small pilots, these are statewide initiatives that have a fair amount of use. And MyDirectives is a non-state activity with a fair amount of use. So, in a sense they're beyond pilot, but they may not be at the level of broad use that would be a foundation for meaningful use.

We, I think, heard a pretty strong message from the vendors and their providers to make sure that what we wind up recommending is achievable both technically, organizationally and socially. And that this very well could be an area where we wanted to enable capability and build on things that are already out there and learn from things already out there.

So, things to learn from, so existing repositories certainly could be drilled into further about what they're doing and how well they're working. What the vendors have done, what the providers have done, and specifically we heard that there's a lot of flexibility in the vendor products for providers to create their own capabilities for handling and flagging different patient conditions and different patient statuses and different orders and order types. And so this is an area that in that, if you will the gray zone, of core capabilities that have been used by providers in the implementation and so the learning's here would need to be core based and not just what's in vendor products, but what providers have implemented.

There's work within the S&I Framework that we should be looking at to learn from around key advances to Consolidated CDA to support care planning. An interesting suggestion around Blue Button, that while Blue Button may be primarily seen as a way to get expert information, it also could be a way of teaching how to access things, outside resources including accessing repositories. And finally there might be opportunities for ONC and CMS to do – to support partnerships and act as a convener, and bring organizations together. So, that wraps up the slides and I think we've got plenty of time for discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Wonderful Larry. Very nice summary of the hearing, I was there as well. Let's see, I wonder if I could ask a few questions. One is, it sounds like some of – it sounds like you're edging towards a recommendation about having the capabilities in EHRs since there – like the New York eMOLST registry would allow links between EHR to their updated registry. So, is it true that that's one of the things you might – you'd be in favor of? A couple of others. One – one of the considerations we are concerned – we'd heard about is, since these are state laws, what about crossing state boundaries and did you look at that, the legal implications of crossing state boundaries? And finally, did you hear any objections to either what we currently have in the meaningful use with regard to advance directive or pushing further on it.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So let me start with the one in the middle, because in some ways, while that's the hardest policy question, it may be the easiest one to respond to, state law and state boundaries. We did hear that this is an issue where the states do not have uniform laws and there are technical differences between how these are handled in the different states. But we also heard in general, a sense of good intentions on the part of the providers, that if you have documentation from another state, that they would do the best they could to act on that documentation. So, I wouldn't say things were perfect here, but it sounded like that if there's documentation that the differences in state law are usually not the problem, the problem is that there isn't documentation .

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you.

Larry Wolf – Health IT Strategist – Kindred Healthcare

In terms of capabilities in the EHR, I think this would be an area sort of to explore and to question. I don't know to what extent the repositories have consistency in how they support links and what they assume about when you link in, what you're going to get to and what their ability is to provide some kind of query response to documents that you might want to view or embed in your EHR. So I think in terms of capabilities in the EHR, we didn't hear enough specifics to know is this something where there's a – of standards that could be built on or actual standards being used. So, an area to explore and I think one of the reasons we were being encouraged to consider pilots, rather than a rush to regulation without testing. Objections to what we currently have, we did – the only objections we heard were people encouraging us to do more, that this should be broader than just people 65 and older. That it should not just be for people who are currently critically ill but for people who are well or generally well. So –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I hope that hits your highlights Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

No, that does help Larry. And I see Troy has his hand up.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Yeah, thank you very much. Actually we're kind of on the same page with the state laws versus the federal guidelines, things like that. What – hopefully I can make this brief but it looks like I've got three separate questions. Now we've identified this as POLST, which is physician orders, MOLST, which is medical orders and OLST, which is orders for life-sustaining treatment. I'm curious, in the conversations was there any discussion about why there were differences in the way that we were actually describing this? Could it have something to do with the state laws in regards to advanced practice providers being able to enter information into an OLST form versus a POLST form? And the last thing I wanted to find out in reference to the varying state laws, in areas in the upper Atlantic Coast, the states are small, people work in one state and live in another, was there any discussion about the state rules in regards to close proximities and release of information? I mean, would we have to go through the same process for release of information to find out if they do have an OLST in another state and we can actually pull that data in?

Larry Wolf – Health IT Strategist – Kindred Healthcare

So let me – so I don't – I'm not an expert on differences among the different MOLST, POLST, and OLST. I agree with your speculations that it could be state differences, it could be an attempt to recognize that in cases it's not just the physician who might be involved with a POLST or an OLST. But I think in terms of issues around release of information, these are really seen primarily as things that individuals control and so it wasn't so much the state releasing it, but I would be choosing to release information about me to my providers. I don't know if that clarifies, we didn't specifically drill into those questions in terms of release of information.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Yeah, I'm just curious about how that would play out, because typically people don't speak of their orders for life-sustaining treatment until unfortunately, there's an adverse event. And then – and so I'm curious how we can actually – if we are looking at vendor capabilities, is there a way that we can actually flag that to say that there is one on file or there is not one on file. And looking at the HIPPA rules and regulations, state laws for release of information, how we can actually have discussions around that. Because I think this a little different than anything else that we've talked about.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'm actually hearing in your question Troy, a different line of thought that might be worth pursuing which is, the extent to which the situation doesn't – I'm living my life, why would I go and fill out the MOLST, even if I could, right? I live in New York, I could do it, maybe I even saw a poster that encouraged me to do it, but I didn't. And now I'm in the ED, I'm sort of okay enough to deal with stuff and maybe as part of the care process, the care team says, hey, it would be really important for you to fill this out. You're doing some things that are high risk or you've now got a chronic condition you should be dealing with. And so I'm wondering if, in fact, we want a bridge that's not just EHRs linking to bring in information in that's in the registry, but linking out, if you will, to have an easy way to take the information that's been collected in the care setting and ship it out to the repository, so a two-way communication. I know it creates complexity, and the answer might be, just give the patient a Tablet and let them – or their family directly go to the registry site. So, we don't need to create additional capabilities, but I think the conversation goes both ways, you're in a critical health situation in a care setting and you might be generating documentation that you'd want to submit to the state registry.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. Any other questions? I don't see any hands, what about people on the phone not accessing the Internet? All right, well thank you very much Larry, that was very informative, both the hearing and your summary and we'll take that in in the Meaningful Use Workgroup and see what we can do to move this forward.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Take care of that, Paul, thank you. Good bye.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thanks a lot, Larry. Okay, next we have an update from the data portability topic from the Information Exchange Workgroup. Micky Tripathi and Deven.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

This is Michelle, do we have Micky Tripathi yet? Deven would you feel comfortable going through the slides or should we try and switch things around?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well, unfortunately the way we divided it up, Micky was going to be doing the background and I was going to be doing the recommendations, so he had the front end of this presentation. So, it would actually be better for me – you'll get a much better presentation and one that doesn't just read the slides if we wait for Micky.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, Michelle, this is Paul, I – if you want, Deven and I could do our presentation now, in place of it.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

If that's okay with both of you, I think that will work.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

That's fine with me.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Great.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, so we're going to switch to the Privacy & Security Tiger Team, data intermediary update.

Paul Egerman – Businessman/Software Entrepreneur

If we could just get the correct slides up.

Caitlin Collins – Project Coordinator, Altarum Institute

Yup, in one second .

Paul Egerman – Businessman/Software Entrepreneur

Great, and is there any chance I could get – terrific, thank you. So, good morning, I'm Paul Egerman. I'm here with Deven McGraw and we're going to tell you a little bit about our virtual hearing on intermediaries and also talk a little bit about data intermediaries. Here is a list of the Tiger Team members, and of course we want to thank them for their significant efforts. And again, the two things we want to talk about, we want to talk very quickly first about our – an update on the status of our virtual hearing on Accounting of Disclosures. It was a hearing that was held on September 30, just before the government shutdown, and it was an extremely popular hearing. We had over 200 people who were interested in participating in this virtual hearing. We learned that the hard way because we learned that the capability of the website was that it could only hold 200 people. And so a number of people were not able to sign on to the Internet, and we were very appreciative of sort of I guess concept of family hold back, that members or ONC and OCR, the staff people signed off to let the public participate.

There's a lot of interest in this topic. There is some information in the attached backup slides. We will be talk – we're talking about it right now, and we will be telling you – presenting more information about it on the Accounting of Disclosures in December. We're purposely not telling you more about it now right, however, because it's such an interesting topic. And we want to make sure we focus on the deliberations relating to privacy and security considerations for data intermediaries, because that's our topic and because of the government shutdown, it's actually a couple of months old, so we're doing catch-up in terms of reviewing where we were with data intermediaries.

And because it's a little bit old, we'll very quickly do our best to try to refresh everybody's memory. As you see on the slides, the very first bullet, in advance of Stage 3 of the EHR Incentive Program, the Policy Committee and the Quality Measures Workgroup convened a subgroup called the Data Immediately Tiger Team. And it made some recommendations on data intermediary roles, including those related to privacy and security. And it's actually very good that we're talking about some of this – these issues right now because it may relate to the quality measures discussion that's a little bit later in the agenda. And as you see in the second bullet, the aim was to have certification criteria that would allow data intermediaries to serve as the module for quality reporting functionality. And then after the Policy Committee meeting, the Privacy & Security Tiger Team was then asked to provide guidance on whether there are privacy and security considerations to be addressed as part of the certification process for data intermediaries. So that's the background as to why we addressed this issue. And now Deven's going to take us through a little bit more information about how we addressed it.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay great. Thank you very much, Paul. So when this issue first was brought to our attention, we realized that we already had vetted with the Policy Committee and gotten accepted, a series of recommendations relating to what we then called third-party service organizations, which broadly relates to sort of entities that sit in the middle and facilitate a broad range of potential healthcare transactions. And frankly, a quality data intermediary is an example of one. Another example is a health information exchange, for example, that facilitates the movement of data from one place to another. And there's a whole range of sort of different entities and types of entities that might provide this third-party service organization type of service. And when we were addressed – when we were asked as the Tiger Team to address the issue of consent for health information exchange, we first dove into the issue of these third-party service organizations and came up with a – of recommendations that we thought were potentially relevant for this issue as well.

And just to refresh your memory, and again these are all recommendations that the Policy Committee adopted just over – years ago, as a matter of fact. We thought it would be important for third-party service organizations to just essentially be using data in order to perform the services they're hired for, clearly, and anything incidental to this – but not beyond that. They're hired to perform a service, they need data to do that but it shouldn't be sort of an open door to data use. Consequently, there ought to be some time limitations on how long they have data, as long as is necessary to perform the service, but not indefinitely and at the end of the life of the service arrangement, the data should either be securely returned or destroyed.

We also had recommendations on openness and transparency. And we really thought that these third-party service organizations ought to disclose in their service agreements or under HIPPA, their business associate agreements. They need to disclose to their customers, and in this case their customers are providers that they are contracting with, they should be disclosing how their using and disclosing the health information that they are receiving from these providers to perform the services, including how they use and disclose de-identified data, not just identifiable data. And what their policies are regarding retention and data security. Can I have the next slide please?

Now we recognize that holding third-party service organizations to these commitments requires some accountability and we recognize that at least under HIPPA, the mechanism of accountability for that is the business associate agreement. But we also recognized that it's not clear that these agreements have historically been sufficiently effective in limiting how these third-party service organizations use and disclose identifiable information, much less providing the type of transparency that we thought was necessary for a trusted exchange ecosystem. And we also acknowledged that while significant strides have been made want to clarify what needs to be in a business associate agreement, those agreements by themselves likely don't address the full complement of these governance issues. And at that point we recommended that we do further work on these governance issues.

And you may remember from a timing perspective that this was all before we kicked off the efforts around governance that began with the Governance Workgroup, the Nationwide Health Information Network Governance RFI. So we've been around the block, so to speak, on some of these governance issues but it has essentially landed a place where we are now, which is largely reliant on HIPPA to police these kinds of arrangements and hold entities like third-party service organizations accountable. So when we got to this data intermediary issue, we really thought that our past recommendations really sort of hit the nail on the head. But the recommendations that have been teed up by the Quality Workgroup was a recommendation to use the business assoc – to make sure that business associate of agreements had appropriate provisions regarding use of data. And our concerns about the adequacy of these agreements in limiting how business associates use and disclose data, were still really quite present.

