



**HIT Policy Committee
Advanced Health Models & Meaningful Use Workgroup
Final Transcript
October 17, 2014**

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is the first meeting of the Health IT Policy Committee's Advanced Health Models & Meaningful Use Workgroup. 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'll now take roll. Paul Tang?

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

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Paul. Joe Kimura?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Joe. Amy Zimmerman?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Hi there.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Amy. Art Davidson? Charlene Underwood?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Charlene.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Cheryl Damberg? Devin Mann? Frederick Isasi? Ginny Meadows? Jessica Kahn? Lisa Marsch?

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health - Dartmouth College

Yes hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lisa. Lisa Patton? Mark Savage?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Mark. Marty Rice? Marty Fattig? I think Marty Fattig is on.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Marty. Mike Zaroukian?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Mike. Neal Patterson?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
Present.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Neal. Norma Lang? Robert Flemming?

Robert Flemming, MHA, MBA, PhD – Health Insurance Specialist - Center for Medicare and Medicaid Innovation

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Robert. Shaun Alfreds? Stephan Fihn? Terry O'Malley?

Terrence "Terry" O'Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Terry. And Terri Postma? And from ONC do we have Alex Baker?

Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology

Yup.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Alex. Samantha Meklir?

Samantha Meklir, MPAff – Senior Policy Advisor - Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Sam. Any other ONC staff members on the line? Okay, so now that roll is over, if everyone but Paul and Joe can mute their lines that would be wonderful.

Lisa Patton, PhD – Branch Chief, Quality, Evaluation and Performance, Center for Behavioral Health Statistics and Quality – Substance Abuse Mental Health Services Administration

Hi, Lisa Patton from SAMHSA, I just joined.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lisa, thanks for joining. And I'll now turn it over to you Paul and Joe.

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

Thank you, Michelle and thanks to everyone for joining our inaugural call of the new workgroup. Some of you were on the Meaningful Use Workgroup from the past, we've shaped this when Karen came in to focus...to join on a new focus. Well, it's actually we've been always focused on sort of new health models, but we've brought in some of the things that contribute to building the HIT infrastructure for the new health models, for example, including quality measures into this workgroup. So as you'll see from the charge and some of the things we have on deck as far as candidate things we would work on, it's very, very broad. So we may end up breaking up into subgroups as we've done in the past, in order to get some work done and then brought back to the bigger workgroup on its way on to the full committee.

So, I just want to welcome everybody and thank Joe Kimura for co-chairing this and I'll turn it over to him for any words that he wants to add.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah, no, thank you Paul. I just want to add my sort of thanks to everyone on the committee and share my enthusiasm and my excitement as well. I think we have had some very ambitious early conversations about potential areas that this workgroup can work on, and I think all of them are very exciting to me to be thinking about and to be able to contribute. So hopefully our enthusiasm will help us drive through and make a big contribution.

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

Great. Thank you. Why don't we go to the slide with all the member's names and wonder if we'd sort of do a round table just with some introductions; just your name, your affiliation and just a couple of things about your...either your role in your own organization or your role in the national scene in terms of the topics that you work on and your background. So it's just like a couple of statements, since we have so many members. Shaun, do you want to go ahead? Oh well, let's see, Shaun's not here so, are Shaun, Cheryl or Art Davidson here?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I think Marty's the first one that's here.

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

Okay, Marty, go ahead.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Marty Fattig you mean?

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

Yes.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

Marty Fattig, MHA – Chief Executive Officer – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Yes, okay, yeah, my name is Marty Fattig, I am a critical access hospital CEO and I've been on the Meaningful Use Workgroup since 2010. And I serve at a hospital where we have recently attested for Stage 2 of Meaningful Use, so we are a meaningful user and we have been on the American Hospital Association's Most Wired list 8 of the last 9 years.

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

Thank you. Lisa Marsch?

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College

Yes, hi everyone, Lisa Marsch. I direct an NIH funded research center called the Center for Technology and Behavioral Health which is housed at Dartmouth College. And which includes collaborators all over the world and focused on developing, evaluating and implementing various technology-based behavioral health interventions and working with various systems of care and implementation of those.

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

Thank you, Lisa. Ginny Meadows? And if any of you joined in between, please speak up.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Ginny's not on, she had an emergency.

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

Okay. Terry O'Malley, please.

Terrence "Terry" O'Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

Hi, I'm an internist and geriatrician at Partners HealthCare in Boston, Massachusetts and I was Co-Chair of the Transitions of Care sub-workgroup under the S&I Framework for transitions and then one of the leads on the Longitudinal Coordination of Care Workgroup. And I sit on the NQF Care Coordination Measurements Maintenance group. So, happy to be here, sounds like great fun.

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

Thanks, Terry. Neal Patterson?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Yeah, Neal Patterson, Chairman and Chief Executive Officer of Cerner, got all those titles by being one of its Founders. I have very few credentials, other than I desire to create a better alignment between healthcare from systems where the care is provided with the people that receive it and pay for it. So, I'm hoping we're in pursuit of an alternative to fee-for-service.

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

Thanks, Neal. Mark Savage?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Good afternoon, Mark Savage. I'm the Director of Health IT Policy & Programs at the National Partnership for Women & Families and was, until now, was on the Consumer Empowerment Workgroup, but glad to be joining this workgroup. Thanks, Paul.

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

Thank you, Mark. Charlene?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Charlene Underwood, I'm Government & Industry Affairs for Siemens. I've served for the past couple of years on the Meaningful Use Workgroup and coordinated the care coordination aspect of Meaningful Use.

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

Thanks, Charlene. Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Yeah, hi. Mike Zaroukian, I'm also coming from the Meaningful Use Workgroup. I'm a practicing general internist and Vice President & Chief Medical Information Officer at Sparrow Health System. I'm also Professor of Medicine at Michigan State. I work with a couple of different EMRs, one that will succeed with Stage 2 this year, one that will not, so that perspective might be helpful. I'm also trying to direct the formation of an ACO-type environment and I represent a few organizations, HIMSS Board of Directors, the International HIMSS Board, the CCHIT Board of Trustees and for the Association of Medical Directors of Information Systems, I'm on their Board of Advisors. So, I bring a few perspectives from that. Thanks.

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

Thank you. And Amy?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, hi, this is Amy Zimmerman. I'm the State HIT Coordinator in Rhode Island. I am sitting right now in the Office of Health and Human Services. I had been our state health department for many years; I'm primarily responsible for our Medicaid EHR Incentive Program, sort of also promoting the adoption of electronic health records and been involved for many years in our state health information exchange which is run by a state-designated entity. I work on our all-payer claims database and we're hoping to get a SIM Implementation Grant, which has a lot of HIT components and sort of integration of different state systems driving to support value-based care.

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

Thanks, Amy. And Joe.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah. So, hi everyone; I'm coming from Atrius Health here in Boston, Mass. I'm a general internist and also serve as the Deputy Chief Medical Officer here for our organization. Under that capacity I do lead our Analytics and Business intelligence Systems for the enterprise as well as our Quality Improvement and Safety Divisions and our Medical Education and Clinical Research activities. I was actually previously on the Accountable Care Workgroup and on the subgroup around quality measures. And Atrius, being a Pioneer ACO, I led our sort of 32 Pioneer ACO data analytics workgroups for the first two years that we were actually sitting around and sharing stories.

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

Wonderful. All right, thanks. Do you want to go on to the ex-officio members? Robert Flemming?

Robert Flemming, MHA, MBA, PhD – Health Insurance Specialist – Center for Medicare and Medicaid Innovation

Oh sure, I was on mute there for a second. Yes, I'm part of the Center for Medicare and Medicaid Innovation, I'm the project officer for several different demonstrations we're working on with primary care medical homes and the concept of value-based purchasing as well.

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

Great, thank you. And Sam?

Samantha Meklir, MPAff – Senior Policy Advisor, Office of Policy – Office of the National Coordinator for Health Information Technology

Hi, my name is Samantha Meklir; I'm in the Office of Policy at ONC. And I believe we also have Lisa Patton, who joined later, Paul.

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

Okay, thanks. Lisa, why don't you go ahead?

Lisa Patton, PhD – Branch Chief, Quality, Evaluation and Performance, Center for Behavioral Health Statistics and Quality – Substance Abuse Mental Health Services Administration

Thanks Sam, nice to hear your voice. Yeah hi everyone, I'm Lisa Patton. I am the Branch Chief for Quality Evaluation and Performance in the Center for Behavioral Health Statistics and Quality in SAMHSA. And so I've been leading SAMSHA's work around behavioral health quality indicators, measure development and implementation and working on the National Behavioral Health Quality Framework. And I work closely with the folks doing the Health IT Initiative at SAMHSA. So, glad to be here today, thanks for the invitation.

