



**HIT Policy Committee
Advanced Health Models & Meaningful Use Workgroup
Final Transcript
November 5, 2015**

Presentation

Operator

All lines are bridged.

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

Thank you, good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Advanced Health Models and Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end of today's 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? I think he's running a little late. Joe Kimura?

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

Present.

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 Expert, Government & Policy for Health IT – Cerner Corporation

I'm here, hello, Michelle.

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

Hi, Charlene.

Charlene Underwood, MBA – Independent Consultant

Yes.

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

Cheryl Damberg?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation

Here.

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

Hi, Cheryl.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation

Hi.

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

Devin Mann? Ginny Meadows?

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Here.

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

Hi, Ginny. Jessica Kahn? John Pilotte? Lisa Marsch? Lisa Patton? Mark Savage?

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

Good morning.

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

Hi, Mark. Marty Fattig?

Marty Fattig, MHA – CEO – Nemaha County Hospital (NCHNET)

Good morning.

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.

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

Hi.

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

Neal Patterson is unable to join. Norma Lang?

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

Here, good morning.

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

Hi, Norma. Patrice Holtz? Robert Flemming? Shaun Alfreds? Shawn Terrell? Stephan Fihn? Suma Nair? Sumit Nagpal?

Sumit Nagpal – President & Chief Executive Officer – Alere Accountable Care Solutions

I'm here.

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

Terry O'Malley? Hi, Sumit.

Sumit Nagpal – President & Chief Executive Officer – Alere Accountable Care Solutions

Hello.

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

Good morning, Michelle, this is Terry.

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

Here.

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 Policy – 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

Is Kelly on as well?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yes, I'm here.

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

Hi, Kelly. Anyone else from ONC on the line?

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

Yes, this is Kevin Larsen.

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

Hi, Kevin.

Maggie

Maggie...

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

I didn't hear, who was the last person I'm sorry?

Maggie

Maggie.

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

Hi, Maggie.

Maggie

Hi.

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

Okay with that I will turn it over to you Joe.

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

Great. Good morning everybody and it has been a little bit of time since we've talked I want to sort of wish everyone a happy fall as we're heading into fall and we're having a little bit of a warm trend up here in the Northeast but I'm sure the weather will turn soon.

So, today I think for our meeting we are bringing a report over from a technical expert panel that was convened by ONC to think a lot about what kinds of HIT technologies could be helpful for an advanced health model world particularly around the payment models that Medicare is hoping to advance going forward and I know that Kelly is going to go into a little bit of sort of the scope and the purpose, and what specifically they want our committee or our workgroup to respond to in terms of this report today, but I think the interplay of conversations that we had in the expert panel I think dovetail pretty nicely to a lot of the conversations our workgroup had when we were talking about the interoperability roadmap and the work that we did this spring.

So, I think a lot of the conversations and a lot of the thoughts, and things that we had talked a lot about back in the spring may start to surface again here as we're listening to the report from Audacious Inquiry, but I think the goal is to try to get some reactions and to get some feedback to put some context around the report findings from our workgroup's perspective at the HIT Policy meeting next Tuesday.

So, it's a little bit of a reaction sort of a listen, absorb and react kind of meeting today. Did I frame that out right Kelly from your perspective?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, that's great, Joe, thank you.

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

Yeah, so at this point I think I can turn it over to you and let us run.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, that sounds good. So, just to give a little bit more background and context, this work was done through a contract to Audacious Inquiry and really with the intent of trying to do some qualitative research, literature synthesis and then the convening of a technical expert panel largely of providers of chief medical information officers who are really on point for implementing a lot of the infrastructure for alternative payment models such as Joe and really trying to use those sort of three inputs to better understand what are the health IT requirements for various alternative payment models with the sort of focus on Accountable Care Organizations, bundled payments and patient centered medical homes as context.

And really, now, with ONC and HHS, and CMS as our partner trying to think through various aspects of the Medicare Access and CHIP Reauthorization Act, MACRA, we are really trying to understand this more clearly so that as we implement different provisions of MIPS and alternative payment models we can do that understanding what sort of this continuum of health IT ecosystem that we need to be supporting and ONC in particular is interested in what the scope of certification needs to be to enable a more robust set of health IT products and services that will meet the demands that providers will be facing in trying to perform well in various alternative payment models.

And Section 101(e) of MACRA actually points to a new requirement for eligible alternative payment models where they will be needing to use certified technology. And so understanding what the scope of that certified technology is will be important. Really it is intended to...our intention is to try to really figure out what is going to most serve providers needs so going beyond the basic electronic health record or point of care application to thinking through the suite of products and services that are going to be needed in the market over the next 5+ years for a large number of providers that are going to be moving in this direction.