And so we wondered whether they were some additional vehicles to reinforce the recommendations we had already made about intermediary or third-party service organizations use of data. And really there were two potential vehicles, one is, of course, is the meaningful use requirements, something that we rely on for much of our policy work on the Policy Committee. But there is also – was this CMS proposed rule on revisions to payment policies under the physician fee schedule, not something we discuss a lot on the Policy Committee, but something I'm sure a lot of you are familiar with. And we noted that in the notice of proposed rulemaking for this rule, clinical quality – quality clinical data registries or QCDRs would be required to enter into and maintain appropriate business associate agreements. So here again, you have an effort to sort of look at an entity that might play a middleman role with respect to data, and the recommendation from a policy standpoint is, well, they have to have business associate agreements. So one could argue that this is already required under HIPPA, so we looked at whether we could do more than just say, we'll sign the business associate agreement, given that we had raised concerns about whether business associate agreements would be sufficient to really create a trusted ecosystem here. One of the issues that we were very concerned about was that the bargaining power between a business associate and a provider often weighs in favor of the business associate, particularly when there are – when they're larger and they serve multiple clients and there's less ability to sort of be specific about provisions in a business associate agreement

So we thought about whether it would make sense to require providers, for example, as part of either meaningful use or as part of the physician's payment rule, to attest that their business associate agreements with data intermediaries provide for the kind of transparency. Again, this is transparency to the healthcare provider who's the customer, of data uses and disclosures of the health information by the business associate, or maybe even to provide or be willing to provide a copy of this business associate agreement provisions focused on transparency. And the idea here was to cr – almost to expand our knowledge of what's really out there in the field in terms of what's in business associate agreements with respect to transparency. And at a minimum, it sort of surfaces the issues in a more coherent way.

We also considered whether we ought to require quality measures to be defined in a way that only the data in the EHR would need to be used, and thereby you would limit the number of intermediaries that would have to be involved in order to process the measures. But ultimately we decided that at least with respect to the business associate agreements and requiring people to attest that they include transparency provisions or even to provide copies of those provisions or make them available, would not work. It just – we were very concerned that holding providers, healthcare professionals and healthcare institutions, accountable for the behavior of data intermediaries would be problematic. And we don't have a policy vehicle beyond HIPAA to directly regulate those entities, which is essentially what I think we would – it would be the most direct policy vehicle for accomplishing the recommendations that we had already put forth. We also noted that there's – that some healthcare professionals and institutions have a large number of data intermediary business associates, it might be hard to both identify them, collect them all together, and then define exactly what is meant by business associate provisions regarding transparency.

So we just didn't think we could – we had a vehicle available to us in order to try to enforce the intermediary provisions that we had already recommended, and particularly the ones on transparency. So – but of course we always reserve the option as the environment continues to evolve, to continue to look at this issue and think through what might be an appropriate policy data vehicle.

So we still thought it was worth sharing some key points with you all, just to engender some discussion and to sort of keep it on the medium burner. I wouldn't call it back burner, it's not front burner, but it's maybe simmering in our background a bit. Because really the discussions, as I mentioned earlier, highlighted a quite serious concern that the superior bargaining power of some of these larger data intermediaries or third-party service organizations, who are BAs, potentially or frequently, I mean we just don't have a lot of evidence about what's really going on out there, other than anecdotal, results in providers essentially being forced to agree to business associate agreements or data use agreements that grant business associates broad rights to future uses and disclosures of data. We do think that is an issue, we just can't figure out how to resolve it.

We thought – among the issues that we identified are the following: patient control and autonomy. Patients really have no say in whether or how data intermediaries use their information and these uses are not transparent to patients. Proliferation of data intermediaries, obviously the larger the number that are out there holding patient data, it potentially magnifies the risk that problems will occur. We did – I would say if we reached consensus on anything, it was the desire to ideally have quality measures defined in a way that they could be derived from data that's already in the EHR systems, potentially limiting the number of data intermediaries that need to be involved. But we also recognized that there were a lot of factors in play with respect to whether an intermediary is or is not desirable in this space. And we thought that recommending that quality measures be defined in a way that could only – that they would only need data on hand in the EHR was probably really going beyond our scope. But we did recognize that would be helpful from a privacy and security standpoint, if data didn't have to go to a third party intermediary.

So, we don't have anything for you to vote on. Essentially the HIPPA rules do require these data intermediaries already to sign business associate agreements. We do not think those are necessarily sufficient, but we don't think at least at this point, that we have a good policy vehicle to address the concerns that we raised.

Paul Egerman – Businessman/Software Entrepreneur

So, this is Paul, good comments Deven. One thing I would simply add is the – during our Tiger Team

discussions, there was a lot of frustration described by one Tiger Team member about his ex – this process of signing business associate agreements with somebody who’s taking your data. The individual said, you know, I don’t have any choice, I have to – in that case it had to do with some credentialing issue, I have to give them the data and I don’t like what they’re doing with the data. And that’s not a good message. And so this issue is a very important issue about the proliferation of data and data intermediaries. It should be something that we try to – the view from the Privacy and Security Tiger Team was from the perspective of privacy and security, we should try to do it within EHR, to move as little data as possible outside the EHR.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So thank you Deven and Paul, and thanks Paul for highlighting the concerns –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, thanks Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– because that was the original reason for asking you to look at that. So let me try to – let me offer something potentially that – see if it’s something you want to discuss or already discussed. So clearly you outlined the lack of knowledge, awareness and control that patients have, and those are the subjects of the data, and you highlighted your concern about the effectiveness of using the BAA as a vehicle. A lot because of what you said was sort of coerced consent. Do you – what about the possibility of making the BAAs themselves transparent to the subject of the data, i.e. to the patient not just the provider? I understand the providers are the customer of the BAA, but really the subject of the data probably has a more vested interest and should have some at least awareness. The one possibility is to extend the transparency not just about the BAA to the provider, but the BAA to the patient, and one possibility is either make that part of meaningful use for the provider. So, as you said, they’re not accountable for the acts of the intermediaries, but at least they can make it known to the patient. Or, given the HITECH extension of the BAA responsibility, potentially to use that to have the business associate make transparent on their website their BAA with the provider. Are those – would those hold any water?

Paul Egerman – Businessman/Software Entrepreneur

Well, it’s – I think part of our discussion that was important was a belief that we are concerned with what the data intermediaries are doing with the data. Because once it leaves the EHR systems, there is no control. And the observation was made that the policy levers that we have is within HITECH are certification and meaningful use, those are policy levers that involve providers. But we didn’t want to put the burden on providers in order to try to impact the behavior of the data intermediaries.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

But the burden in this case would be just disclose, like an NPP –

Paul Egerman – Businessman/Software Entrepreneur .

Well, there is notice of privacy practices that –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Correct –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, but that's much more high-level disclosures to patients about the ways that their data can be used and disclosed, as opposed to who the data goes to. I mean to some extent we're picking up a bit of this in terms of accounting of dis – as part of our accounting of the disclosures post-hearing discussion. So in many respects Paul, we may or may not, depending on how those discussions play out, be able to tackle this as part of the transparency work that we're trying to do around that effort. But I'll also say, just to illuminate one of the reasons a bit more why we rejected the suggestion that there be transparency about business associate agreements that the providers would attest to as part of meaningful use. And then even potentially make those provisions available, is that there was very strong pushback from the institutional member of the Tiger Team who sometimes have hundreds of business associate agreements. And I don't know that it's necessarily all that transparent to a patient to have a list of hundreds of business associate agreements.

And I think the other thing we would have to tease through is whether there are business and proprietary concerns that are triggered when you ask somebody to essentially expose all of their business arrangements with third parties that involve patient data. But it is something that if you want us to consider it, we could do so in terms of sort of vetting that specific suggestion more specifically with the Tiger Team. But I will say that given the pushback we had just on the transparency piece, that we were prepared to – that we initially discussed as part of a potential solution to this, it just didn't work. And again, I think Paul emphasized why. What we're trying to do is get the business associates to really be on the hook for their own behavior versus holding the professionals responsible for it, either through transparency of those agreements or some other thing.

One other thing that occurs to me is that they're – recently the Office for Civil Rights, which has oversight over HIPPA, has announced that it's a ne – not a new audit program, but that it is going out and auditing more entities that are covered by HIPPA. And it's probably worth exploring with them the extent to which, now that they actually have authority to directly regulate business associates, that they're going to be actually looking at what business associates are doing with the data. That would be, I think, an important piece of information to uncover .

Paul Egerman – Businessman/Software Entrepreneur

I think that was where I was headed, sort of, because HITECH allo – makes business associates directly accountable, that may give them new authority.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So I think one of the points is that because the Tiger Team was left with an unsettling position – members would, too. So, further looking at some of these other options might be useful. I have a couple of hands up. David Lansky's first.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Thanks Paul. Thank you Deven and Paul for that very interesting presentation. I definitely ended up concerned about the potential direction of saying the quality measures should be potentially restricted to EHR available data. So I think that is in kind of support where we need to go policy-wise. But I am also sympathetic to where Paul Tang was going a minute ago, about thinking more about the patient opportunity to influence reuse of the data –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

– without getting into the kind of cumbersome issues you just raised about the BAAs and proliferating notice from those. So I have an example that I want to run by you and see if you think there's any pathway that this suggests. So we have a number of issuants where there are intermediaries capturing data, both claims and clinical data. And the next use of that data would be to, for example contact a set of patients, a subset of patients, to capture post-treatment patient-reported outcomes. So you want to essentially do case finding from a database and then go to the patient and say, tell me how your symptoms, pain, whatever is today. To do that from an aggregated source like a registry or an all-payer claims database, there's no mechanism now. But implicit in it, obviously is the patient is going to consent to supply additional data, but one is not permitted to go back to that subset of patients, even to solicit their postoperative result without getting the individual provider's permission today.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yup.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

So it seems like there's an opportunity there, you're going to be trying to contact the patient, but even the case finding to say, oh, you have diabetes or asthma, we're going to contact you, obviously exposes the PHI. Is there any way to develop a solution to this, which is maybe less policy but more process that, maybe there's a blend of policy and process, where certain uses conducted by a data intermediary are not permissible, but some uses, which involve patient consent, are permissible. And then it's a process question of how that consent is acquired. Does that make sense as a question?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I think it does, and frankly, I think the HIPPA would allow a registry that had a business associate agreement to contact those patients for any further follow-up, if it fell within the definition of treatment and care coordination under HIPPA.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Deven, I'm raising the question as a quality measurement question where the providers –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Ah.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

– as the opposite side of this coin, is providers can obstruct quality measurement by virtue of withholding access to those patient for post-treatment follow-up information.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Ah. But you – but it's an opportunity to essentially allow the patients to affirmatively –

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Yeah.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

– take that obstruction off of the table.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Right.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, I mean the policy vehicles are in place, I think you would just have to think about the process of how that would happen. Maybe not though if the way that the data is being sent to the quality intermediary doesn't really tell them who those patients are. So, we'd have to think that through a little bit more, but it's an interesting issue.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul. Your example also illustrates some of the dilemma providers face, because they may have a data intermediary who's offering a service that is valuable to the providers – to the patients. But at the same time they may be very unhappy with something else that that data intermediary's doing, perhaps the data intermediary's selling de-identified data or is doing something else with the data and they don't like it. Well, the provider has no control or power over what happens to the data, neither does the patient and the provider's in an awful situation of not having a lot of choice if they want the patients to have whatever the positive thing is, they have to take whatever the negative aspects are.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

That's why I was wondering is it not a policy solution to the permitted uses. So right now in the qualified entity debate that's part of the SGR Fix Bill, there's quite a lively discussion about what would be the restrictions on what a qualified entity can do with Medicare data, in order to be financially sustainable. And the original QE program was quite restrictive and therefore the QEs don't have any way to survive economically so it's a circular sort of policy paralysis. However, the question is what restrictions should be imposed on a qualified entity as a data intermediary that would let them monetize some functions, but not violate some of the concerns, obviously policy and privacy concerns, that are there. So I do think more work has to be done both in our context and these other contexts to try to get these additional uses appropriately –

Paul Egerman – Businessman/Software Entrepreneur

– David, I just have to say that when you say modify some functions, I get nervous.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

I understand that.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But it's the reality. Yeah, I mean the – it is frankly easier to take these issues on a use case by use case basis. But – because you can sort of define all of the context that you need to be able to define in order to figure out how to move forward. But it's not terribly efficient.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. Neil is next.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Hi. I'm extremely happy that I wasn't involved in this discussion –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But we missed you.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

– because – I know but I have absolutely no idea how you deal with this. But here's the comment that I probably would have made if I was. And that is, remember that we're always balancing the privacy issues against another part of this, which is the ability to move data around. Learn new things from it, make it available for science, mine huge amount of data that we've never had access to before, to try to learn new things that are going to improve the health of people in this country. And I think that we just, I feel like we're trying to cage a wild animal that'll never be caged. We've sort of let this cat out of the bag, people are using data now and the fact that you mentioned even the use of the de-identified data that people need to – the thought that somebody would sort of be able to restrict their data well.