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

Thank you. Alex?

Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology

This is Alex Baker; I'm with the Office of Care Transformation in ONC and previously helped to support the Accountable Care Workgroup.

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

Michelle?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Oh, they know who I am. I'm Michelle Consolazio, I'm the FACA person.

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

She runs the place. She's a big boss. So why don't we...speaking of Michelle, why don't we go on to review sort of the operating procedures for work on the FACA committee. Some of you...many of you have participated on this before, but why don't we go into some of the operating procedures, some of the guidelines we have, Michelle?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thanks, Paul. So first of all let me thank everyone for volunteering to be a part of this workgroup. We know you all are extremely busy people and we can't thank you enough for donating so much of your time to help us and give us advice. Hopefully this will be fun for you, at times there will be a lot of work, but we want you to understand how much we appreciate you volunteering your time.

That being said, as part of the reorg, we've also started to implement standard operating procedures for all of our Federal Advisory Committee members and workgroup members. So we just want to make sure that our workgroups are as active as possible and that we are getting the advice and guidance that we need from our workgroups. And in order to do that, we're just hoping that you all can actively participate and stay engaged in meetings, making sure that everyone is prepared.

We need to do our part to make sure that we get you materials in time, so that you have time to review them before the meeting. And then once we do our part, we're hoping that you'll do yours and review materials before the meeting.

We also have implemented a policy on missing meetings. So in the past we've had a few problems with attendance so there will be a summary available after each call and in that summary will be the attendance status for the workgroup. So it will be shared across the workgroup so we'll know who's attending and who's not. If attendance becomes a problem, we may have to ask a member to be removed from the workgroup. So, something we definitely don't want to do, but again, thank you all for volunteering and we greatly appreciate it.

I think the next slide might be mine as well...Paul, I don't know, Paul mentioned this earlier, but as part...when Karen came into office, we decided that we wanted reorganize our workgroups to better align them with the strategic priorities of ONC. So in doing that, we have a number of new workgroups and these are the workgroups. I won't read them to you, you all can read, and these are the Chairs of those workgroups. But we really are using this as an opportunity to re-enliven, rejuvenate and gather greater perspective across the country and learn from all of you.

So thank you again and I think that is my last slide and I can turn it back to Paul.

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

Thank you, Michelle. So just to keep a clear conscience, if you weren't given informed consent when you were asked to serve on this workgroup before, just wanted to let you know, it's a lot of work. In return though, it's very meaningful in terms of the contribution that the FACA committee makes and these workgroups make, because a lot of the work, obviously as you know, happens at this level and in the subgroups of the workgroups. So, it is a lot of work, but it's definitely not thankless in the sense of so much is made of it, ONC, CMS, HHS really listen to the advice. It doesn't mean they have to do everything, but they really respect the advice that they're given, so thank you so much.

Next slide, please. Okay actually this might have been one...

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Sorry, just one more in the section about the information flows if you want to touch on anything here.

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

Yeah so Michelle, do you want to cover this or?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Sure, I'll go through it and maybe Paul you can interject if I forget anything.

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

Sure, absolutely.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

So, when the Health IT Policy and Health IT Standards Committees were set up, they were set up so that the policy would essentially...Policy Committee, I should say, would essentially provide us with what we want to do and the Standards Committee would help us figure out how we're going to do it. So typically the workgroups underneath the Policy Committee is really where the work gets done. The workgroups will present their recommendations, usually working towards recommendations though sometimes we may just be working towards commenting on a Rule or identifying tools or needs that are currently missing in the field.

But when recommendations are brought forth, the workgroup will present to the Policy Committee. Typically we present draft recommendations first and then we'll come back, update the recommendations at the workgroup level and then have the workgroup Chairs come back to the Policy Committee and have their recommendations hopefully approved. And once recommendations are approved, they get reviewed by the Chairs of the committee, Paul and Karen, and then a letter of transmittal is sent to the National Coordinator. You can find all of the past letters of transmittal on the HealthIT.gov website, if you are interested to see the enormous amount of work that the committee has already done to date.

So once a letter of transmittal is sent to the National Coordinator, the National Coordinator will then identify what work may need to be done on the standards side and then will charge the Standards Committee with coming up with the standards or whatever it may be that needs to happen on their side. And so then the workgroup on the standards side will get charged with that work and depending upon what their recommendations are the same process will follow; workgroups bring it to the committee to get it approved and once approved, they could be sent to the Secretary for implementation.

So, that was a very high-level, quick overview, but hopefully I didn't miss anything and Paul, you've been deeply involved in the process, so, hopefully you can interject if I forgot something.

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

No, sure. Thank you, Michelle. As Michelle mentioned, these are two FACA committees, Federal Advisory Committees that were set up in statute in HITECH. One thing to emphasize on here is you see the public input; this is so a FACA committee has to be open to the public at the committee level. In addition what we've done is we've opened up all of these workgroup calls to the public as well, so that's just going beyond what's required.

In addition, in the past, particularly in the Meaningful Use Workgroup, as you know, in rulemaking there's a Notice of Proposed Rulemaking, public comment before a Final. We've even introduced additional public formal comment by having things like an RFI, information or request for comment where it's essentially been almost a pre-NPRM. So there's been an enormous attempt to make sure that the public has adequate hearing about what's being contemplated and what's being deliberated, as well as having formal input. And all of that input is read and summarized and goes as input into the deliberations of whether it's the workgroup level or the committee level.

We've had vigorous participation in the past, particularly around Meaningful Use, meaning several hundreds of comments by large organizations. So this has definitely been one that has been out in the public and had the benefit of all the public input. Any questions on this, the process, for folks who might be new to this? Okay, let's move on, please to charge.

All right, so as I mentioned, the Meaningful Use Workgroup always has had as its guiding principle, we're not looking...just like we're not looking at an EHR to computerize the paper of the past, we're also not looking to just computerize and support business as usual. We're moving towards the advanced health models that's much more in the accountable care arrangements, I'm calling it that so it's not just the ACOs, the federal ACOs, but it's really doing value-based purchasing or really delivering value and health as a goal rather than just sick care and just doing transactions.

So what does it take, what's the HI...what's the information support? What's the HIT support for that information so that we can operate in the new models of health and healthcare delivery? That's really the reason for changing this name. And what are all the components. As I mentioned, well, there are EHR components, there are broader HIT components, there are things that support consumers and caregivers. There are quality measures for us all to be measured against things that really matter, matter to the consumer, matter to the patient, the caregiver and matter to the provider. That's sort of a new orientation if you look at where we have been in the past.

So our role is to make recommendations to our head committee, the HIT Policy Committee on the policy issues that would support operating in this new paradigm. It's outcomes-focused and its value-based, in terms of payment. Next slide, please.

So what we want to do is we don't want to start from scratch, there is an enormous amount of work that's been done since 2009 by a number of workgroups, a number of committees and we want to leverage that, including sister committees. So for example, National Committee on Vital and Health Statistics is a sister FACA committee that is mentioned in our statute that we need to coordinate with, and we'll be hearing from them in November.

So what are some of the relevant workgroups in the HIT Policy Committee that have talked about topics that we're going to concern ourselves with? Well, they include Meaningful Use Workgroup, the Quality Measures Workgroup, Accountable Care Workgroup, Data Intermediaries Tiger Team and the IOM work on social determinants of health. We're introducing that concept because again, when you switch from paying to do things to people, particularly when they're sick, to one where we're managing the health of a community, it goes way beyond just sick care. So social determinants are an important attribute of a population and an individual, as well as a ticket to better health and well-being; so that's the reason we're emphasizing that as well in this workgroup.

So we also need to coordinate our activities with other workgroups that are working in parallel to us, such as Interoperability, where are we going to get the data if it's not coming to us electronically? privacy and security, consumer and caregiver perspective, the standards work that's gone into data capture, access framework, clinical quality framework and governance. A couple of these topics we heard in detail earlier this week. Next slide, please.

So I'll mention...so what we're going to do is just get a very high level, go over some of the related efforts that have already been done by other workgroups and we will have an opportunity to get more detailed briefing as this workgroup needs or requires or requests. You're going to hear more towards the end that we have a very aggressive agenda ahead of us with a number of almost pre-determined deadlines. They're predetermined because they are things...we support HHS and ONC in particular and they have a number of deadlines, like the Federal HIT Strategic Plan, like the Interoperability Roadmap, that we need to provide input into in a timely way. So that's going to guide our work plan as you'll see towards the end.