So, it is going beyond, you know, sort of our historical reference point of Meaningful Use and point of care applications to really thinking more broadly about what are all the products and services that are needed for alternative payment models and also not focusing on defining how they are used or how the use of those products might be measured. So, we're not interested in that or the accountability around that, we're really interested in certification of products themselves.

So, when it comes to the software and services what should we be thinking about in terms of standards and certification so that there can be some consistency in the market and that providers will have what they need to perform well in these various models.

So, all these inputs, the literature synthesis, the qualitative research and the technical expert panel is really informing us to sort of make some better planning and better decisions internally on how we plan for and implement MACRA.

So, with that context I think Lammot du Pont and Marc Falcone are on the line who were two of our leads for this work. And also maybe just...also before I pass it off them, in terms of your feedback today it would be really helpful to understand if what you're hearing in terms of the output of this work is consistent with your experience as clinicians or, you know, sort of, you know, active people in your communities.

Does it ring true with you? And is there anything that we missed? Were there any gaps in health IT capabilities or what certification could do or not do? What did we miss? So, if you could keep an eye or keep those mental notes in your head as we go through the results that would be really helpful.

I think we also wanted to keep this interactive. So, you know, if you want to be asking questions to Marc or Lammot as we go through please do.

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

Joe, this is Marc, can I jump in with a framing question?

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

Absolutely, go for it.

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

So, Kelly in looking over the slides I noticed two things, one is it didn't look like there were any consumer representatives either among those interviewed or on the TEP and yet I also noticed on the results that there was a lot about sort of patients and care planning, patient engagement things like that and I'm wondering if there was a reason for not including consumers? And I did I see it correctly? Were there no consumer reps and I'm checking if there was a reason for that?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

No, I mean, we were primarily interested in getting into the sort of more technical and clinical aspects of what needs to be done with these systems. So, that's not to say that we weren't sort of squarely centered on what would be needed for patients or consumers, but we thought that the primary set of expertise we needed to be making these judgement calls or giving expert-based opinions on the TEP would really require a deep understanding of the clinical processes and, you know, how does that relate then to health IT products and services, and subsequently certification.

As you know we have a hard time finding, you know, consumers that can really be expert in all those areas, but this is not the only input into this process and we're clearly going to be getting a lot of public input from other channels, you know, on the call today obviously, next week will be the full committee discussion on this, there is an RFI that CMS has out that touches on some of these things.

So, we're very interested in the consumer input and as you noted there is a lot related to care plans, shared care plans, patient engagement that's really critical and we're keenly aware of that. So, I think that there will be ongoing discussion and lots of opportunity for input from consumers.

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

Okay, thank you.

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

Other clarifying questions? Okay.

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

And Joe I should throw out that I sent this message to Paul unfortunately I'm going to have to drop off at 1:00 o'clock.

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

Okay.

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

I will be quiet when I drop off just so that...

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

If you want to fire us off anything by e-mail if you have any comments or feedback that would be great, because I think we're going to try to collect things for some context for next week too.

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

Perfect, thank you.

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

Thank you. Marc/Lammot?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Great, thank you, Joe, so if...Lonnie, thank you for advancing the slides and if you could go to the next slide we'll hop right into the agenda, thank you.

So, this morning Marc and I are going to walk through three things, we're going to talk about the research process, the assessment of the qualitative information, the synthesis of our findings and then a discussion of next steps.

And to begin with, next slide, please, we're going to start with the project drivers and goals, and Lonnie if you go to the next slide, what Kelly was talking about we offer a visual representation of the genesis of our project and that really is the Medicare Access and CHIP Reauthorization Act which birth twin tracks for payments to Medicare Providers. The first is the Merit-Based Incentive Payment System or MIPS and that's essentially the default track for Medicare providers with payment adjustments that are designed to incentivize quality and clinical practice improvement, that's the baseline default track.

For participants in alternative payment models, and as Kelly mentioned those include Accountable Care Organizations, those with bundled payment contracts and those participating in advance primary care initiatives they have a second track. And the models in this alternative payment models track are not subject to MIPS payment adjustments and are also eligible to receive up to a 5% incentive payment.