I know a lot of people really want to do that, they don't want it used to be monetized or other things like that. But I think that there's a lot of stuff, we've talked about this before, that a lot of places this data exist already and we kind of live in denial of that, but it's true that our data is out there everywhere. Our insurers have it, Medicaid has it, and Medicare has it. All of this information is there and now pharmacies have all this information of everything that we're doing. So I just feel like we should always in these discussions think about the other side of this issue which is, are we perhaps trying to lock things down to an extent where it doesn't – where the data doesn't become mobile. And I think we just have to keep balancing that against the privacy issues and making sure that we're not going too far overboard. So I'm not troubled that we haven't solved this problem yet, I think it's an important one and I know from talking to my own patients that people are concerned about this. But they're concerned about a lot of things that we're not able to control and this may just turn out to be one of them.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yup.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Any other – I don't see any more hands, anybody else on the phone – Gayle?

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

Paul, this is Charles. Hey Paul. Paul, this is Charles, I just want to backup to Neil's point. I think when we look at ACOs from that perspective, I think the challenge as we say surrounds the mobility of data and the problems we're trying to solve around clinical care fragmentation. When I look at the role of measures in that and quality measures, so many of the measures that we are attempting to execute we find really dramatic differences between what we see in the electronic medical record data set. And then what we're able to see in terms of the data intermediaries who have access to a broader set of data or inclusive of claim data, really creates dramatically different understandings of the patient and can have a fundamental impact on quality. And so I just want to say from a quality measurement perspective, I think limiting it to data in the EHR may limit its overall usability and value.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul. Those are interesting comments Charles. One of the ways I look at accountable care organizations is, but maybe – I don't know if this is right, is I view an accountable care organization that it's like a covered entity.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But it's –

Paul Egerman – Businessman/Software Entrepreneur

Pardon me?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I mean it might be and it might not be, depending on how the ACO is structured.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, that at least it's an organization that exists for a purpose related to the patients and patient's health as opposed to a data intermediary, which is sort of like, I think, a vendor that its main function and source of revenue relates to the data.

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

I think that's right, but we run into either – I've run into circumstances where the ACO may be a

percentage of the overall business, usually a small one, that a group of physicians or a hospital may be using and the use of quality measures and/or efficiency measures can only be done through a broader patient set when you're looking at trying to re-engineer care, which naturally extends beyond specifically the ACO members. So it does introduce a level of restriction or complexity if we only try and use the EMR data set.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And of course, restricting the meaningful use, for example, quality measures to having data elements in the EHR doesn't say the provider can't do anything else.

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

Yeah, but it's –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So you have something else Charles?

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna

I was just going to say, fair, but it does create this – it begins to create a duplicative process, but fair enough, that's a fair point.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Gayle?

Gayle Harrell, MA – Florida State Representative – Florida State Legislator

Thank you. I'm sorry I'm late getting on the call, I was in committee hearing – committee week this week. But – and I did miss the discussion of the Tiger Team. I do want to add though, from a patient perspective, that this is where the education and information that the patient's going to receive from their provider about the potential use through business associates – is very, very important. They need to understand, and this is part of meaningful consent, that there is – out there. I didn't – unfortunately there's a very difficult situation and providers can't control a lot of what – people's business associates and what they do with the information. The patient needs to be aware – I mean, that's a key component and something that we probably ought to discuss a little bit more within the Tiger Team, about how (indiscernible) can inform them and make sure a patient understands the potential out there.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you, Gayle. Anybody else? Well I think it's been –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

(Indiscernible)

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Go ahead.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

This is Judy and I was just thinking if there's some way that we can define good intent and – good use and bad use. Because listening to what Gayle just said, I was thinking of the paper processes and how with paper, people weren't informed it was going to a transcriptionist, going to go to billing, it's going to go to x-ray, it's going to go to these different places. There's just a lot that it goes to and people were never informed on paper because those were always legitimate uses. If we can somehow separate legitimate from non-legitimate, just – it would be better.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

I think that would be very helpful if we could. Your paper comment, most of those were inside the organization and the organizations mission and charge and revenue are all derived from care. I think part of the issue is the electronic dissemination, it goes to so many more places and there can be other –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

I think that's accurate for some things, but I do think that there are – there were all sorts of billing organizations that you outsourced your billing, even on paper and you outsource transcription.

W

Hello?

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Yeah, so I think that that – there's more now and it's much easier now to do electronically, but I think it always occurred before.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Was someone else trying to make a statement?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Paul, this is Kevin Larson. Just a quick context, part of the reason we addressed this issue was in response to the clinical data registry requirement under the Taxpayer Relief Act. And so this Tiger Team's input and that of the Quality Measures Workgroup Data Intermediary Tiger Team informed CMS as they wrote the physician fee schedule rule around PQRS. And so, that is still in its comment period, but it does, in the NPRM, ask for a business associate agreement to be part of this. So, that's just some additional context for this discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right. So I think this has been a very productive discussion, raising a lot of issues. The concern still remains and I think people recognize the balance. There's a lot of good that can be had by combining comprehensive data sets and learning new things about either the science, contributing to the science or about an individual's care. I think people are uncomfortable with the nature – the lack of ability to control some of the uses that may not be sort of the will of the patient. We're concerned about the – what we'd like to do, I think, is tip the balance in what – coerced consent that's going on now, really there is no way the provider cannot agree – almost feels like they can't not agree with the BAA that's given to them by the intermediaries. So if there's a way, if there are tools to tip the balance so that there's a more level playing field, I think that's what would give people a bit more comfort. And there may be some ideas that are raised here that could be further deliberated in the Tiger Team, does that –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well, I think we'll take on frankly pieces of this issue in different contexts, but I think with respect to data intermediaries, we should sort of bless that particular piece of it and sort of – and move on. Because I'll tell you honestly, we could probably take up another year just on this issue alone, as opposed to taking it in bits – taking it on in the context of a set of issues that we would like to move forward. Does that make sense?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Not sure I understand what you mean by having –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

We're in the midst of some very robust discussions around transparency to patients on data uses and disclosures and implementation of the Accounting of Disclosure Rule.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

So a piece of what we've talked about over the last half hour or so is likely to get surfaced as part of that. To the extent that there are recommendations that are needed with respect to accountable care organizations, and we take it on in that context. Again, it's much easier to sort of aim at a particular set of desirable uses than to take this very difficult issue on in a global context.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I don't want to take a set of issues back to the Tiger Team, we think we're done. We don't have anything more to say on this issue. But to the extent that the issues that were raised here are similarly raised in other contexts, we can and should take them on in those contexts.

Paul Egerman – Businessman/Software Entrepreneur

And the other observation I still want to make is, from HITECH we have these provider oriented policy levers, certification, meaningful use, but once the data gets outside of the providers world, we don't really have policy levers to deal with things. So, beyond the business associate agreement, there's the issue of, well how do you monitor what's going on? How do you enforce something? What do you do if there is a violation? There's a whole series of interesting issues that could be discussed, but we don't really have any policy levers to discuss it.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

I think the one thing you brought up relates to the HITECH and business associate accountability, direct accountability. So you mentioned like OCR could look at either the providers BAAs or potentially look at the business associates agreement, from their perspective. That's the door I didn't want to close because that seemed like a new thought.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, and they already announced sort of what their plans are for audit going forward. And we can certainly do a check-in with them, report back to the Policy Committee on it and then see whether there are sort of – after we sort of understand a little bit more of what their plans are for exercising their new authority to regulate business associates. We might have a better idea about what additional questions we might want to tee up.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, I think that would be helpful.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Because, it's really your slide 11 and the second bullet saying the superior bargaining power of the large data intermediaries result in providers being forced to agree to BAAs granting broad rights to future uses. That's unsettling, if there are ways that we can tip that balance a bit. And I know that would – that would be nice. And I think what you just mentioned could be one of those ways and if we could wrap that into a recommendation from the Policy Committee, that would to add some force to that approach.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay. Sounds like a plan .

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

All right, any other questions? Well I appre – let's see, does Troy have his hand up?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Troy, are you on mute?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Yes I am, I apologize. Thanks Paul. Now what we're talking about is de-identified data that comes from a clinician and goes to an intermediary for research purposes.

Paul Eggerman – Businessman/Software Entrepreneur

No, that's not what –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– EHR that's going there and then they –

Paul Eggerman – Businessman/Software Entrepreneur

It's identified data.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, it's identified data.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Okay. So why would the intermediary, if they are using it for research purposes, why would they need identified data? Is there – I mean, we're kind of looking at two different pathways here. We have health information exchange where you need to have identified data, so that another clinician can actually utilize that in rendering care to the client when they're in front of them. Then we have the research aspect of it where it really needs to be de-identified before it leaves that health entity. So, was there any discussion about functionality that could de-identify it prior to it leaving and going to the intermediary?

Paul Eggerman – Businessman/Software Entrepreneur

Well, we didn't really have those discussions. I mean, there are models, I think, of mini – FDA Mini-Sentinel program, if I'm saying it right, is a model like that, but that was not what we were asked to talk about, we were asked to talk about –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, Troy, this is in the context of a particular use case that was developed by the – I mean – Kev – I don't know if Kevin Larson is still on the phone. But we got this – a fully baked sort of use case for which only the privacy and security issues remained to be dealt with. And our understanding was that the data that would need to flow obviously has to be the minimum necessary in all contexts here, other than treatment. But that – it's not necessarily de-identified and it's not really a research use, it's a quality measure's use.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Yeah, this is Kevin Larson, that's correct. The use case was for quality measure aggregation, calculation and reporting, especially in the context of these clinical data registries, which – many of which are currently not certified electronic health record technology.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Umm. Now again, I mean I raise the question again, what is the purpose of having identified data in quality measures outside of the clinical workspace? I'm just curious as to why they would need identified data.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

So this is Kevin again. The – speaking from many of the consumers of that information, they want to integrate across a multitude of providers to be sure that if the same patient's data is reported through three or four or 10 different providers, that the responsible entity, the payer for example, can know when they're looking at the same person's information versus when they're looking at different information across all those organizations.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Okay.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

All righty. Well, I want to thank Deven and Paul again for a really informative discussion and we look forward to more follow-up, and possibly it's in the context of your Accounting for Disclosures deliberations. All right, is Micky on the line now?

Micky Tripathi, PhD – President and Chief Executive Officer - Massachusetts eHealth Collaborative

Yes, I'm –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I think Micky is and thank you Mickey for staying on with us. Before – while we get Micky and Deven's slides up for the Information Exchange Workgroup, I think Jacob just wanted to make a quick announcement.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Jacob Reider, MD – Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Thank you Michelle. This is the commercial break between shows.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Instead of a ladies or a men's room.

Jacob Reider, MD – Chief Medical Officer – Office of the National Coordinator for Health Information Technology

You can do that while I am speaking as well, if you so choose. So we – I wanted to do this at the beginning but we weren't quite ready and now we're ready. So quick announcement from ONC about the CHPL, the Certified Health IT Products List; a) those who tracked the CHPL carefully know that it wasn't updated during the shutdown. So I wanted to just announce that the great folks in Carol Bean's group at ONC have now caught up and so the CHPL is now up-to-date. So products that were certified, because the certifying bodies and the test labs obviously weren't, since they're not government entities, they weren't shut down, so they continued to churn and do their work, which is certifying health IT products. But those newly certified products couldn't be posted to the federal website because we were shut down. So all of that work has been done and the CHPL is now up-to-date, so if you check and make sure you're produced is certified, if it has been certified in the past month, it'll now be posted.

In addition, and I think this is really an exciting piece, we have started to post the test results for the product. And this is, as everybody knows, one of ONCs – in fact the first of ONCs guiding principles is open and transparent inclusive decision-making. So the decision that the test labs and certifying bodies made to certify these products were based on test results and those test results historically haven't been open and shared with the public. They now are and so we are in the process of back-loading all of the test results from all of the products that were certified from the beginning of the 2014 certification program and that will be complete by the end of November.