So we want to do a lot of the prep work up front, and so we'll be asking you for what more detailed briefing you'd like to have, as we prepare to start doing the actual work against these deadlines. So the first relevant output is from the Meaningful Use Workgroup. As you know, it dealt with all the Meaningful Use categories, but there are some that pertain specifically to what we want to do in supporting the advanced health models such as care coordination, public and population health and patient and family engagement. Those are key things, a lot of which were not necessarily there in full force in the existing EHRs or the HIT infrastructure that we've over the stages, particularly 2 and moving into 3, tried to bolster.

So we will be shooting for what data? What information? What HIT infrastructure is needed to get data to move amongst...wherever the patient goes and in a way that care can be coordinated. So as an example, a shared care plan, the topic has been raised numerous times, not only in the Meaningful Use Workgroup but in others. It seems like if we're going to coordinate care, we need to have a shared game plan, so that's going to be probably one of our projects that this group undertakes, working along with other workgroups and other organizations to try to catalyze the work on a shared care plan, because it almost doesn't even exist in the real world and the electronic support of that.

Things like electronic notification, how can you keep track of your patients, your panel, your population if you don't know where they go? And how can we be more timely in our interventions to help meet them where they need us, not just when they walk in our four walls? Patient engagement through the VDT; we really, I think, made a major step forward in unleashing this information about them to the people the information concerns. So that's been a very gratifying experience. And how can we move more towards working on evidence-based practices through using one of the most powerful tools in these systems, clinical decision support?

So, there has been, I guess, logged over 125 meetings, public meetings, to discuss even Meaningful Use Stage 3. As you see a list of hearings, we covered a number of topics and all of those we have access to, it's on the Web, and we can bring any more detailed briefing that this workgroup feels is relevant. Next workgroup we're going to talk about, Joe's going to talk about the recommendations that came out of the Accountable Care Workgroup. Next slide, please.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Thanks Paul. Yeah so in the Accountable Care Workgroup you're going to hear, I think, similar themes that Paul had touched upon in the MU group and in general sort of at the top level. Understanding and recognizing that accountability within sort of complex delivery systems and communities really required people taking sort of ownership and responsibility with that accountability, needed to have information exchanged as fast and quickly as possible. So the four areas that were covered and recommended hit upon that.

The first obviously being exchanging information across the healthcare community, talking again about ADT exchanges for value-based purchasing programs. Again, thinking about giving more guidance around sort of how we can electronically share discharge information. And again, sort of in terms of trying to figure out how to help ACO partners sort of be encouraged to be sharing this information as much as possible.

As we talked about that and sort of went further into the accountability and portability, clearly there's an element that thinks about that the information again, the value of that information to improve health and healthcare was really critical and the accountability models that we were starting to see, the fragmentation was starting to be a problem in terms of really being able to match performance of an organization with the accountability measures with the measurement cycles that were being sort of introduced in many of these contracts, etcetera. So, I think, again, thinking about portability through for population health management as well as data standards I think we very important and again, from the vendor's side, to be able to sort of ask and to require folks to be thinking about that portability in a more robust way. Next slide.

And sort of continuing in the themes, a little bit more targeted around clinical use, again, so the concept around care plans and continuum of care being really important and how do we actually take this information that's being exchanged and driving change in improvement at the point of care? How do we accelerate some of those things as best as possible so that it's not information falling on deaf ears, but really driving improvement around patient care for sure?

And finally we talked a lot about the fact that again, with these larger scale communities with lots of organizations participating to try to improve care for a population that again, the exchange of information from the claims side again offered opportunities. And a lot of organizations and states were starting to invest in all-payer claims data and recognizing how claims data, and other data sets honestly, could be leveraged to help an organization or a community really elevate its performance in accountability. How do you actually help get that information organized and streamlined in a way that the groups could actually really start to take advantage of the information to translate that into action? And there was plenty of conversation around how we do that, how we can sort of standardize some of these data elements.

And again, I think these were pretty similar and definitely overlapping with many of the themes that Paul had mentioned before. Again with the bent that accountability was the key sort of element that added an operational reality to some of the points and recommendations as we thought about the health information that was required, fully knowing that there would be measurement at the end of some measurement period and then consequences to that measurement was what put sort of a finer point on some of these recommendations.

And I think as we move from here, the subgroup then focused on one particular area of measurement which was quality measurement. And I think the next two slides go into this a little bit. And this subgroup merged and talked through a fair amount of thinking about so in the community-based or the future state of value-based purchasing that the construct of measurement and the types of "quality measures," and quality was defined pretty broadly to include the spectrum of value; patient experience, quality as well as medical expense management. And thinking about how do we capture this more robustly going forward.

And I think the bottom part of this chart sort of captures some of those buckets and tries to sort of say there are things that we do a pretty good job on, in terms of trying to measure process wise. But then ultimately we want to challenge the framework to get even broader, particularly thinking about those things from the population perspective that Paul had mentioned, saying there are constructs around the social determinants of health that we know have an impact not just on individual patient health, but for community health and community well-being and those have clear repercussions on some of the classic measures around patient experience, utilization and expenditures.

So trying to elevate the model and broadening out the thinking as to what are we trying to really optimize, not just the classical process measures or intermediate outcome measures, but really trying to push the frame a little bit more was the vision that was proposed. And I think the next slide gets into a little bit more detail here, where again classically there was a recognition that the science of measurement and the science of really being able to capture value across the continuum, particularly when being elevated to the point of accountability.

I think there was a recognition that there was a lot of work that still needed to be done to help guide that...the maturation of those kinds of measures. And I think again here, thinking from the bottom and going upwards to saying there are lots of process intermediate outcome measures that can get measured and used pretty classically across the country. But as you go upwards in this scale and try to say, is there healthcare or delivery system type outcomes as opposed to community-based outcomes around health that we are really trying to look at.

And how do we use that framework across any population and trying to be as agnostic as possible, whether it's the elderly population or the ACO for CMS versus again, a pediatric population or populations defined by diseases or condition states. And really trying to push to say that the framework around accountability for the future state of value-based purchasing had to really try to take into account these elements around functional state, understanding about shared decision making, fully recognizing the role of shared decision making in all the other metrics, coordination of care, efficiency, safety and then clearly prevention, in terms of healthcare.

So again, not a full, comprehensive list, but I think it was a framework that was proposed to sort of to really push the thinking outside of existing quality measures, to try to provide some guidance and directionality to where we thought quality measures should be going, particularly if we felt that value-based purchasing and accountability were going to be the way that we were going to be delivering care in the future. So, I think those were the two slides there, I think there's a final slide maybe around final QM recommendations. Umm...

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

Sure, oh...

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Go ahead, Paul.

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

So, from a quality measure recommendation highlights, it focuses around key measure concepts that Joe just talked about and its focused a lot on these new kinds of delivery mechanisms, new kinds of models of care, not the old process measures. So that's where we're trying to go away from and work more as in the next stage of measures might be something I refer to as measures that matter. Matter to whom, matters to the individual and their caregivers and I think in a derivative way, then matters to the providers and the healthcare professional team. So if we focus on what does matter to them in their daily life, their functional status, their pain, how they improve over time, that I think will be more meaningful to the individuals.

So one of the ways, as you know there's a pipeline of measures and there has been a long history of measures. A lot of them have been limited to what you get out of administrative and claims data, just because that's what was available. In the new world we're now over half of providers and hospitals have EHRs, we should be using more of the clinical measures and with the patient portals, more patient reported outcomes. So, how do you jump start that process and put measures in the pipeline for this new kind of measures that matter?

That's why one of the recommendations that came out of HIT Policy Committee to CMS, and we're waiting for how they rule in their NPRM for Stage 3, is to have an innovation pathway. A separate way that when individual organizations have a way of coming up with measures that may not already be NQF endorsed, but is meaningful to their population or to their provider or to their communities, how can we make that more visible?

So one of the proposals was that you have a waiver; let's say there are six quality measures, CQMs that you had to report on, let's say you got a waiver for one or two of the ones that are required in return for you putting forth something that you've already worked on, developed, implemented and has provided benefit to you. If you're willing to share that and share the specifications for the numerator, denominator, etcetera, then that...our proposal is a way of getting you to substitute for one of the core measures that already exist; that was our proposal in order to have people submit their more innovative measures, measures more that are meaningful to individuals.

Want to keep working on the established criteria, emphasizing the ones that are patient...I'm getting a bit of an allergic reaction to patient-centered because I think as we moved from healthcare to health, we should move from patient to person; so you'll see me sort of stumbling over the old vernacular. But in terms of watching out for a person's overall health, longitudinal health from their early years through their older years, want to track how people are adapting health behaviors, for example, not smoking, participating in exercise, eating healthy foods, etcetera. That's a lifelong sort of a mission. And so our goal is what is the health IT infrastructure needed? And that's a very broad term; the standards, the policy, the culture that's needed in order to support the goals of an advanced health system.