And so a component of this is as folks may recall, we had a certification test criterion that we called user centered design, and some know that this is something I'm quite passionate about, which required vendors to test their products in the domain of usability. And so those test results are now posted, and this was one of the methods that we thought would be effective at helping health IT vendors create more usable products. So now, if your product has been certified by the end of November, you'll be able to look and see what exactly were the test results for certification tests in the domain of usability user experience. And you can see what percentage of the time were users successful in accomplishing these tasks and perhaps even what the error rates were. And we think that this kind of transparency will help vendors compete with each other in the domain of usability, without some kind of subjective testing. So, we'll get – obviously we'll get feedback about that and whether it's effective, but we wanted make sure everybody knew that these are now posted. And now back to your regularly scheduled program.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Thank you, Jacob. All righty. We're now returning to the Information Exchange Workgroup update on data portability, Micky and Deven.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great. Thank you and apologize I wasn't on the phone before. I'm just not used to meetings being early, so –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

It's a new world Micky.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, I know. I'm clearly an old style person, I need to catch up. So today we want to present to you our rethinking of the data portability recommendations. I'll go through the background and Deven, in the interest of making sure that Deven's a part of every presentation today, Deven will talk about the recommendations from the IE workgroup. So, why don't we dive in. Next slide please.

So just by way of background and again, we did do a more full presentation I believe in August, but a lot of time has passed since. So, thought it probably made sense to spend a little time on the background, even though we may be rehashing some of what we covered at that time. But as part of the Stage 3 recommendation development, the Policy Committee had tasked the IE Workgroup with looking at a number of exchange related items and we put in the RFC that I guess was issued about a year ago now, on Stage 3 potential options, something related to data portability. And we got a lot of feedback back related to the – related to some of the thoughts there as well as what's in the Stage 2 certification rule. Next slide please.

So at the August meeting the Policy Committee, after a very thoughtful discussion I think, asked us to revisit the data portability recommendation, get some more information, perhaps think a little bit more about the scope of the recommendation and then come back. And so that's what we're doing today. What we did in the interim is we heard from folks from EHRA, the Electronic Health Record Association as well as folks from the S&I Framework, both of whom had some sort of specific thoughts on this. Some of the key points from their presentations included, first, thinking about the two areas of data portability or the two use cases that one could think of that would require some form of data portability as separate use cases. And those in particular are what we might think of as data migration, which relates to a providers wanting to migrate data from a legacy EHR for example, to a new EHR, in the circumstance that they're changing an EHR. To what we would call patient portability, which is a patient changing a provider and wanting to have their information conveyed from one provider to the next, changing a PCP for example. So those are two distinct use cases that we asked those groups to talk about.

So – and it also became clear that the current standards efforts, what’s going on in the S&I Framework for example and the data framework work that’s going on there aren’t specifically addressing these needs right now. Certainly, there’s a sort of broad context that I think this could fit into within the S&I Framework, which is kind of what we heard, but that isn’t specifically being considered now. So that’ll form a part of the recommendation that you’ll see from Deven. But – so what we heard was that the key parameters, the drive, the method for migration, there’s a wide variety of them. Care setting, configuration of the old EHR, ability to map old data, the intended use, there are basically a large sort of set of variables and a large variation in what people might want to get out of data migration, based on where they are. So, that was one of the challenges that we need to address as we think about this.

From the EHRA in particular, their thought on this was that the data migration – for data migration, the document approach, meaning an approach just to recall what the original recommendation was, which was to say that we should build a portability construct on the CCDA construct, that as you all know, is already part of many use cases, from – in meaningful use and certification. And their thought from EHRA was that that construct didn’t work really well for data migration, meaning one provider – a provider who wants to move from one EHR to another on. In particular, the thought was that the CCDA can satisfy some of the needs of that, but there are other methods that are more about database – exchanging full database information from one to the next that would be required to move all of the relevant data as we think about textual notes, images, administrative data, a wide variety of things that aren’t currently captured in CCDA.

So their first thought was that that didn’t seem to apply for data migration, but that they thought that it was relevant for the patient portability use case. And so, their final thought though was that complex data migrations don’t really lend themselves to uniformity that would be imposed by product certification. So again, that’s another one of the challenges that we want to deal with here is, how do we get something that can address the needs that we see for data portability, but that also are – allow enough flexibility to accommodate the huge variations out there in the market.

So one other point I should make by way of background, before we dive further is that in the 2014 edition certification, there are currently data portability requirements. So, just so everyone understands that that’s already there. And it does require that EHR vendors or that certs, and that the part of the base EHR certification requirements have the ability to have some data portability, basic data portability of the common meaningful use data set, as well as some other categories of information and be able to do it in a CCDA construct. And that they be able to do it for all patients for the most recent encounters. So that’s already required in 2014 edition certification. So everything that we’re talking about is building upon that. I just wanted to make sure that everyone understood that. Next slide please.

As I’ve already alluded to, we see two use cases that need to be addressed to promote a more efficient HIT marketplace and to support safe and effective care delivery. One is that provider data migration, which we’re calling data migration and then the other would be the patient portability. The goal here is to enable patients to switch providers, to have their care continue seamlessly and then for providers switching EHR systems to allow them to continue providing seamless care to patients. We also recognize that there’s going to be significant work that’s needed to reach these goals. And so therefore we’re going to – we recommend sort of a multistep approach, so that we just start to do this in incremental ways, start to tackle some of the things, start to tackle it from a 30,000 foot level and then drill down over time is kind of the approach that we’re recommending now. Next slide please.

Why do we think this is important? First off, there’s a lot of evidence to suggest that there’s going to be rising demand for data portability across vendor systems – or data migration I should say, across vendor systems. First, it’ll just be a function in terms of absolute numbers of a growing install base. The second though is there’s a lot of market survey data and other evidence to suggest that we could see something on the order of 20 to 30 percent of providers switching EHR vendors in the next couple of years. Certainly what we’re seeing in terms of the pace of 2014 edition certifications compared to 2012, or 2010, I forgot what year it was for Meaningful Use Stage 1, would indicate that that’s probably going to be the case.

There are a lot of vendors who are not going to go forward, particularly small vendors who are not going to go forward with Stage 2 certification. And assuming that most of those providers want to continue on the meaningful use path, they're going to be switching vendors for the Stage 2 attestation that's just around the corner here for eligible providers and is already under way for eligible hospitals. The difficulty of data migration is a barrier to exit for providers who are switching vendors and a barrier to continuity of care, I think, as I've already discussed. Right now, it is pretty much an ad hoc process. It is difficult to include an EHR contracts, because it's hard to imagine all the contingencies that one might have when they're in that circumstance where they have to do the data portability. So that makes it very difficult overall. Next slide.

It's also the case that if it's not done effectively, there are lots of issues that can arise in the area of safety. If data is incomplete or is actually migrated with errors, I discussed in August a personal case of a friend whose physician switched from one EHR to another and actually had someone else's medical record information in her name after the migration. So there are those kinds of issues that I think are certainly out there and are possibilities. We also have the issues of, but to the extent that we want to be able to enable robust CQMs, robust clinical decision support, if the data supporting that isn't migrated over, then you're going to have a break and essentially practices starting from scratch when they try to move forward with those essential capabilities. And then finally, from an administrative perspective, there are all sorts of things that can happen, revenue cycle side. Administrative stuff is harder, as we discussed at the last meeting, so now as a part of the challenge in front of us and also a part of the recommendation to do this in an incremental way and do what makes sense as we think harder and harder about this. Next slide.

So, this is the last slide on background, then I'm going to turn it over to Deven. So what we would suggest is some type of common baseline – or the goal would be some type of common baseline for medical record continuity. And the challenge again is that it is quite difficult because of the heterogeneity out there. The provider EHR migration use cases covers lots of workflow and data that sort of are beyond the core clinical record that may be required for continuity of business. So it may be that we have to think harder about those additional things, as we think about this. But setting a floor seems like it would be a great first step, and that's kind of the thought here as we think about the stepwise approach that we recommend. So, let me pause and see if there are any questions on the background and then I'll turn it over to Deven to talk through the two recommendations that we have.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul, am I supposed to raise my hand?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, go ahead. You're –

Paul Egerman – Businessman/Software Entrepreneur

Either a question or a comment. Your slide number five, we talked about this as a barrier to the people changing systems. In my experience, it's really the cost and the user training is a much bigger barrier here, the people challenges are much bigger than the technical challenges.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

There are multiple barriers, absolutely.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

I think in our discussions with Information Exchange Workgroup about this and in our discussions with the EHR Association as well as with Doug, undoubtedly there are lots and lots of factors. But this is one of them and I think overall we concluded that this is at least one that we can take steps to try to help resolve. So with that, we have the following recommendations for your consideration, evolved from the last time we presented and taking into account both your comments as well as those from presentations from the EHR Association and from Doug with the S&I Framework.

So, we propose that the Health IT Policy Committee recommend that the Health IT Standards Committee, by Stage 3 of Meaningful Use, develop the standards and technical specifications to address both of the use cases, provider data migration as well as patient portability use cases. And within the – what they should consider in developing these technical standards and specifications should include ensuring that patient care is seamless and that clinical quality metrics can go forward and clinical decision support still works, even when data has been migrated and patients have been ported a record from one provider to another. And we suggest the clinical core record, again given that there's lots of uses of records that need to be continued in the case of – for providers and porting from one vendor to another and with patient portability, nevertheless, we are suggesting that this start at ensuring clinical care capabilities are not disrupted.

And so we encourage the Health IT Standards Committee to determine the necessary elements of the core clinical record that would really establish the first step on the path toward improved data portability for patients and providers. And we also suggest that the Standards Committee explore adopting a core clinical record, so they define the elements of it and then sort of adopt it in a way, again from a standards and technical standpoint that enables it to be easily extractable and consumable, in order to support both the provider data migration and patient portability use cases.

But we also have a recommendation for ONC in that, we want ONC to take more of a leadership role in this. And that they also should really establish kind of a long-term path to really be able to move the industry towards practical patient portability and provider data migration solution that really addresses the key policy concerns that we've identified and that I think were very much part of the background presentation that Micky just gave. ONC should really investigate the current state of the field and create a needs assessment to sort of lay a path forward for future standards work to reach this vision. Really beyond just the ability to extract and consume a core clinical record to enable patient care, but really addressing all of the issues that the Information Exchange Workgroup identified and that Micky presented, and to explore policy levers that are an addition to certification, that could help facilitate the greater patient portability and provider data migration portability.

It's – again, in keeping with Micky's point that we – that this issue has multiple facets and goes beyond what is probably – for us to achieve in certification, even though we think that's the place to start. We think ONC can play a role in facilitating the kind of portability that would – the kind of technical – both technical and policy environment that would enable portability at both the provider and patient level and not necessarily be present just for those using certified EHR technology. Micky, I hope I articulated that appropriately. I want to give you a chance to add anything that I might have missed and then we can open it up to the Policy Committee for questions.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Nope, I thought it was great Deven, thank you.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Okay.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, thank you. Questions from the group? Let's see, it looks like Paul, well, Paul?

Paul Egerman – Businessman/Software Entrepreneur

Yes. Well, I'll just say thank you Micky and Deven for your presentation. I did make the comments back in August, I'm going to make again is, I guess I'm pretty skeptical that this kind of certification standards approach is the right approach for dealing with the issue of data – what's called data portability. I wasn't sure, I thought that might be also what some of the feedback was from EHRA. But it's just, there's just such large differences in these systems between data models, data definitions and it just takes something very small, like a single data element that one system uses as structured and the other system uses as unstructured, to make this whole process very difficult. And, I also have to say, that I have a concern, a significant concern about the recommendation that says you're going to have a specification or a standard established by Stage 3. Because, as I understand this area, there are no standards right now and you just can't make a standard up out of like whole cloth. To have a standard for doing something like this and to roll it out on a national basis, you have to have some level of operational experience with that standard. And so to create a standard for doing this, is my opinion a multiyear effort, it can't be done as part of Stage 3.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

So, Paul, thank you for that and I think we did try, and coming back to this, try to take into account some of the comments that you had and that Judy had in the last meeting. I mean guess the thing I would just point out again is just that in the 2014 edition certification, there already are requirements that have defined – that define that it has to be the common meaningful use data set, a number of other categories, cognitive status, immunization, encounter diagnoses, discharge instructions, functional status and in the CCDA construct. That's already a requirement for 2014 edition. So we are starting from a place that does provide some structure to it, this is really saying that what we would like is for the Standards Committee and for the S&I Framework to pick that up and then essentially extend it out to make it usable for these use cases – for these two use cases. Because we think that that's just not quite sufficient where we are. It was a place to start, and that is already in place. And I agree that it's a difficult area, but I just want to remind everyone that that's already in place for 2014.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

This is –

Paul Egerman – Businessman/Software Entrepreneur

But those things for 2014 was there not for the sole purpose of data migration. Those are items that are there for other functions also.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right, but besides – certification –

Paul Egerman – Businessman/Software Entrepreneur

– migration. I mean, I don't have any problems with both of those items and things similar that really also advance our information exchange capabilities. But this is a specific standard for data migration, which doesn't exist.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

This is Judy and I'm going to support Paul pretty strongly on this. I think that slide seven, which says the challenge is that it's difficult because of record retention, lost patient preferences, etcetera really needs to be expanded I think to cover just what we're saying here, that the vendors never sat down with each other and mapped their data elements one to another. There are a lot of vendors and we all came up with different ways to define the data elements. And I think a simple example, two simple examples are sex, which, there's male and female, but there are a lot of other variations that could be in there as well, and they're all done differently, even though on the surface it seems like a very simple data element. And I agree with Paul in that once you've mapped it for interoperability, you've also mapped it for your CCD standards to send back and forth, and everything else. We – I believe there's a little over 100, 150 data elements, somewhere in there, that are being defined now and the vendors often will have 100,000, so you get a sense in the difference in proportion if you're going to do interoperability.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

So does that then suggest – I mean, I almost want to take us back to maybe breaking this down a little bit. If we agree that, in fact, these two use cases are important to pursue over some pathway. Both from a – from a technical standpoint, and based on what we learned in the Information Exchange Workgroup and from both the presentations from the EHR Association and from Doug Fridsma, that current interoperability standards help, but don't neces – were not designed to address this use case, and so they don't. And that there is some technical work to be done on this, does it make sense to direct the Standards Committee to look into this, but maybe not place the Stage 3 timeframe on them so rigidly? I mean, we want to make – I think what we ultimately want to communicate is that addressing use cases is a priority. I don't want to speak for Micky, but I think we're less – if we don't think that that can happen by Stage 3, or we don't want to constrain the Standards Committee to developing this for Stage 3, then I think that's something that we can talk about. But making this a priority from a policy standpoint I think was very much what the Information Exchange Workgroup wanted to promote, and certainly based on information we got from both Doug and the EHR Association, it's not an issue that's currently being addressed. But there are interoperability issues that are being addressed that can be built on, in order to address this.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

The way it's being done now is it's being addressed per customer and per vendor so if vendor "A" converts from vendor "B," they have processes that they put in place to do that particular conversion. And if it's vendor "C," it's a different process, because they're all different.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

How does that work from the patient portability standpoint?

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

I'm not sure what you mean by that question.

Paul Egerman – Businessman/Software Entrepreneur

Well –

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Because the patient is not – when the patient changes from one provider to another, they don't necessarily have the ability to negotiate with the applicable vendors about whether the data is both extractable and consumable by their new PCP.

Paul Egerman – Businessman/Software Entrepreneur

But Deven, your own slide suggests that the CCD – the CDA is a vehicle for the patient portability

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well that was suggested by the EHR Association and I – that would be something that it's really for the Standards Committee to decide whether that's appropriate, and not for us. We're just (indiscernible)

Paul Egerman – Businessman/Software Entrepreneur

Let me an – try to answer your question, is, my view is the way one proceeds is continue to make progress on information exchange, things like the CDA, and to choose various documents that allows the patients to have that level of document approach, allows those patients to have that level of portability. And in my opinion, this should not be a priority for the Policy Committee to address because it isn't information exchange and because addressing it – it's questionable what progress we're going to make, but it's not questionable that it's a real hard problem. It's going to take a ton of work and I'd rather see that kind of work be put into information exchange or quality or some of the other things that are listed as goals for us under HITECH.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Deven, this is Christine, if I can jump in on this.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Go ahead Christine.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So, I don't agree actually with you Paul, Egerman, not Tang, in that, we heard a lot about the challenges of switching EHR vendors and we know that many of them are switching in the next couple of years. And so, I think you did a good job of pointing out there are other big problems around training and the cost of switching and so, I think for both of these use cases, we do want to facilitate making this problem a little less challenging. And particularly doing so in a way that my – I can have confidence as a consumer that if I bring my record over to my new provider or if my provider switches systems, my data is still going to be there. And it will be there in a way that is actually usable by clinical decision support and things like that, which suggests to me that we need the Standards Committee to weigh in on what level of detail would work here. So that's my comment. I think part of my question is, how much you guys at the workgroup level considered the core data set that is already specified for either Blue Button or the care summary in this. Because the list of data is different than the standards, right, which I think is definitely the domain of the Standards Committee. But part of what I'm hearing you ask the Meaningful Use Group is to say, what should be core data set should be that can be mobile either because a patient is changing providers or because a doctor is changing EHRs? So I was wondering if you guys looked at those at all?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Yeah, we didn't look at an element by element sort of comparison of what's in Blue Button core data set versus what might be a recommended one. Because in part, we didn't want to get to that level of specificity and suggest in detail what that core data set might look like. But as I said, there already is a baseline, which is a common MU data set plus a bunch of others that are already required in the 2014 edition requirement. What the 2014 edition requirement doesn't do is it doesn't specify for example, longitudinal data that might be important for quality measures or decision support, like lab results for example or other types of historical results. If you look at the test scripts and what is intended, there are all sorts of indications in there that that's where ONC was hoping that this would head as they were thinking about where data portability might go. So they have the test scripts that say, it's only for the current encounters; however, there's strong encouragement for people going through certification to include longitudinal data in that to support the ability to enable CDS and CQM, for example, in the receiving or the system that is going to be receiving the information from the legacy system.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So, Micky, I have a question that – it's kind of a technical question and I'm not a technical person, so it could be a dumb one, I'll warn you. But, when I – that makes a lot of sense for the longitudinal data component. When I think about Blue Button and view, download, transmit, I mean the whole concept I think was that a consumer could download their data and transmit it to an EHR that needs to be able to upload it. Is it enough to have just standards for these data or does there also need to be created a function that helps to ingest the data into the record or can EHRs just do that now?

Paul Egerman – Businessman/Software Entrepreneur

That's a great question, Christine – what you call ingest, I call consumed when we did the discussion in August.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Yeah. I mean they certainly can't routinely do that now, although that is a part of the path of meaningful use certification. In Stage 2 they are supposed to be able consume CCDAs, for example, with specific elements specified for what they need to be able to consume. So I think that that can certainly be one pathway for it. I mean, some of the issues that even some of the vendors in our deliberations have talked about, is not that that is a bigger issue. But that their systems for example, right now aren't configured to allow the user to say, I would like a set of C – the set of CCDAs to cover the entire patient history, for example. They can generate a CCDA, but it may only be what was in the most recent encounter, for example. And so if someone were to ask or a patient were to ask for, give me my entire history, they may not have the ability do that or some systems may or may not, which would be the argument for say wouldn't it be good if we had a floor that sets the functional capabilities around this.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Christine, this is Judy and I am a technical person, that's my background. And I think what you said is really good aspirationally, but, I believe that if we got a committee together to go over possibilities, everyone who's technical would say, well yes, there's a base of data that you could bring over, but you can't bring the whole record over, expect it to be there and be actionable. That – you said actionable and I think that's the concern. You could bring it all over in a scanned format, you can bring it all over and make it readable, but to make it actionable is where it's difficult. Because it's not just the base data that we're bringing across right now for the CCD document, it's the details of cardiology, diabetes, OB, oncology, transplant, orthopedics, dental, ophthalmology, GI, all that stuff is – there's a lot of data in that. And the vendors did it differently and there are no standards for that, that's a lot to go through. Things like allergy and meds, we are defining, because that cuts across everything but it's when you get into different areas, that's where it really isn't there anymore, to move over –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

And just to ground that, I mean that's obviously a great point, in the certification for 2014, what the criterion does do is it encourages EHR technology developers to include patient longitudinal information for three categories, labs, immunizations and procedures. And then they say they want to build on that over time, but they do recognize, I think, the great point that Judy's making is that we're not talking about the entire record, but there are certain things that are important from a longitudinal perspective and that would lend themselves to being actionable across systems.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

And I'm in absolute agreement with that, Micky. That part is doable, it's when – it's when people have the belief that their entire record can come over, that that is unrealistic.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

And that's fair. But isn't that exactly why the recommendation is framed with an – like approach, as Micky put it, which is to sort of talk about some – the necessary elements of a core clinical record that would really be the first step toward expanding the two portability use cases that we're talking about. And we're asking the Standards Committee to look into it.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Is that really clear?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But again, I think we're amenable to not having it be tied to Stage 3, given that we do have a lot of priorities and this one could be complicated, notwithstanding trying to build on interoperability work for other purposes that's the – we would try to take. But we heard very clearly from both the EHR

Association and the S&I Framework that focusing on the portability issue, even in this sort of first step way, is not something that is currently being done. And so what we're trying to do is to spearhead that work.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

And I would just add, it could very well be that the Standards Committee looks at it and says, it doesn't make sense to go beyond what the 2014 certification requires. For all the reasons that I think Paul and Judy and others have been pointing out, that there's a lot of other data there that makes it much more complex.

Paul Egerman – Businessman/Software Entrepreneur

And my response to what you said Deven is, I guess I'm not convinced that having a core set is necessary that's best to the vision that you're talking about. I just question whether or not a standard in certification or portability is by itself feasible. In other words I look at, for example, something that's been written a lot – about a lot, the whole process of the VistA system, the VA and the DoD merging together.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Right.

Paul Egerman – Businessman/Software Entrepreneur

I can't imagine having this standard in place would help them, and I actually suspect there's a way it might hurt. Because the reason that you have that problem is, you have two different data models and two different systems of data definitions and to insert the third data model might actually be counterproductive.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So is there any suggestion about what you mean by "floor" Could it mean the current things in the "encounter-based document," which is problems, meds, allergies and these three elements that you mentioned that were "encouraged, like longitudinal labs, immunizations and procedures?"

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, I mean it certainly could be. I guess I would just – just to be clear, there already is a floor in that the 2014 addition specifies the common meaningful use data set, which I think as you know is 16 data elements plus encounter diagnoses, immunizations, cognitive status, functional status and discharge instructions. That's already in there so the question I think would be for the Standards Committee, is that a sufficient floor or are there any additional pieces, like these three elements that we talked about, to include as longitudinal, which were more in the area of encouragement or certification. I think the – as Deven has said, the recommendation here would be to have the Standards Committee consider, certainly be amenable to taking out the strict timeline for Stage 3, because that may be too much of a lift.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, so that form – so we're concentrating on that as your first recommendation, the second is more a pathway. So we – let's see, I think I have – I do have a couple of people on the queue. So David Lansky?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Yeah, I just, obviously coming from my point of view, thinking about the use cases that are around both patients shifting providers and the quality measurement and payment purposes measurement, I think it's very important that we do keep to the Stage 3 timeline and try to get the core data set, whatever you want to call it, defined. But I realize there's a lot of fluidity in what that's going to be for all the reasons Paul and others have said. I'm wondering if there's an intermediate step that the Standards Committee or someone could do essentially an options paper or a couple of scenarios that says, here's what the core set needs to include and how feasible it is to accomplish use case "X," "Y," and "Z" by a timeframe.

My concern is, if we let the timeframe drift on this task, there's a lot of public policy and marketplace activities that are dependent on solving this one. And I know a lot of people who are really frustrated right now that they can't integrate clinical data with other data sources for purposes of fair quality measures that reflect clinical complexity and so on. So, I think we should keep an aggressive timeline on it, but I realize because of the complexity, maybe we need to be presented with as a policy body, presented with some trade-offs or options.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Fair point. Deven, Micky, your comments on that, because that's a – so we're in agreement about asking the Standards Committee about the feasibility and the approach to these. What about the timeline – well, one question I suppose is, what could be done in the Stage 3 timeline and what would be the next timeline recommendation?