So we're going to pause now, and I know we've been talking...well, I guess, let me give one more which is sort of the guiding principles, next slide, please. It's very similar to what we took with the Meaningful Use Workgroup, let's focus on the future, which are the advanced health models of the type of accountable care arrangements, medical homes, bundled payments, all the things that put a provider more at risk for the overall outcome of health, for not only an individual, but a community rather than just focusing on the processes that happen one at a time for each person that comes to see you.

That we put people and family's front and center as an equal partner on the health team that is responsive for that. That we look at not only the medical sides of an individual, but the social determinants that we all know affect both the long-term outcomes as well as the shorter term health surrogates. And there are ways that we can collectively work at that at the community level that is far different from just working at one patient at a time in an office.

That we look at how do we work together. We use the term accountable care communities instead of accountable care organizations. Right now we somewhat ironically we have standalone organizations within a community that end up competing with each other, even though we should have a common goal. It's interesting, Marc Probst, a couple of days ago, was mentioning we shouldn't be competing on data. So that's the name of the game here; we're providing the infrastructure so that we can share the data in order to achieve health outcomes at the community level.

So how do we not...even as we look at the future, don't lock in any one style, any one model, but how do we support an evolution of ways of improving health better and better. You have to look no further than the current Ebola crisis to know what can we do with information, what can we do to support each person in an ER, on the plane, so that public health matters can be brought to bear and can be just another part of everyday life in the professional life as well as the consumer life.

And what can we do? We can't...right now we're a Federal Advisory Committee. We need to focus on policies that the government can do. A lot of our attention, as we talked about a couple of days ago, more and more, just like we have global health and not just individual health, we need to be working both in the public and the private sector to get our jobs done. So what are the policy levers we can apply that jointly in the public and private sectors we can work on together and throughout the agencies within the federal government?

So a sorry for the long introduction, but we wanted to sort of have a level playing field of information and sort of history as we bring this new group up to speed and let's pause now and get your comments, feedback, questions before we move into more of sort of the future work for this group.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Hey Paul, this is Mark Savage...

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Hey Paul...

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

So I heard two voices, go ahead. Who was the first voice?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Perhaps Mark Savage.

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

Go ahead Mark.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

It seems implicit, I wonder if it's worth lifting up, there is diversity among the patient populations across the United States, different models serving different populations in different ways and I'm wondering if, we at the National Partnership have sort of thought about as a design principle to recognizing that we're designing, we're making recommendations for diverse patient populations. And I'm wondering if that is, it seems implicit in several of the principles, I wonder if it's worth articulating that explicitly or whether it's sufficient as it is?

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

So let me make sure I get your point that we design for the diversity of people in the country?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

No, that these are not...we're not sort of recognizing the complexity in a homogenous population, that we're actually trying to build systems that will work...a system that will work well for one population in one part of the country and will work well for a different population with different characteristics in another part of the country or a different age range.

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

Right.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Just recognizing that we are not trying to have one-size-fits-all.

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

Okay, we can include that perhaps in guiding principle number 2, recognizing diversity.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah, sort of robust and agnostic is what I'm hearing.

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

There was another voice...

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College

If I could just add...

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

Sure.

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College

Could I just add to that briefly? This is Lisa Marsch. I think that's an important point and I think also its relevant surely to the selection of the measures that we're going to be discussing, to ensure that they're appropriate for that diverse sampling.

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

That's a good point and just for your knowledge, part of the recommendations for Stage 3 was to report, you know how you have CQM reporting, to report against...choose one CQM and report against disparity measures. So that's an example, sorry.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

So Paul, could I just add another area...

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

Sure, go ahead.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Sure. So one question relates to patients and families and communities, I wonder if there's been discussion or we could ponder the notion of patients and families as accountable partners in this process, just thinking about how to try to move the engagement to the various tools that help in that regard including having some skin in the game with regard to their overall care through the continuum and their participatory decision making and then follow up from that.

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

Okay. We probably can add that to one of these, either one or five or something like that. Thank you.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

The second one, if we added just sort of accountable partners or partners with...yeah, thanks.

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

Got it. Thank you.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

This is Joe, would you push that further to talk about just basically you're trying to align everyone's sort of accountability motivations across the spectrum, in the entire community. I know expanding the patients and families is one, but sort of really trying to ensure that everyone involved in that community has that alignment. Is that too much to expand or just specifically patients and families?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

So this is Mike, I would certainly support that as well and that was part of my intention. Thank you.

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

We also now have a tool, if you see on the Web, in the upper left, there's a hand...a little guy with a hand raised, if you use that, then I can call on you instead of having voices all over. Any other comments about what we've covered so far, sort of the background material and the guiding principles going forward?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

Yes, hello. Can you hear me? This is Norma Lang.

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

Hi Norma.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

First of all I'd like to say that I've been here since the beginning, but I've been hassling with the operator to be able to be sure I could be heard and I finally am, so thank you for that. And maybe you could list me as present. And I also would like to ask a question, is there any idea that there might be anything dealing with costs or charges or anything with these kinds of measures or is that a whole different ball game? You know, when we talk about patient accountability, etcetera, it sort of strikes me as patients are pay...and people are paying more and more in terms of costs and sharing and motivating factors, etcetera and I just never see anything dealing with that in all of these measures and all of these discussions of quality and value.

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

That's a good question, let's see, how is that...so it may be missed in these princip...so we should incorporate that somehow. Good point.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

Well if you're talking about value...

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

Exactly.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

...and value does come along with some measurement, I think.

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

No, you're right; I can't find it in these words right now, but, so thank you for bringing it up.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

Okay.

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

I think Charlene has her hand up.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Okay, I unmuted. I was on a call the other day with the Medicare Innovation Center and they talked quite a bit about some of their experience with the different care models and different payment models and I just wonder, in terms of this is the background material, if at some point we should coordinate to them to some extent to see maybe what some of their findings and learnings might be and if that would inform some of our recommendations.

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

Good, thank you. Mark, is your hand back up?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

It is.

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

Go ahead.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Wanted to come back to I think it was Mike's point about the accountability and to check to see if it was accountability in particular or if it was even broader than accountability to engagement...so, which could reach...anyway, I see that as being an even broader concept, but an important concept as well.

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

Okay, any other comments? I don't see any more hands.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Paul, this is Amy, I think I just tried to raise my hand.

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

Okay.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

I think it's implicit in some of this, but I think it's important to also in the guiding principles continue to think about how to, in an accountable care community, weigh how to leverage and build on what's already in place in communities. And I guess what I'm thinking of is whether its data that's already being collected in non-clinical settings or HIEs, but just to really be able to not always...to really be able to somehow in our thinking, and it will be variable, it gets into that sort of...you sort of almost hit it with if you have your own measures, you can propose them.

But, I just think as a guiding principle it's really important as we move forward in this and we're moving to more advanced care models that we think about how to build off what a community may already have put in place, to the extent possible, in moving ahead. And that could be applied to a lot of different scenarios.

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

Good point and you'll hear us talk about that as we talk about like a hearing to see what is going on.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, or even with alignment of measure, I mean this is...you've talked about sort of aligning the measures...

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

Right.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

...but again, I think it's sometimes helpful to just remind people and be explicit, because I think we have the tendency to sometimes try to think out of the box and new, which is very, very important, and I'm not saying we shouldn't, but we want to do that in the context of what we have in place.

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

Great.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Makes sense.

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

Anybody else? Okay, so let's get on with the work that we have in front of us. We'll begin with, Joe's going to talk about sort of vision for advanced health models. Next slide, please.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah, so I think what I thought may be helpful for us is to begin such that the entire workgroup can begin to paint some sort of concept model in our minds that we all were envisioning. And part of this is a little bit of the Lake Wobegone effect, doesn't mean we start thinking about, is there...if we were all to envision this accountable care community of the future in a generic state within our country, what sorts of capabilities and performance characteristics will this community have?

And if we were able to start to paint that picture of the accountable care community, then think about the gaps that we have between our existing communities and existing infrastructure and this future state community we all envision. And think about that in terms of how then would be the number one, number two, number three, number four priorities that may help steer the work and focus the work of this workgroup as we go forward and see whether or not that construct makes sense for us.

And I think the conversation we've been having over the past couple of minutes, the concept of an accountable care community that's inclusive of multiple organizations, governmental agencies, employers, health plans, hospitals, everyone together that is trying to optimize patient, person, consumer and community health is, I think, the high level construct. But as we pushed that concept a little bit further, we started talking about these incentive alignments that I think we just touched upon also, not just for each one of the members of the community, but also as the community as a whole to try to really drive for, to continually improve patient and community health.