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Well one potential way to address that would be to say, that we – I'm not quite sure exactly how to frame this. But something similar to what David said, we ideally want this – we'd like to get a sense of the timeframe for when this could be addressed, from a standards perspective. I think – we don't have any – I don't know that we can direct the Standards Committee to write a paper.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

But getting some – communicating to them ideally that this is a priority of the Policy Committee and a suggested approach for getting there, which is essentially what's on the slide in front of us. But getting some feedback from them on what's a realistic timetable based on work that's already done – been done around interoperability for Stage 2, but what would it take to sort of advance it meaningfully. Even at a first step, would that be Stage 3, would that mean something beyond that? And what more do they think needs to be done from a standards standpoint?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Deven, I was suggesting something a little bit on that track but upside down. If you take what Micky was saying about the 2014 requirements, I'm wondering how much will – how far will that particular data set get us in addressing some of the use cases or what gaps does that leave? If I were to put forward a use case around physician payment and based on value, and defining a set of quality metrics that physicians would regard as fair, because they're clinically subtle, that requires a certain kind of data to address most, let's say primary care or some other groups. Whether or not the data set Micky just summarized would be adequate to support helpful value-based payment, I don't know.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Right.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

But it would be nice if someone could say, well yeah it could if we added the following longitudinal lab results or whatever it is that needs be supplementary to make that legitimate. And so there are other applications like a patient wanting to move from one doctor to another needing a minimum data set to avoid the clipboard phenomenon. That's another use case that we may be able to say, yes, it will or won't, we can or can't meet that by 2013 by – I'm sorry, Stage 3.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Right. I totally agree with you, Dave. And I – that's one of the challenges that we always face in the IE workgroup, particularly because we have a couple of Standards Committee members on the IE Workgroup. How do we refrain from – or restrain ourselves from diving deep into the specifics, which would be in the realm of the technical specification that is obviously the jurisdiction of the Standards Committee, and keeping it at the policy level. But I agree with you, those are the kinds of issues that we would hope that the Standards Committee could look at.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, Terry?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Sorry, I had to unmute myself, just because we were referenced. As you know, we're in a major – between VA and DoD for interoperability. We've taken on seven domains, we actually have had pretty significant oversight, far beyond those of our departments. And even with that and a commitment and funding, we're translating meds, allergies, labs, vitals, immunizations, document notes using LOINC titles, problem lists using SNOMED and having very, very serious matching problems that harken back to what Judy said is that, even if you think you have your mapping done to move towards interoperability, there are lots of issues. As soon as you want to hit semantic interoperability, you're really in trouble. If you want process interoperability, it's very difficult to achieve that.

So I – my only, I guess my experience here would tell us that we need to push on this but, it is a slow moving animal and will require a lot of work at both the vendor and the provider level. And I like what David said, perhaps one – encapsulated use case where you can push through and see what you can match and what is available out there in the public sector would be helpful as an analysis. I'm worried that we're going to push something out that people are not going to be able to do, even though it needs to happen.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

So Terry, what would a recommendation that provides the appropriate push, but doesn't set expectations unreasonably high look like?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Well I think just establishing, because there is some stuff in 2014 perhaps, and I know you can't – you don't want to do a white paper, and I don't like white papers myself, I want to execute, but I think we need to get a sense of what is available out there. And then do, I actually really liked David's use case, maybe just do one use case, push it through, see what the technical specs are, where they are in terms of being enacted out there. And then do some pilots, maybe. I just don't see in two years how you're going to get this done, that we're going to get this done.

So I think you can do parts of this. I think you – and the other thing we can do iteratively. What can you extract from a core clinical record that has the value with it? That's a standard terminology. Then, what can you send, what can you import, what can you build and what can you do with what can – and what do you do with what you cannot – ? So I mean if we think of it as a message, and the steps in the message, perhaps that would help delineate it more.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Hmmm.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay I think. why don't we start to bring this discussion to a close. The recommendations on the table, and I think you are asking for approval, is that correct Micky and Deven?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, we are.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So the two recommendations, one is that, we ask the HIT Standards Committee for their advice on the ways that we could advance – start this journey of data portability and also ask their advice on the timing. I mean, we've heard how it's desirable, we've heard how it's hard and we've heard how it takes time. So if they could give their opinion from those – a comment about that, that would be appreciated in recommendation one.

Recommendation two is that ONC develops a pathway and trajectory on how we would solve this in a more comprehensive way. Again, we've had the discussion that this is really pretty hard and it's not clear that there is a comprehensive plan to have interoperability in an actionable way from – amongst all vendors. So that may be one of the things that comes back from that, but I think the most important recommendation is the first one, which is to get specific advice from HIT Standards Committee. Have I summarized that correctly both from Micky and Deven's point of view and from the rest of the committee members?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

I think so.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Yeah, no I think so, too. It's asking the Standards Committee to give us feedback on how we address this priority.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. Then may I entertain a motion for that – approval of that.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Oh, I'll do it. It's – since I'm on the committee. I mean, if you think that's an appropriate, also I'm co-chair of the workgroup, but I believe that that articulation of what we recommend, I move that the Health IT Policy Committee adopt it.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, is there a second?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Christine also.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. And any further discussions? All right, very good. Any – so any approval? Those approving?

Multiple speakers

Aye.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And any opposed or abstain? Thank you much. Thank you Micky and Deven.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Right, thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And I think we're still pretty much on time to allocate the full amount of time to the Quality Measures Workgroup update, specifically on some of the draft proposals with regards to Stage 3 and the deeming program within Stage 3. Helen and Terry.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Terry, this is Michelle. Can I just ask, it was really hard to hear you when you were commenting earlier, if there's anything you can do on your end to help us, that would be appreciated.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Are you talking to me?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No, to Terry.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Is that better?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yes, that's better. Thank you.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay. So I'm going to start and then Helen's going to finish. And I may be talking out of both sides of my mouth, given what I just said about how difficult it is to share data because we actually have a huge focus on this on sharing data. So, next slide.

So, this was an ACO Quality Measures subgroup that was originally asked to develop recommendations that would be applicable at the ACO level, which is why the ACO committee was joining us in this subgroup. And as you can see here, the original focus, the main concepts and infrastructure that could be applied to ACOs. We were asked to focus on that originally and then our charge was expanded to focus on deeming. And you will recall, Paul has presented to the committee, I think once or twice, on what the concept of deeming as it applies to Meaningful Use Stage 3. So next slide.

So because we had this change in focus that extended recommendations, we were asked to develop recommendations for how quality measures could be used to deem providers and hospitals within the context of this population health/ACO workgroup. We were specifically asked about criteria and potential framework for EPs and EHS to look at measures that currently exist in CMS programs that could be used for deeming and then what would happen if we had a group reporting option all on ACO option for MU overall. Now, I need to preface the rest of this deck by saying, we didn't get through all of this. Once we got thrown deeming, we kind of went on a different path. So for instance, we have not specifically looked at answering the question about measures that currently exist in CMS programs. The other part here though as you see, is this group reporting option. If there was a group reporting option, which doesn't exist right now, how would we attribute provider's membership, his/her ability to receive incentives? We did not answer that question yet either. Next slide.

So, on the next slide you'll see what we did. We originally focused on, well what is the framework for answering these questions? What do we really want to achieve as the end result for these measures? And we spent probably one session on this and what we elected to decide – what we came to decide on was that we were really focused on health. And you're going to see that in the upcoming slides. Not healthcare, not health outcomes, but really health itself, and we embraced that concept and it really fed the rest of the conversation.

We did have a focus on a population base, which is why the sharing of data, longitudinal data, and interoperable data becomes really important. As you'll see, we did develop a framework that would be applicable to EPs and hospitals, but really our focus was this population based, patient centered and longitudinal with the recognition of the difficulties that surround the ability to achieve a longitudinal health record at the current time for patients that are getting care in multiple places. And a belief that we needed to support higher improved performance, reduction in disparities, and the achievement of health equity basically, and there's a focus also on patient-reported outcome measures, because we were focusing on health as opposed to just the healthcare system itself. Next slide.

So, the next slide itself just really shows you where we believe we are today. And you can see, if we move to where we want this measurement to go, we would obviously be focusing on health. And once again, you'll see that as we go through the slides. So we have intermediate outcomes, many of which will look familiar to you, they will be things you've already seen. We have some healthcare outcomes, a little bit sparse in that area, but definitely some measures there. And then this, what's small today and large in the future, which is this achievement of health itself. Next slide.

So, the next slide really talks about the deem – so if you'll recall, we had a focus that was given to us on developing what we could use for deeming. And we just stood back a second and said, okay, what would be the framework we could use? And if you go to the bottom, these are things that you may be familiar with, these are your intermediate outcomes, which we talked about on the slide previous to this. Expenditures, patient experience, outcomes, many of these which you will see as we go through this deck, because we did try to apply this framework to some exemplars and see if it would work.

And then if you go up, you see healthcare outcomes and you see that both in the blue and the red, with some examples there, the CAHPS Survey in public health and in the health experience, health outcomes. And then in the middle the patient centered value of health. So our real goal was to try to push the discussion a little and say, what would those measures be? How would we ever get to them, especially from a population perspective, that was still be respectful of hospitals and providers in terms of meaningful use? Next slide.

So our assumptions for the deeming criteria were that the criteria had to be for a measure set and not for individual measures. This goes back to what Paul has previously presented on deeming, which is conceptually a way to have someone – to have adherence for three, four, five measures, take your pick, and have them met by one overarching deeming measure. We also assumed that the criteria would have to be applicable to both individual EPs and EHs, but we also, because we were with the ACO workgroup, pushed on this concept a population and now we enter into the concept of group reporting, which we've heard previously discussed on the Policy Committee. As we know, that that's not really an option right now, but we did spend time looking at the possibility of group reporting, what that would mean. And we wanted to propose it to the Policy Committee as an important idea that we think needs to be at least addressed and thought through, with the belief that the reporting could be a self-defined group. So it's not necessarily a predefined group prior to going into the measurement cycle. Next slide.

And with that, then we next went to population level reporting with the belief that this would only occur at the group level. Once again, the group could be defined loosely, but not limited to how they are defined in an ACO. So what we wanted to state was, even though we did this work and informed it through the ACO workgroup members, we actually believe it may have a flexibility far beyond just ACOs themselves. And there was this belief, and this goes back to interoperability in terms of a data set, that we wanted to promote shared responsibility across settings and providers. Now that is consistent with the ACO philosophy and the ACO goals. But the caveat here is, if this is extended beyond ACOs, is there a way to do that if there's not a defined relationship perhaps between the hospital and the provider within, right now at least, an ACO. If there's no – is there the ability to establish a different relationship between a provider and a hospital that would embrace this concept of shared responsibility, especially if we move to population level reporting? Next slide.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

And Terry, this is where I'll take over. This is Helen Burstin. So I'm going to review for you at least the draft criteria as the workgroup and subgroup really thought it through at the various levels. And I think it's important, as Terry has been sort of pivoting back and forth between understanding what might be applicable at a group or population level, versus what might fit in sort of a current MU mindset of EPs and EHs. So on this slide, there's just a summary of all the ones that we'll go through in a bit more detail, but specifically on the left-hand side are criteria that would be applicable to EPs, EHs and populations. And some of these may look somewhat familiar to work we've done in the past looking at measures appropriate for MU, but certainly a preference for ECQMs or measures that could leverage data from HIT systems, as HIT sensitivity concept still being at the fore. Secondly, giving a more patient focused view of longitudinal care with a bit more details on what that means in our current construct coming on subsequent slides. And then being able to assess health risk status assessment and outcomes.

Now more applicable, on the right-hand side are additional criteria for the population level. So for example, a preference for reporting – the ability to report once across programs that can aggregate data, the applicability to populations obviously. And since we know this is a heavy lift, wanting to make sure that what's measured specifically would be able to, with some time and some additional work, be able to demonstrate that the benefit of that population level measurement would outweigh the potential burden of getting to it. And then finally actually as a result of our workgroup call this week, added this additional criterion around the promotion of shared responsibility. So next slide we'll go into a bit more detail on these.

So for the first set we just talked about, the EPs, EHs and populations in a bit more detail here. The first one is HIT sensitivity as I mentioned. The second one has a bit more specificity about this patient focused view of longitudinal care. And it really is thinking – the ability to think across EPs or EHs, across a group of providers and potentially even being able to pull in non-eligible providers to get that more patient focused view. So for example, behavioral health or post-acute care, to get to that really very patient centered view that may not be possible in EP versus EH alone space. And then lastly this one I mentioned about supporting health risk assessment outcomes and specifically thinking about how it could be used for both risk adjusting other measures, but also being able to assess the changes in outcomes that could drive improvement. Next slide.

These are the ones that we specifically thought would be more applicable at the population or as the group reporting option as Terry mentioned. Again, the idea that if you're able to report these once, you should be able to use them across multiple programs, for example listed here, including the MSSP for ACOs as an example. Applicable to populations meaning the hope would be these measures would be reflective of the broadest possible experience of the patient or population. And would likely, for example, require interoperable systems to really get to measures that can do that. The benefit outweighing the risk, I mentioned, specifically the benefit of measuring at the population or group level outweighs what we know would be a significant data collection and implementation burden. And then finally this newer one we added about shared responsibility, that the measure as designed would really require collaboration and/or interoperability across settings and providers, so kind of pushing us to the next level in terms of measurement. Next slide please.

We also worked through a set of what was referred to as exemplars, meaning examples that would help us really see how the criteria played out for different populations. So here are four examples, we'll show you the one on frail elders. But for example you could think of population or group looking at frail elderly population, Million Hearts to get a cardiovascular risk, disabled or under 65 population – and under 65 – or for example, primary care with mental health diagnosis. So on the next two slides, next one please, you'll see the exemplars laid out. These measures are – the measures on the left-hand side there are really illustrative examples of what we think logically makes sense as just a part of this exercise and then the criteria are listed across the top. This first one here is with the population focus, for example, an ACO or another group. And just assignments of high, medium, or low, in terms of meeting those criteria, just to give us an overall sense of what was likely.

So this is the population example for the frail elders. You'll see there are couple of lows, but a fair amount of green or at least yellow across most of these. On the next slide please, this was an example, again a frail elderly example, but instead taking an EP focus with the criteria as applicable for them. And again, just going back to Terry's earlier point, there wasn't an expectation that each individual measure would meet all of these criteria, but instead you would be able to look across a set here and get a sense of whether the set would logically meet at least a good number of these criteria. And certainly, in this case, at least the first three here since at the EP level, the other ones are primarily more at the group or ACO level, so really just a proof of concept to share with you. Next slide please.

So, potential implications here, and I think Terry laid out many of these, so just briefly. I think there is an implication that it would likely promote interoperability and access or reliance frankly, on data that may currently be outside of the EHR you've got. There would also be an implication that population or group reporting would need to be defined more broadly, i.e. not just to a single provider group. And reporting on measures by a self-defined group, like an ACO or another group that may be in a purchasing relationship or something along those lines, could be identified on behalf of EHs and EPs. As I mentioned, it could include a broader set of providers, including folks currently not eligible for MU, but who would help to fill out that more patient centered focus. And it would also really, I think, point out as you'll see on the subsequent slides, it'll point out how the prioritization would need to move forward in terms of building additional capabilities of HIT and the national infrastructure to meet some of these new measure types and more population focus. Next slide.

So, we've got a set of questions we wanted to bring to the Policy Committee. First off, with your conceptualization of deeming, do these seem like the right criteria? In terms of thinking about getting to higher value, what's the capability for new measure types or alignment with existing programs? And are there times when deeming will be insufficient in terms of meeting these goals? And then finally, just on the last slide, and we can return to the questions slide afterwards – next slide please, laid out perhaps some recommendations for future work that the Quality Measures Workgroup or the ACO subgroup or anyone else would logically potentially want to move forward with, if you think this is a reasonable approach.

Certainly this question of being able to have EHS and EPS measure together for mutual benefit; whether there might be a possibility for a group reporting option going forward. How population health might be aligned with emerging or new business models, and we got some very important comments from David Lansky that we shared with our workgroup, for example, as we were working through this. And again, this issue about interoperability, which keeps coming up again and again, interoperability that matters. So how do we look toward measures that depend on that data from outside your current organization? Measurement coordination with non-eligible providers and how that might move forward and then finally, really beginning to take a deeper dive on thinking through the infrastructure and the architecture for ACO measurement. I think that is our last slide. So perhaps we'll just bring it back to the question slide and I'll turn it back over to you Paul.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Great, thank you very much Helen and Terry. Let me look for hands in terms of questions. If I understand your first question, are these the right criteria? So as I go to your colored matrix, if we look for things that had mostly green, there are a few of these. A row would be a "set," is that correct? A row would be a measurement set, you said concentrate on sets versus individual measures, so assuming you're –

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

No, the row would be an individual measure.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, so the whole matrix is the set.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Exactly, the matrix would potentially be the set, for example, for frail elders at the population level or the EP level.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So if you looked at these, you would say, hey, it seems achievable and relevant, if you say mostly green and a couple red. And then that would say, it's meeting most of – it's satisfying the criteria fairly well and could be used as a deeming set? Is that how I'd read this?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Ahhh.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Then I guess the question for us, the Meaningful Use Workgroup is, and what would performing well on this set deem you and – deem you out of satisfying the objective measures?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Um hmm.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah Paul, this is Terry. That would be right. The thing we didn't not do, but we had a dialogue about this was – this back to specific, for instance current specific measures. We did have a long discussion on patient reported outcomes and whether, if you did well on one of these, so say you do patient focused view on longitudinal care, and you do well on that, is that enough then to say that you still wouldn't need to report on their measure? So the one thing that I think we may have missed in our report was this belief that there are certain measures that are probably so critical in and of themselves that we do not believe they're eligible for deeming, with a measure set. But, we didn't go into real details on that, we just – the one about patient access to data kept coming up though.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So the fact that there's a fair amount of green in your first column, which I think is the HIT sensitive one –

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Um hmm.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

– means that you believe that this would probably deem you in fulfillment of some subset of objectives?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Potentially yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yes.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. David Lansky has his hand up.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Well Helen, it's a really good job, and Terry. I think it's a very good framework for us to look at and I do think that the measurement set that emerged from the criteria looks right and viable for what we want to do. My questions are more about the deeming policy issue that – and Paul, you said a minute ago, if someone performs well on these measures, they'd get deemed. Actually we're just saying if they're capable of reporting at all, regardless of their level of performance, then hypothetically they would get deemed, just as they qualify today. So –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Actually, hang on David, I think for the deeming program, we did call out in our draft recommendations that you'd have to perform well, i.e., the top quartile of something, or improve significantly in order to get deemed. So it's unlikely –

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

Yeah, I think the anomaly will be that we don't have the historical data on many of these measures to determine –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

– I mean we don't have a universe of subjects that we've measured. So we're probably going to get self-selection of some organizations and individuals who perform hopefully well on these things, but we won't really have a framework for assessing that. So I think we'll probably be looking at reporting initially, which is fine. But then I was wondering, who gets deemed and whether, since there may be an organization like an ACO where a group, let's say a large group of 100 physicians reporting something like this. And maybe some of them care for frail elderly and some don't or in that particular reporting group or does an entity that's reporting and getting qualified in effect deem the individual EPs who are part of it? Have you all thought about what this kind of an approach – or to whom this approach would apply within the EHR Incentive Program?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yeah, to be fair – yeah, I don't think that was part of their charge.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

I think it's one of the issues that we teed up, though, this whole question of group reporting and linked reporting and things along those lines. I think it is harder when you're thinking only at the EP or EH level, but I think Terry was trying to get in as well. Terry? Hello? What just happened? Hello?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Terry, are you on? Maybe she dropped off.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, maybe. Sorry.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So David, did you get your question answered? Probably not.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health

No, but if I understand, this – that the deeming discussion has been percolating obviously for quite a while and I think there are some interesting policy problems. This particular presentation doesn't address them all. I'd also go back to the idea that what we really want to do is encourage HIT to be capable of measuring the kinds of things that are shown here and thinking through what's the infrastructure and certification requirements and interoperability requirements, like our last discussion. If you took even these slides that we used as examples today as the use cases we were talking about in the last hour and say, what would it take in terms of data portability to produce these measures that would be a good test, as these two conversations intersect.

Deven McGraw, JD, MPH, LLM – Director – Center for Democracy & Technology

Indeed – this is Deven. We had data quality measurement as one of the use cases, but we had others on there, too. So –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

And this is where Terry's talking out of both sides of her mouth, I think.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yes, I know I am.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

This is Judy. I have some really serious concerns about the whole deeming concept. I worry that we are the HIT Policy Committee and the money that was supposed to go for a meaningful EHR that's used meaningfully, and to pay organizations for – with that money when in fact they aren't using HIT worries me. I think it takes a lot of – to figure out how to do this. I'm worried that when you put in an EHR and have it able to do certain things, that could stay for years, but quality can go up and down as your people change. And we may be seeing that maybe this year it is good and next are it isn't as good, you can read the US News and World Report and see that sometimes it's the same places that are there but sometimes it's different places. And what was the top quartile is no longer the top quartile.

I think that the person who said, what is the top quartile, that's a really good question. How do we know that because only a certain group of organizations will be reporting this. I'm also really worried that the vendors are going to have to do two systems, they're going to have to do the system for deeming and the system for those who are going through the normal meaningful use. And I kind of feel like if the organization doesn't have to have usable IT or good IT, should the vendor then be required to do all the programming to prove that they don't have the good IT?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Umm, I'm not sure we should – some of this discussion is going off into the deeming program itself. The charge to this workgroup and the Tiger Team was to look at criteria and examples of measure or measure – that would be suitable to be used in deeming. There's a core assumption Judy, that the measures would be HIT sensitive and so maybe there is a special case for that first column.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation
(Indiscernible)

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

But is the connection and we're trying to move –

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Well could you remove the vendors from having to do the – all the reporting for deeming?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Why do you think it – we're hoping to have reusable – the same measures that would be part of CQM, a subset of those measures could be used for the deeming program. So I don't think there's – there's two systems from a vendor perspective.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Well that would be good, if in fact it's all the same.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

It's still a program under evolution – in evolution, but these are some of the things we're trying to – remember, the goal was to try to almost retire the installed EHR program in favor of use the tools effectively, meaningful use, use the tools effectively to deliver the end goal, which is improved outcome. So we're trying to make that transition.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

I understand that, but it still seems weird to pay people as if – pay organizations for this, when in fact it can change, as I said. Or, in fact, they're not using – they don't have to spend the money on the tools because they're not actually using them.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well that's the assumption, is that we do have HIT sensitive measures. I'm going to go to the next person with a hand raised, which is Paul Egerman?

Paul Eggerman – Businessman/Software Entrepreneur

Yes, thank you and thank you for this presentation. My comments or questions relate exactly to what David Lansky just said and a little bit of what Judy just said. Which I look at this process and I understand why we're doing it, but it just somehow doesn't feel like it fits with deeming. Deeming is like a highly effective use of an EHR system and simply participating in a population health study does not, in my mind, make you a highly effective EHR user. And if you participate in your popula – and your patients are in the top 10 percent, it also doesn't necessarily mean anything about how effective you are using their EHR system. So my question is, does this really belong with deeming? Maybe this whole discussion belongs with certification and meaningful use?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Paul, could I just make one clarifying comment? This is Helen. We worked on the assumption, and Kevin may want to chime in here, that to be eligible for deeming potentially as part of this program you would have already demonstrated that you were a very high performer on those MU objectives. So, that would have been a given in the first two cycles, not that you wouldn't know that somebody was a highly effective user, that was a given assumption. And then therefore for Meaningful Use Stage 3, would you be able to move to a different level and not have to demonstrate that you could already meet, which for you was the floor.

Paul Eggerman – Businessman/Software Entrepreneur

It still strikes me as somehow not quite fitting with the entire deeming process. I mean, part of the challenge here is you're talking about sort of, I don't know what the right word is, like a collective, a statistical evaluation, a collective analysis among a large number – potentially a large number of providers. The entire Medicare Program takes individual physicians, it does not pay teams or groups. So the payment process is inconsistent with the concept of what an ACO is all about. But if you are going to be involved with deeming, it seems to be the criteria to be involved with deeming should show effective use of the EHR. And the way I'm looking at it is, if you simply – I don't know if I'm saying this right, but if you simply dump your data into some data intermediary or some ACO, I don't see that as necessarily deeming. And if you're lucky enough that somehow something about your population puts you in the top 25 percent, I still don't see that as necessarily an effective use of the EHR system. So I don't think it's one of the deeming criteria, so I think – that doesn't say it's not valuable, there are some valuable things here.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So let me try to put this in context, and I'm trying not to go completely in deeming discussion right at the moment. But, the assumptions, and I'll piggyback on what Helen said, one, we're not deeming any function or objective that has not already been tested in a previous stage. So, in our case, functions that would be eligible for being considered to be deemed would have been success – people would have already achieved, and you saw some of the graphs below before, that 90 percent use in a consistent way of some – of EHR function.

And then what we're trying to do is make the transition to encouraging both the development of tools and effective use of tools that would help us help providers be successful in the New World of an ACO-like world. That is, managing the health of a population and not just doing individual transactions with individual patients. So instead of continuing the approach of certifying and checking use of individual functions, we're trying to move towards assessing your ability to achieve good outcomes with the tool we've put in your hands. And so that's the thought behind deeming, which again I'll remind you, is an optional program. You can continue to demonstrate your effective use of specific functions in the EHR, i.e. what we've done in Stage 1 and Stage 2. Or, if you're already achieving a high performance or a high improvement rate, then we are assuming, because of the criteria you saw, that it is much – it's near impossible or too expensive to do all of this on paper without effective use of EHRs. That is an underlying assumption of the deeming concept and, if that's not true, then of course the whole concept falls. But it's one, we think you cannot be a successful provider organization without use of these electronic tools. And two, by definition as one of the criteria in this exercise we just heard about, HIT sensitivity is one of the attributes that probably needs to be a mandatory part of the criteria.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Paul?