And I think the themes that have come up from the previous workgroups, one of the major ones was that, again I think that Paul also mentioned from Mark Probst that the idea that we're not competing upon the data itself and actually competing and encouraging each other to improve care across that entire continuum of care. And in this fun, Lake Wobegone sort of scenario, that information gaps no longer were the root cause of inefficiencies in effective patient care and that everyone would be using innovations and improvements...will be promoting, excuse me, innovations and improvements to continually discover and test better ways, within their own systems and collectively, for the community's purpose.

So, A) I'd love to hear the workgroups sort of concepts of, do we think we can paint that picture of an accountable care community. And using that construct to help prioritize and frame up and maybe provide some structure to areas of focus as we go forward in the future for the workgroup. These are suggested bullet points that aren't by any stretch of the imagination sort of comprehensive, but can we imagine something like an accountable care community? What are people's initial reactions? Don't like it, like it? Is it too abstract?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

So...

Terrence “Terry” O’Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

Hi, this is Terry O’Malley. Sorry, I don’t have my computer going.

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

Okay. Okay, go ahead Terry and then Mike’s up next.

Terrence “Terry” O’Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

My apologies, Mike. I think the concept is a great one, and the reason I like it is that if you think about any community, you need a bunch of shared infrastructure to make it work.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yup.

Terrence “Terry” O’Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

And you need a form of governance to make it work. And I think those are two really critical criteria for our community and if you think about the shared infrastructure, I think we’re talking about how do we move information around efficiently? And how do we standardize it? How is it interoperable? Getting back to all the other principles that we’ve used before, but around the issue of governance, I don’t...to my knowledge I’m not sure we have structures in place in real-life communities that represent sort of the level of governance around healthcare that we do, for example, around the level of road maintenance or local government. So, I think we’re going to need new structures in healthcare that are really local governance structures so, those two thoughts on that.

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

So Joe may I...I wonder if right now you’re asking for comments on the vision. We’re going to go into specific areas along the lines that Terry was just mentioning, after we...a little bit later. So, are you asking just about comments on the vision?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah and the concept of the vision; so we can shift to the next slide that sort of says, when we distilled everything together, I think there were some common themes that had popped up as potential for steps around sort of the focal areas of data sharing across the measures that really sort of help this space. Clearly the tools around patient and population health management and then a little bit more around the payment models and supporting of the payment models. So, again, I guess the collective response of saying, if we are envisioning a future state of an accountable care community, and I think it was Mark that said sort of the governance structure and the data infrastructure points, I think they fit into these four areas, but sort of we were trying to push to say, can we come up with one to four areas that have enough meat that seemed like they were the most important first and second, third thing and fourth things to be working on as a workgroup. This is, I think, what had come up or was distilled through the workgroups before in the past, so it made sense that this kind of fit together here. And so Paul, I'm thinking can we get some reactions to these four areas?

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

Well, let's go one...let's do this and then we'll do one more slide because it will have some sample of what we're talking about and then we can ask...we'll plan to open it up.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah, so there...

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

Why don't we...so, first off, so the four things are making sure we get data across wherever the patient needs it to be, that we measure ourselves for care improvement, that we support population health and that we have a way to support the new...not only the new models, but the new payment models. So along these four dimensions, if you go to the next slide, are some sample topics; and this is where I think you're going to see some of the things that probably people are thinking about.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Okay.

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

Under data sharing we have, I don't know how readable it is, but it's the notification services, so you know where people are, that we have data from not just one EHR but from many data sources and that we are transparent about the performance measures. Not only around the clinical quality, but actually quality about your exchange of information; David McCallie mentioned that a couple of days ago.

In the measurement side, these are just sample agenda topics, we could be talking about what measures that matter to people, like patient reported outcomes, to communities, to clinicians and it's a real win when you get common measures that matter to all three is when you get the most bang for the buck. Measures that encourage collaboration across the organization and that have data standards that support really semantic interoperability.

Tools and services like decision support, whether that's on the clinical side or as Norma mentioned, including the cost sensitivity both from a consumer point of view, but also from a clinicians point of view, as you're making treatment suggestions or recommendations. That we go after this shared care plan that helps us coordinate across boundaries, across specialties and certainly with the person and family. And that we have population management tools, not just sort of the retrospective kind like, well how did you do last year, but really we talked about, in the Meaningful Use Workgroup, like a real-time dashboard, every day you can say, how's my panel doing today? How are the people that I'm going to see today, what can I do to improve their health? Dealing with mobile devices and health at a distance, telehealth.

And finally the data infrastructure which are the models that give us the ability to combine both clinical, administrative, claims and patient reported outcomes all together so we can optimize what's best for the individual. The infrastructure collects social determinants; that's something that doesn't appear in our EHRs today. What about the all-payer databases that we talked about? Not just an EHR, really broad electronic information, HIT more broadly and the vision around what would it be to have a person-centered measurement infrastructure across disease states, across settings, across state boundaries and across the continuum.

And I notice that this hasn't yet touched on what Terry was mentioning and what about the governance around this? Now, to let you know, Terry, to sort of reassure you, governance is a top priority. We spent actually a whole day on it...it was included in our whole day proceedings a couple of days ago, and is being considered in the...there's an Interoperability and HIE Workgroup. So, there's a workgroup that is including those elements that you just raised.

So now a little bit with more drill down, building upon the vision that Joe started with and the four key topic areas, let me go back to the hands raised and maybe you can see some of the candidate things here as you weigh in on, hey, these sound like the appropriate topics or this topic I really hope that we cover, etcetera. So Norma was first up on the list.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

Hi, thank you. A question from the last slide and this one, but I think I can combine them. When I worked with the group that had quality measures in the last period of time and we kept coming back to the fact that we could only deal with those things that dealt with eligible providers, is that still a limitation that it really means hospitals or doctors who are being able to be paid? That's one question, because we then have a really hard time going out to data that really affects patients that deal with long term care, primary care, the community based care, if that is the case.

Also, our comfort level with dealing with single medical diagnosis in our database is pretty strong, even going to the repositories. As you try to move over to health determinants and other parts, we're going to need to have some experience with doing that and I hope we have some innovation there. And then my last comment, which I think deals with that is, we are very short on dealing with the complexity that people really face out there every day, both I think clinicians face that as they're dealing with people, but people really very rarely show up with one problem. I mean, it's nice when you can get a knee replacement and get all the data right out there and do the comparisons, but most of the people and the older you get, I'm finding that out every day, the more you collect a number of problems. And so I'm hoping that those things can be dealt with.

And of course my final thing is I am really representing nurses who, the 3.1 million give an awful lot of care to an awful lot of people who have been pretty much disassociated with the electronic system. And I even think our Ebola episode has almost demonstrated that sometimes the other healthcare clinicians and providers are not really in the real database. So those are a number of things together, so thank you.

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

Thank you, Norma. I'll just answer your first question that was a question you posed. No, we aren't dealing only with eligible providers, yes the Meaningful Use Program itself covers only the eligible providers, but thinking more broadly about HIT policy, as you know, there's a voluntary certification program that's being proposed for the non-eligibles; so the answer to your question, which I think will be an opening for others, is that no, we're not only dealing with the eligible providers. Next on the list was Neal Patterson.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Thanks. I raised my hand way back when Joe asked did we think that the envisioning this all at the community level was the right kind of core vision model. And I'm not sure I totally agree with that. The only thing at the community level, for the most part, the only thing that the community level that has agreed to share systemically has been blood banks. And so we do have a fragmented, competitive delivery system, so I don't think, unless we're planning on creating a single payment, I mean, using the UK model and saying, here's a population of people that are registered with these general practitioners and here's your budget. So, I'm nervous about the kind of core concept around alignment at the vision level.

So then I collected a few other points. I think there's way too much focus at the EHR level and there's a lack of understanding that there's a layer of data that's going to come above the EHR. So at some point, when you get to social determinants, a kid's grades are going to be deter...and the amount of education and their attendance in school is a determinant of health. And that's not going to be in the EHR, there is a layer of data above EHR and our narrative here doesn't represent that, in my personal opinion. And then...

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

Just to clarify Neal, you're suggesting we include that extra layer, is that what you're saying?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Yeah, I mean...everything is defaulting to the EHR. I mean, it's throughout, so you do have the claims and PBM data, but at some point we'll get...if we...and I do believe we should go down the social determinants, the GIF data, the school data, is highly correlated.

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

Um hmm.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yup.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

So if we want to predict, we're going to need to find the variables. And then the thing that I think is also missing from the narrative is the only place to totally connect all the information about Neal Patterson is my personal health account. And so, and it's not the portal, there was a very nice step forward where we started sharing information with...via Meaningful Use, through portals, but there has to be an ultimate aggregation of that and it won't be inside the traditional provider organization. So to me it's the way you deal with your...you choose what bank you use. So, I do believe there will be a banking system out there, responsible people that you'll trust your aggregator of your medical record and provide a whole bunch of service around that. So, that's...sorry about being somewhat random.

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

No, good. Thank you, Neal. Amy Zimmerman?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, so I had a, well actually, a growing list of thoughts or comments. But getting back to sort of the vision and it's sort of a question and it's sort of an assumption. I'm assuming when we're talking about healthier that we're including behavioral health and I don't know if we need to be explicit about that or if my assumption is wrong, so that's my first question. And I say that because it's sort of it's a little bit, I mean, we need to be...I think we need to be cognizant of the general effort if we're talking about accountable care of com...accountable communities of care, how much behavioral health drives cost and medical care services. And so I just think we need to clarify where we're placing that in the overall dialogue here.

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

That's a good point, would you agree Joe?

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yeah, I would say, so I guess the question would be, so would it be that at the health level, where sort of medical health, behavioral health lead to sort of person-oriented health. Is that a good construct that sort of that highest level actually is doesn't matter what kind of traditional health buckets we've got? Is that acceptable?

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, I mean I didn't want to actually have to go through and say, do we actually have to define health, but in essence, that's kind of...it's been segregated out and there is lots of emphasis now in all different arenas, especially around value-based care and stuff, to really do more integration of the traditional way of thinking about primary care and behavioral health and whatever. And they're very different systems in a lot of places and there hasn't been a lot of connectivity and it gets back to the previous person who was asking about, are we talking about just those providers that have been covered under Meaningful Use or not? So, I mean to me, I assumed it was in, but I thought it was worth asking.

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

We certainly can be explicit.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Yup.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

And so the other thing I just wanted to mention is as we go through this, I mean, I think these four buckets are good buckets to start in and I was sort of thinking, were we really missing anything and I think whatever I thought we were missing could probably fall under one of those and I'm not sure I can even be explicit about it now. Just in terms of thinking of resources as we move forward, again there are states that have put SIM Planning Grants together, SIM meaning State Innovation Model, if anyone is not familiar with that, and both planning and implementation and a lot of this is around how to bring pieces together. In the most recent applications that needed to be submitted where states are waiting to be funded, there was a required HIT plan to get put in there. So again, just as we move forward in this, it's just a suggestion I wanted to say it before I forgot, there may be thoughts and ideas or expertise coming in from either states that have already tried to do some stuff or that are planning to do some stuff if they get funded.

And lastly, regarding the sort of the data sharing and the major aggregation, I'm not sure I fully agree that we're all going to end up in a future state with our own PHRs as aggregators, although I do know and hear constantly that people, and myself included, don't want a zillion patient portals to go to. So, whether that...whether health information exchanges where they exist are a root to that, or are a mechanism for that or other mechanisms, I still think we have a long way on the patient engagement for patients to really want to be able to take that responsibility on and I think they assume that their providers are doing it or will do it for them. But we all know the gaps in that.

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

Thanks, Amy. I have a number of people still in the queue, but let me also tee up another comment that Neal made, because it's sort of central, about his nervousness around aligning around the community, so if people want to comment on that as well, please raise your hand. Next comment, Mark.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Yes, I'm back on the vision slide, the third point about aligned financial incentives that encourage market competition to optimize patient and community health. And it struck me to just check, are we...is our vision to focus on market competition as the way to do things to focus on financial incentives. Or is it broader than that because I think in many of the underserved communities that I'm familiar with, there are other important forces and values at play. And I wondered if we might want to broaden this particular principle to maybe remove the word financial, check something broader than market competition.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

I think that makes sense. We can say sort of aligned incentives, and again, it's sort of collaboration and the concept of multiple organizations working together that balances internal and external sort of priorities, right, is the concept that I think we were trying to articulate.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Hmm.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

I hear your point on that one, yeah.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Okay, thank you.

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

Lisa?

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College

Yes, thanks. Well just two comments on these draft agenda topics, before I jump into this, I just wanted to underscore a comment that I think it was Amy made, I wholeheartedly agree about the importance of prioritizing a focus on sort of an integrated discussion about behavioral and more traditional sort of physical healthcare in thinking about health and wellness broadly. It seems to me it would be difficult to talk about accountable care communities without doing that, given how we know how often these problems co-occur and impact one another. So, I just wanted to underscore that point.

But, two thoughts that we might want to consider as we map out our agenda topics. One struck me as we were going through this slide with these sort of four main areas for our agenda. A key consideration for us, I think, in many of these areas is for us to have an ongoing parallel dialogue related to privacy and security and data sharing around this. So for example, when we're talking about where people are and what services they're asking, a lot of this discussion may intersect with some of the discussion that's going to happen in one of our companion workgroups on privacy and security that I think Deven McGraw leads. So it would be good to ensure that we're aware of that discussion and ensure that there's some efficiency in sort of our discussions and what they're discussing around this because it intersects in such important ways.

And the other piece is about data communication. And I think a lot of this relies on data communication, I'm thinking about systems for efficient and optimal data communication. And I think it's important for us to think about what are people really going to be willing to share, want to share, how do we, when we're talking about incentives and incentive alignment and I think also we need to talk about how do we and do we want to incentivize patient sharing of information.

So I think we know that a lot of individuals will share data about data that they need to get to certain healthcare systems that they need to have there in order to access services or to provide efficient...services they receive. But...and they'll share data for use of some of these tools and measures you've got here around mobile tools, for example and self-empowerment tools, when they're relevant to their experience, when they bring value to them, when they want to engage in extended community of their choosing.

But I think when we start talking about sharing about lots and lots of data, sort of we haven't talked about big data per se, but lots of information about people's behavior, about their health status, about factors related to the social determinants that relate to their health and that are of relevance to the healthcare system. I think it's important for us to add to the list a discussion about what's going to incentivize people to do this in any large scale way? So you're going to surely have sub-populations that do this, but what value will that bring to the end use and to the individuals that contribute that level of data. And I would suggest adding that to the agenda, if we might.

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

Thank you. Charlene?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Okay, I got it. I just wanted to comment that one of the gaps I saw was the need to identify, and I don't know if it goes under services or it would go under the next column about the need to track and keep track of the care team, because that is certainly a challenge because of the variability and the scope of that. So, I just wanted to add that as one of the items that we want to think about.

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

Thank you. Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Yeah, so thanks. I'm just dovetail on opportunities around social determinants of health and how to have people share data. Just the reality that a lot of patients today who are using loyalty cards to various places are perhaps unwittingly sharing some other information about their either purchasing or habit behaviors.

And to make that a more conscious and voluntary process as it might relate to things that impact on their health, whether they're buying subscriptions to gym memberships or buying the right kinds of foods or the right kinds of medications, etcetera, etcetera, would, I think, be very helpful. And I think if patients had a voluntary process by which to say, when I do these kinds of activities, I am willing to share the health-related parts of that back with the system if our social determinants and other infrastructure can help support that. That, I think, for a lot of us who are practicing providers, would close a lot of gaps about knowing whether patients followed through with some of the healthy behaviors we hoped for.

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

Okay. Well thank you a very, very good point. And I think one way to do this...eventually what we're going to do is tee up, after we do some more background briefings, is tee up what topics we want to deliberate upon and get some recommendations. So maybe what we do is we add some of these points that have been raised here to the set of samples, and we may end up doing sort of a Delphi to get us started and then have further not face-to-face, but synchronous communication about that to prioritize some of the areas for us to focus on. These have all been very good points.

I do want to go back to one of...Neal's point about community and maybe ask Neal to expand on that, because that's a critical assumption or principle and wanted to see people's thoughts so that we can see where we are from a consensus point of view. Neal, you want to raise that a little bit again about how possible it is to align around the community? Might be on mute or maybe he stepped out.

So if Neal's not around, so do people want to comment on that? And I think he was wondering how likely or feasible it is for people to be aligned for multiple organizations to be aligned within a community around health, short of the situation they have in the UK.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Paul, this is Amy and I've lost my Internet connection so I can't raise my hand, I apologize.

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

Okay, go ahead.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

You know, again, I'm in a small state. I think market forces absolutely have created competition and I...in my experience in the years of doing this work, the competition around data sharing, at least in our community, I'm beginning to see actually go down. And we have a number of multi-payer initiatives and we have an HIE with 78 data sharing partners. Not everybody is in, but I think more and more I'm beginning to see it a little bit less market-driven, although I think some of the big players and the big vendors are trying to get enough market share where some of that sharing may be less threatening.