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I think that's the problem – this is Neil. I think that's the problem with the exemplars, at least is that when you read through them, it sounds like a lot of things could be done without an EHR and I think that might be one of the things people are responding to.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

If that's true, then that should show up as red in the first column and probably, as I say, one of the feedback is to go back and say, okay, one of the critical tests, one of the critical attributes is that it be "HIT sensitive," and be pretty rigorous about that.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Is that going to mean – saying that they have to get through Stage 1 and Stage 3 then?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

They all have – by Stage 3, they all have to have gone through 1 and 2.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Okay, so that is the assumption.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

It is.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

And then the next question I have is, that kind of implies that Stage 3 won't have new things in it that would be really valuable for these folks to do. That Stage 3 is just, how are you doing on your quality indicators, but there can be some really nifty things that are in Stage 3 that therefore would not become more universal in our country.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, so let's make sure we understand two assumptions. One is that in order to do any future stage, you have to have passed the earlier stages. So in order to do Stage 3, you will have had to successfully attest to Stages 1 and 2. And the second is that deeming is an optional program. And the third is that deeming would only deem your satisfaction of a subset of the objective. So there will still be new functions that are introduced in Stage "N," in this case Stage 3. Those would, by definition, not be eligible to be deemed.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

What is the difference between deeming and scoring high scores on the KPIs that we already have in there that you do have scores on?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Right now, none of the CQMs – those are all reporting requirements, there's no performance requirement. As an optional program, deeming would allow people who are already performing well, under the assumption that it's pretty hard to perform well and not be using these electronic tools.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

I get that. But if in fact you're going to separate scoring well in healthcare from other places where you're using the tools, then deeming is just on those criteria – well anyway, I'm concerned can we really make a clear line there.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay. And have I addressed – I'm going to go to Christine next. Neil, does that help with your –

Neil Calman, MD – The Institute for Family Health – President and Co-founder

Yes it does.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, let me go to Christine then please.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So I – Helen and Terry, thank you very much for doing all this. I think it's directionally going in a great way. I had a couple of questions, but some of them might be answered if I could understand more what you envision as the next steps. Like do you envision if the committee asks you to continue in this direction, coming up with measure sets and are they based off sort of a series of exemplars? What would you envision doing next?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry. We are cognizant of the work that we didn't do that we were tasked to do, so if you went to slide 16, the recommendation for future work. We did, and not necessarily us, but somebody that we believe that we could get into that specific measures and cross-walk them for deeming. I do want to offer one thing about what Judy said. We did have this long dialogue internally where we believed our – we probably can't do part the deeming in steps, that they will have to stay as individual measures.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right. So I mean I think that's helpful. I think it's a challenge I think, and some of the discussion you're hearing on the phone is that deeming is fairly conceptual. And when you describe the concept, I think the Policy Committee in general has been extremely supportive because, and it usually always comes after we've had a big deep dive into meaningful use functional criteria and people feel like we're micromanaging provider workflows. And so then we get a lot of support for the deeming concept, but I think in the absence of the specifics of what measure could deem, which functions and what functions would be left, it's natural for folks to raise the questions that they are raising, and I think Paul's done a good job of responding to them. I think – so I had a couple of additional thoughts. One is, and perh – I think there's a big component in my view missing from the criteria, and that is reducing health disparities.

That was one of the big focuses that we had when the Meaningful Use Workgroup really started to look at how –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I'm sorry Christine, can everyone please mute your lines if you're not speaking? We're getting a lot of feedback. Sorry Christine.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No problem Michelle. So I think I would add in there, that there's some element to this that's missing and I don't know if it's in a criteria or if it's in an exemplar set. But we had actually kind of originally proposed that if you're doing a measure set, everybody also has to be reporting on health disparities, and they can choose whether they're reporting on race, ethnicity, language, gender, SOGI status, disability status, but they need to report at least a subset of the measures they're already reporting by disparity variable. So that to me was one thing I wanted to put back into the mix.

And then I wanted to say also that I agree very much with Terry, I think you raised this issue and it's on, I think one of your – this is on slide 15, are there times when deeming will be insufficient? I think part of what you're hearing today is, yeah, there will be times when it's insufficient. And I think to the extent that a criteria could be developed that specifically says that it – that the measure set, taken together, needs to reflect the full extent of any criteria that it is deeming. I think that would be helpful because it's hard to go on a – I think a one-for-one, oh, well this measure deems that function. But taken together, it would be pretty hard to perform on a lot of these areas if you aren't using clinical decision support and things like that. But then again, it's harder to make the argument that you can – that performance – or high performance is possible regardless of whether you are doing secure messaging, for example, or online access for patients and so those might not be deemed. So I would actually suggest a very explicit criteria around that as well.

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, and this is Helen. I think it would be fabulous to add the disparities focus to the population slide, I think that's a great suggestion I think it would really push home the importance of disparities in this quality work.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So as part of you're next – what you're going to bring back next time or earlier to the MU Workgroup is some more examples of measure sets that would fulfill your criteria?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

If that's the direction you would like us to take

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

It certainly would be very useful because as you can see, we're going to need those kinds of examples as we try to explain to the Committee in December, the deeming program. And I think actually having some more exemplars with this color code potentially with column 1 as required, would be very helpful. Because that will shape –

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Paul, this is Kevin Larsen, I've got another clarifying question. There were a lot of questions as well about which objective criteria this particular deeming set would potentially replace. Do you see that as scope for this Quality Measures Workgroup or is that Meaningful Use Workgroup activity?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

That would be MU. So the Meaningful Use Workgroup, which is why I think we need some early additional exemplars as soon as possible, because that'll feed into our discussions this coming month.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And Paul, I guess I'm not sure I agree with that. I think it – I mean maybe perhaps in terms of making the final decision, but I think it's really difficult to say to a group, come up with great measures that could deem functions without asking that group to tell us which functions got deemed, based on the measures they created. So I would much rather see a list of measures or measure sets and the functions that would be deemed, because they may be different in different measure sets, as recommendations from this group, that then the Meaningful Use Workgroup can work with as well.

Neil Calman, MD – The Institute for Family Health – President and Co-founder

Yeah this is Neil, I would agree with that. And also because part of this is simplification. So if it turns out that this whole process that we're deeming one or two things, but the process of deeming is so complex, we're sort of working against ourselves there.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Correct. Umm, if the workgroup feels they have – the folks are comfortable taking that on, that certainly would be welcome.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry, I think we could take the first cut at it. Obviously, the Meaningful Use Workgroup has more knowledge about the specifics. But we could say we believe that this will cover these five things or –

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Sure, so we would certainly be –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

I will say what's interesting though is that what you need to know is we didn't look at the measures and then try to come up with – we didn't drive it that way. We drove this from what do we think makes the most sense and then, we would crosswalk back into MU. We didn't look at MU and go – to address that.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Well I think that's the direction we wanted you to go.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And Terry, this is Christine. I think that's – yeah, exactly. And that's what we did when we tried to do the first cut in the MU Workgroup. So I think that's right on. And I really like the more person centered approach that you're taking.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

So I think, to answer your first question, and I think we're supportive of the direction you've taken, the initial way you're presenting it and this colorful matrix. And that we'd welcome additional suggestions in terms of where you think – what functions you think it would deem.

Paul Egerman – Businessman/Software Entrepreneur

Paul, can I ask a question?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Yes, I was going – yes.

Paul Egerman – Businessman/Software Entrepreneur

This is Paul Egerman. I just had a question on your slide, it's on the screen 16, where it says interoperability that matters, there are measures that depend on data from outside the current provider organization. Why do you require it to be outside the current provider organization, especially when you consider there are some provider organizations that are very large that are – that can occupy almost a good – a large part of a state, there are national provider organizations. Why is it a requirement to go outside the current organization?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So I'll take that. And I'm a little embarrassed because this is both sides of my mouth talking, is that we were cognizant throughout the workgroup of the problems that are confronting interoperability and the difficulty in really getting that picked up and used within the health IT systems. So perhaps we said this wrong, but we were really trying to say that, from a longitudinal population health perspective, we believe that interoperability is a critical component to address. And while I agree with you that the individual patient may, during their time period when they're enrolled in a large integrated health network may get their care predominantly there or perhaps all of it, at the time they leave that health network, they're going to need interoperability. So this was really our backdoor way to push on the interoperability need.

Paul Egerman – Businessman/Software Entrepreneur

And my response to that, Terry, I understand what you're trying to accomplish and it's interesting you used the expression backdoor. My suggestion is that you should be focusing in on the measures in the longitudinal and population health and that good stuff. But that's the primary goal. Your usage of the word interoperability, I might sort of disagree with what that is, but we shouldn't be trying to design measures that create certain interoperability capabilities, we should just design the measures and the deeming criteria based on what we think is the right thing for patients.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, and I would agree with you. And remember the ACO workgroup were members of this subgroup and they – their experience would say that even if they are in an ACO, they're still struggling with getting the data they need to track their members with appropriate clinical quality measures. So you're right, I don't think we disagree, it may just be the way we presented this.\

Paul Egerman – Businessman/Software Entrepreneur

Yeah, and to the extent that they have that as a challenge, I would suggest that it should be addressed as what we call a front door issue. Let's face it straight on and understand it and fix it as opposed to trying to say that this is somehow one of goals of how we design our future work and our future measures.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, any other comments? I think this has been a very rich discussion. Did you get your questions answered Terry and Helen?

Helen Burstin, MPH, MD, FACP – Senior Vice President for Performance Measures – National Quality Forum

I think so.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Okay, this is very useful work. We're going to depend on it, we in the Meaningful Use Workgroup, as we consider the deeming program. And appreciate the discussion from the committee because this is going to be an ongoing discussion and I think you've improve – you've added to our questions to consider as we try to propose this back to you next month. Okay. Well thank you very much, Helen and Terry. And look forward to hearing from you next month. And we're going to move on to public comment, if there's no other existing business.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Operator, can you please open the line? Sorry Paul, did you have something else you wanted to say?

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

Nope, that's it.

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay and just a reminder, if there are public comments, we limit public comments to 3 minutes. Did we lose the operator?

Caitlin Collins – Project Coordinator, Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the comment queue.

Operator

We have no public comments at this time.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation

All righty. Well thank you and thanks everyone for participating on this call. We had a few technical difficulties, but we'll be joining you back live and in person next December at the Crystal Marriott. So thank you all and talk to you next time.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you Paul.

Public Comment Received During the Meeting

1. Would the HITPC provide some insight into the timing of the NPRM for Meaningful Use Stage 3 and whether an additional 6-12 months will be added to Stage 2? Thank you.
2. Hello, this is Mike Schmidt from Medflow, a 2014-CEHRT vendor specialized for eye care. I want to comment on Information Exchange. The two use cases of Data Migration and Patient Portability are excellent and have our support, but another dimension to Information Exchange appears to have been overlooked: Specialty Data. EPs are required to exchange health information such as the Summary of Care record according to standards focused on primary care and which omit specialty data. Specialists should be able to demonstrate Meaningful Use while simultaneously exchanging a comprehensive record. Sending "parallel" records for the same patient or visit in different formats is very disadvantageous! The program could explicitly authorize data formats to be extended for specialties, subject to harmonization with the underlying technical standards (HL7 / IHE Health Story Consolidation). Specialty standards groups such as IHE Eye Care could be an excellent venue for creating such extensions.
3. Please review closely the legal ramifications of importing patient data that comes from a mass importation of data from data migration that may occur from vendor to vendor change. Even a small error can have severe patient safety implications and no automated process is 100% effective.
4. It is important to let patients know that their entire medical record might be hundreds of pages....even one significant encounter with long length of stay could be hundreds of pages. This is a difficult concept for all to grasp, but with the 2014 MU requirements we are learning why the practical aspects of data portability and migration are very difficult.
5. The most specific comment on the difficulties of achieving Data Migration or Patient Portability was listing multiple specialties whose data sets were not part of the 2014 data model. That is exactly our point: it requires extensions for specialties such as ophthalmology. The "base" standard should be "modular" so that it facilitates extensions. Extensions for specialties must be developed on a per-specialty basis, with the assistance of professional organizations. Eye Care is essentially "ready to go" since it recently developed an IHE Eye Care standard for a "General Eye Exam".
6. Judy is correct about the vendors needing to have 2 systems for CQM reporting: those using deeming for CQMs and those not using the deeming approach. Or there may be another requirement for those using a hybrid approach: deeming and not deemed CQMs.