So I guess what I'm trying to say is, I appreciate the concern, and I don't think it's going to go away completely, although I do think we're in a much better place than where we were before. And I do think it's possible, maybe not getting 100% to where we want to be, but better than where we've been.

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

Thank you. Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Yeah, so I would agree with that, but I would also add another experience I've had as I've gone out trying to help people sign up for direct messaging and receiving summary of care documents. And that is the issue that even when there is alignment around data sharing, if the packet that's being shared is not sufficiently helpful, concise and harmonized with the data on the other end, or if it requires a significant burden to either translate, understand or incorporate, it will also fail from that perspective. So that will need to be a key consideration.

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

Okay. Charlene? You might be on mute, Charlene.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Okay, got me?

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

Yup.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

I wanted to comment on the community viewpoint. As I look at some of the payment models, we're trying to do bundles; we're trying to do just readmissions, so much of that seems to touch on the long-term post-acute care market. And we do know that market in many ways is starting to consolidate, but it's otherwise kind of the wild, Wild West so to some extent, if we could just start to move from hospital to practice to those settings, it would seem it would be in support of a lot of the near-term payment models that are emerging. So, maybe the scope can be looking at those as we get started and then branching...maybe we have to branch? Maybe we've got to start with maybe what we can get our arms around and build from there. But in that case, it's a little more provider centric.

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Okay.

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

Okay, we're doing perfect on timing. So let's...as I say, eventually what we're going to do is we're probably going to do a little bit a Delphi to try to get a head start with our next conversation about what topics do we focus on in the coming month? But before we do that, wanted to review with you some of our short-term milestones, meaning maybe I should refer to them as short term deadlines, because we are trying to meet milestones that ONC and the federal agencies need to meet. So next slide, please.

First of which is going to be the release of the combined Federal HIT Strategic Plan. So the agencies have been working together to come up with a Strategic Plan for dealing with the Health Information Technology and the infrastructure. They are scheduled to release this at the end of the year, and they would like us to provide feedback and recommendations, response, to that and deliver that by the meeting of the HIT Policy Committee in January. So you can see that's a really short turn-around. So if you're wondering why we've been requesting two hour meetings every month, it's because of deadlines like this.

Followed by the next slide, please, the Interoperability Roadmap as we heard two days ago is scheduled to be released. So they've been gathering a number of comments from everybody...from hearings and listening sessions and stakeholder meetings and they released their draft, what they're thinking about, a couple of days ago in front of the combined Policy and Standards Committees. And they're looking for...they'll be releasing their draft for public comment in the first quarter of next year. They would like us to provide formal responses and recommendations to them by March. So it's common, when they release an NPRM that the advisory committees also react along with the public in a formal way. So that requires us going over what was heard a couple of days ago and responding to it and providing that back to ONC.

Meaningful Use 3 NPRM is scheduled to come...well, we don't have a specific date, but it's felt to come out...it is believed to come out in the early part of 2015. As a successor to the Meaningful Use Workgroup, it's going to be on us to make recommendations to the Policy Committee about what's our response, the HIT Policy Committee's response to it. So, we provide feedback, we provide reactions, we provide further recommendations. Tentatively we would, once its opened up it's 60 or is it 90 days, Michelle...90 days response time so we will...go ahead.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I think it's 90.

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

Yeah, so if we have...

Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health

Move the slide forward...sorry. Just move the slide forward one more, whoever is operating the slides. There we go.

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

Yeah. So then we'll have...we probably will take those multiple meetings to concentrate on that. It's going to be very important, it's the last one tied to incentives and it's scheduled to go into effect in 2017. So, we'll have a thorough review, we'll be presenting multiple times to the Policy Committee in order to get a formal response back to ONC and CMS. Next slide, please.

So we have a couple major topics we already think that will be important for us to deliberate on. One is this whole notion of accountable care arrangements, and we've termed it accountable care communities. That's why I wanted to bring up Neal's comment; we'll need to discuss that more and talk about what is it going to take to, with or without the explicit collaboration of the organizations in the community to have ways of intervening to both measure and improve the health status of individuals in communities. How do we get that done? How do we, from an HIT point of view, support that? And we know that that's going to include social determinants, including what Neal mentioned which was great. Are we educated? That's a known social determinant in health and outcomes.

So we are going to...one of the things we want to hear from is, as I mentioned before, there's a sister FACA, NCVHS, who has been working on community health, community health data and what to do with that. What's needed to support communities with their data that we'll definitely hear from as we begin our work, because we wouldn't want to duplicate work? Next slide, please.

And the other major topic we've already identified, it's sort of a hold over that's come up multiple times in even the past year in the HIT Policy Committee, and that's the notion of essentially some shared care planning. As I mentioned, since care coordination is so front and center, we can't have coordination if there are no shared goals at the very least, let alone a plan. So, how do we support that? The only reason it's sort of out there in Q3 is you've seen the other things that are...the deadlines that are already taking up our time between now and basically the late spring.

But we want to bring together, and this is going to be more than just the sort of the information community. It really...a shared care plan is a professional...the professional responsibility and a professional tool, a plan. And so we actually think we're going to need to bring in the professional societies, because we're going to need to affect the education, the culture, the training and the expectations of all of the professional team working with an individual. There is work going on at ONC already and we're going to get a briefing on that prior to us kicking off this hearing.

So you see, we have our work cut out for us and one of the things we're thinking about in the next call, we may be schedu...I think we have one on November 17, but we may need another one in November, is to start getting more input of what's already available so that we can formulate our thoughts on well what are the gaps and what do we need to know to decide...to develop an approach on overcoming those gaps.

So a couple of things I've already mentioned, one is, the interoperability session we had in the joint session of the HIT Standards and Policy Committees on October 15, not everyone here was at that meeting, so we wanted to give you an overview. It was really an excellent presentation by Erica Galvez and it really brings a lot of the components to interoperability such...including governance, including culture, to bear. And I think it would be a really good level the playing field presentation to us. And the other thing is, I mentioned about, since we're talking about communities, that NCVHS has already been working on it for a few years already, they're actually having a round table on this matter in two weeks, within two weeks, so I was going to ask them to come and present the findings from that round table to inform this group as well.

So we anticipate having a number of briefings, just to get us all up to speed. Again, so we're coordinated and that we're not duplicating work. And as I mentioned, ONC is already working on shared care planning, so they'll bring that information in to us. Any comment, so far, before...maybe we'll go ahead to the next slide just so people see what we're about to discuss. Any comments about sort of the deadlines that we're facing, the kinds of input that we're being requested to provide?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

This is Norma Lang, could you just verify all these goals that we just had, will you be sending those out to us or do we have to go search...

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

No, no, we'll send it to you. And actually, that's why I asked for the next slide, please. We're going to have some of these on the schedule.

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality and Informatics – University of Wisconsin

Okay, thank you. Sorry. Thank you.

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

Charlene?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yeah Paul, do you know the status of the IOM report on social determinants of health and EHRs? Do you know where that stands?

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

It should be coming...to my knowledge, it hasn't been released yet, but I thought it was supposed to come out this year, so it should be in time.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Yeah, so okay, because that would be the other item that would be really interesting to review, okay, thanks.

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

Exactly right, that's another...and George was on that Committee, so he can provide us an update, a briefing.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

Thank you.

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

Thank you. Mark?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Yes, a broad comment that may actually go back even before what the milestones are right now and that is, not finding much reflection of one of the core efforts in the committee's previous iteration to reduce health disparities and it seems like that is a good thing to weave in in various respects. I don't know if you want us to think about more detail on that right now or just sufficient to raise that observation at this point and to think about it for the next meeting.

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

I think when we incorporate your comment about diversity, I think we can also incorporate disparity objective explicitly. It's weaved in, as I said, it's actually weaved in explicitly in the MU recommendations we had and hopefully will come back to us to discuss, but that's part of it. And that obviously is a big part of social determinants.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Right, and will be a part of the ongoing work as well.

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

Right.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

The other particular thing observation is, going back to the point on the Strategic Plan, the slide said end of December with comment due for the January HIT Policy Committee meeting. If end of December really means that, there are no workgroup meetings scheduled...

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

Yeah.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, I don't think it said end of December. We don't know when it will be published, we're thinking...

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Okay.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

...early December, actually but we really don't know.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

Whichever way, I just hope there is sufficient time for us to do something.

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

Be careful...

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

It was looking like there might not be.

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

Be careful what you wish for, I think ONC was known as the Officer of No Christmas before and it's...so, I also came clean at the beginning to say, this is a fast-paced group, involves a lot of time. So we appreciate your time ahead of time.

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

I'm not objecting to that, just making sure that we...it's actually possible to meet what we need to do.

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

Yeah. To its credit, ONC has been remarkably on time in meeting its deadlines according to the statute, almost more than any other statute that I know. So, the corollary is that its advisory groups have to keep up with it.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

This is Amy, Paul or maybe Michelle. I mean to what extent do you think, depending on what happens with Ebola and everything, things will get, just based on bandwidth, things will get either sidetracked...I mean I know there are efforts at ONC now to work with vendors and EHRs around algorithms and workflow and screenings embedded into EHRs, I was on a call yesterday. So, is there any impact there on this that you can tell of now or not? And does that affect anything that we are working on?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, I'm not aware of anything, but it could just be that I'm not aware.

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

The new czar could certainly call on us to do something and we'd have to respond.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

Yeah, no, I thought it was more...my question was less about us really needing to respond versus just bandwidth having to be redirected in other areas, either at ONC or wherever.

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

Yeah.

Amy Zimmerman, MPH – State HIT Coordinator – Rhode Island Department of Health & Human Services

I mean, we can't control that.

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

No, we can't control...I think the last time we had something beyond our control affect our milestones was sequestration, I think, actually delayed us, had a material change in our schedule, but...okay. So, before you is a rough, high-level work plan that talks about...really lays out a bit of the schedule and no, none of the dates are inked or in concrete because they're not known in public, or known by me. So, it's just you can see the stair-step that we just have one sort of deliverable after another and we're already scheduling out to the summer of 2015.

So what we thought we would do with the next session is to have a briefing, and give me feedback on whether these briefings are helpful to you to one, know what's already known about communities, community dealing with health data and to get a briefing of the interoperability. Now actually another thing you could say is, hey, gosh, we already have that, it's on the Web, we don't need that and we can certainly go on to the next subject.

So please...so one, what do you think about these briefings to try to bring everybody up to the same speed. Two, what do you want to do on your own versus covering it here? Interoperability is one of those things you could actually listen to the hearing we had or the session we had a couple of days ago. What are people's thought about that? Mike?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Information Officer – Sparrow Health System

Yeah, I just endorse it; I think it's good even if we have had a chance to do that to make sure we're all on the same page. So that would be helpful.

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

Okay, others have an opinion on that? Mark?

Mark Savage, JD – Director of Health IT Policy & Programs – National Partnership for Women & Families

I agree it's very helpful; you, the co-chairs are going to have a better sense of what we have to get accomplished and what the overall structure is. I would encourage if there are materials we could read even further ahead of time that you think would sort of help us be prepared for something that comes, even one or two weeks out, feel free.

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

Okay. All righty, we'll do that. And just to repeat what Michelle said at the beginning, all of these things are actually, one, they're transcribed and there's plus/minus accuracy, but even the audio recording is there on the Web, usually in a few days, I think. But, just to let you know, there's something...it's called FACA Calendar and that actually is quite good, quite useful. Other comments? Charlene?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare

So the question was, because we're kind of bringing the Accountable Care Workgroup under this umbrella, does it make sense to backtrack and review any of their recommendations or could you send those out. I know they're on the website; maybe we should just do that or is that relevant? So, I kind of just wanted to clarify on that one.

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

Let me reflect that back to the group. So we only went at the high level and we can bring more in detail briefing about the relevant pieces of let's say the ACO or the ACO Quality Measure or Meaningful Use; we can bring that back as a more detailed briefing. Are there any that you in particular wanted to get a more detailed briefing on or getting PDFs sent to you, just so you don't have to go hunt for it? Neal?

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Yeah, hey, sorry, I had stretched the limit of my Bluetooth a second ago and I was on mute so I couldn't respond. But, what I didn't hear here was how many meetings are we going to have, interactive meetings like this and are they all audio or do we ever get together? This is an unbelievable number of deliverables.

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

Yeah, I know. Well, we could pay you twice as much as we pay you now, would that help? So the pace is actually very fast so they are trying to schedule two 2-hour meetings per month. On occasion we have had face-to-face, sometimes it's tied with a hearing, a face-to-face hearing, where we actually get together and what's helpful is maybe...and then what we've done in the past is, and then a half a day later, the next day after you sleep on it, we actually stay together so we can crank out the findings and recommendations right then and there. We've found that to be efficient when we need to get things one, turned around very quickly, but it's also sort of an efficient use of your cognitive time. But so yes, right now it's a twice a week...twice a month 2-hour call time, which you can see could potentially go up, based on the acuity of the situation.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Okay. And then your other question was really what level of detail do you want to go to into our meetings and then how much do we want to consume on our own so I'll let you decide that.

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

Okay.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Because I have no idea.

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

Okay, well, we'll at least do the favor of looking it up. As I said, it's on the calendar, but we'll look it up and send it to you a PDF or at least a direct link so that you don't have to do the hunt and search yourself.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation

Yeah.

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

But, sometimes there are some really good...like the ACO transmittal letter was really good, it explained the background, the rationale and the recommendations. So, it's really good, self-contained reading so that might be an example of something we use...send out. Other...

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College

Just a quick follow up...this is Lisa. So those documents, the PDFs that you'll be sending out, I understand they'll reflect prior discussions. But what about all these other sort of companion workgroups that are going to continue to work alongside us; will we also be notified when there's some product from those groups that we should be looking at just so that, again, to aid in efficiency of this process?

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

That's a really great question. Yes, Michelle, do you want to comment on that more directly?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Sure. So in some ways we often times bring updates that are relevant to this workgroup from other workgroups, it could be a presentation here. We also actually have, Paul mentioned on healthit.gov, there...all of the materials are public and posted so you could look at the FACA calendar and see if there's a relevant meeting.

But we actually also have a FACA portal which has all of the meeting materials from every meeting. Included in there as well, there's a meeting summary written for every workgroup meeting, in addition to all the committee meetings and that can be really helpful if you've missed a meeting but are interested in the topic of discussion for them. There are a number of resources that people I don't think are aware of and we hope that you take advantage of them.

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

The good news is that there is a central place to go and look at this FACA Calendar because this is all of the meetings and then you just click on the...but I think Lisa, what you're asking for and it's fair, what we'll do is we'll point out the important ones and give you a link, so you don't actually have to go...it's a push rather than a browse.

Lisa A. Marsch, PhD – Director, Center for Technology and Behavioral Health – Dartmouth College That sounds great, it sounds like we'll have...we'll never run out of reading, it sounds like.

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

Never run out of reading and thanks to everybody for what sounds like one, recognizing the work but two, being willing to be prepared, we really appreciate that. What we do know is the HHS really listens carefully to what comes out of like the Policy Committee and so the work you put into it is not only appreciated, but it's influential. So, thanks in advance. Why don't we go to the next slide, please? I don't think we have any more content slides, right? Next steps and public comment.

So, to summarize, what we've done is we tried to bring you up-to-date with sort of who the relevant players have been, the workgroups and their output so far, giving you just a high level, just a draft type, point you in the right direction, give us your questions of where you want to hear more about. Prepare the next couple calls probably are going to be more briefing materials for you, raising everybody to the same level and then we're going to just start cranking out the work in terms of providing feedback on things that are coming out in the very near future. And we'll supplement that by external both resources and external comments. Sometimes we have listening sessions as well. So those are things that are determined by the workgroup, but we'll bring you as much information as you need with the caveat that we still have to deliver according to a timeline.

Okay, any questions about that before we go to public comment? Okay, so I just want to thank this group for really one, attending, participating, listening and what sounds like your implicit willingness to do this work and for showing the diversity of input. And we really enjoy the diversity of input and we do try to work towards consensus, so, put on both hats, both the perspective that you bring, but also the roll up your sleeves and let's try to figure out what the consensus moving forward is. So, appreciate that willingness. Why don't we go to public comment then, please?

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Operator, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press *1 at this time. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We have no public comment. I just want to echo Paul's statement and thank you all for agreeing to participate in this workgroup and we hope that you have a wonderful weekend.

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

Thanks all and talk to you next time.

Public comments received during the meeting:

1. Encourage this workgroup to consider reframing social determinants of health to include how the consumer, patient/family caregivers are impacted by the daily context of living, and expanding data sources to include PGHD, neighborhood determinants, and environmental determinants. Thank you Susan Hull RN
2. Consider the how concepts like the Health Record Bank, a community trust for collective impact, and services/aggregation, could extend framing context for this Workgroup. William Yasnoff, Steven Shortell and Ed Shortliffie and the HRBA team have developed some interesting models, including HAPPI, a sustainable model for a Population Health Organization.
3. Consider framing the last item on your WorkPlan from Hearing on "electronic care planning" to Shared Care Planning. It will also be helpful to advance and get concurrence on definition sooner than later. You spoke of the professional accountabilities across provider/continuum/communities -- would encourage you also to consider the person centric nature of the SCP, including the dynamic needs over time for the patient