So, the legislation lays out a framework for payment and as Kelly noted in Section 101(e) it also indicates the use of certified electronic health record technology in two places both in the MIPS and in the alternative payment models. So, with that as a backdrop the details of what constitutes certified EHR health IT modules aren't defined in the law and that's going to be the subject of future rulemaking and regulations and in order to get out ahead of that, in order to position ourselves to have the tools in place for providers to be successful in alternative payment models we launched this research effort. So, Lonnie, the next slide, please.

So, to help inform the process our goal was to help providers have the health IT tools needed to succeed in alternative payment models and it's not just simply to participate we were really looking to the types of processes and technologies that allowed them to succeed and do well in these new models. And what we're doing is we're making recommendations regarding the certification of specific health IT functions that, as Kelly mentioned, would be in place and usable in order to have the participants and APMs ready to go by 2019.

So, there were a couple of framing considerations, the first is that we focused on three types of alternative payment models, there are a range out there, but the legislation specifically identified Accountable Care Organizations, bundled payments and patient-centered medical homes. So, when we talk about alternative payment models we're talking about those three different types.

Secondly, we had a time box around this and our timeframe is January 2019. So, when we think about crystal balling a bit and projecting where the market will be and how we are going to get there the timeframe we're considering is to have folks ready to go by January 2019.

And the final consideration is that certification is not the only recourse to drive adoption to make sure these tools are in place by 2019. We recognize that the market itself, in terms of having more refined understanding of the capabilities from those that are purchasing it, those and the vendors supplying them will naturally come together to create a market for these. There may be some additional types of capabilities in terms of comparative tools that really could create and accelerate the deployment and adoption of these technologies.

So, our work that we're doing today does not prejudice a certification approach, what it does is illuminate what could be done under a certification approach. So, Lonnie, if you go to the next slide.

I'll give a quick overview of the process and over a three month period we conducted background research that included first the selection of a taxonomy, we needed a vocabulary in which to articulate the capabilities and then secondly we used that vocabulary to move through the literature on both health IT and alternative payment models, and then we wrapped up the background review by conducting a number of interviews with experts in the field.

From that background research we identified initial and preliminary findings and gaps that existed in the marketplace. We took that information and worked it through a panel of eight technical experts who were charged with rating and ranking the health IT capabilities and we'll walk through that process. And at the end of that exercise, which we just completed last week, is a compilation of their ratings and rankings in order to formulate recommendations to the Office to the National Coordinator for Health IT.

So that's a brief overview of the process and what we're going to do is walk through each step of the process and talk about the findings. So, as we go through please feel free to jump in and ask questions, we'll have moments where we pause to ask you for some feedback and some suggestions but don't hesitate to jump in. So, Lonnie, if you could go to the next slide and go to the next one. Thank you.

This tee's up the framework for health IT and we had to build our research on a consistent vocabulary and taxonomy so we selected a health IT framework for accountable care that was developed by the CCHIT. And some of you folks maybe familiar with it and participate in its development, and it consists of seven processes you can see at the top of the table running from care coordination all the way over to knowledge management, buttressing those seven processes were 64 functions that you see listed on the columns and then within each of those functions there were a number of discrete health IT capabilities that all told accounted for some 270 specific health IT capabilities. So, we used that as our framework and our tool for analysis. Next slide, please.

So, using that taxonomy we worked through the literature. At the top of the box you can see what our overview findings were in terms of the state of the market and then we've identified some of the challenges that were unearthed.

In terms of the state of the market there is a sense that there is a significant amount of program complexity in the landscape. Alternative payment models not only encompass a broad range of accountable arrangements, bundled payments and advanced primary care they also include variations within those.

So, we heard from providers for example that they are exposed to multiple Pay-for-Performance models, they're involved in a bundled payment and then they have both commercial and federal ACOs that they're working with and that makes for a complex network and web of rules and requirements that they have to navigate.

The second thing about alternative payment models is that we heard loud and clear that the product lines continue to blur and this is consistent with the findings that you had the spring when you worked through these and that this is not just an EHR or point of care centric exercise this spans population health, disease management, care management offerings that continue to overlap in terms of the description of the product.

So, one of the things that we were careful to do was focus on the capabilities recognizing that different vendors and different products could bolt together the various types of capabilities.

The third thing on the state of the market is that the literature spoke to a wide array of users. So, as Mark pointed out it's not only just the clinicians and care managers, and social service agency staff it's also consumers, patients and caregivers that are now not only being engaged but potentially accessing and informing the development of the information that are used in these tools.

So, it's a complicated and complex landscape and the four challenges that were spoken to in the literature covered the following areas, one data exchange. The inability of being able to access information timely, accurate from multiple locations singled out in the literature and also in the interviews were specific settings with long-term care, behavioral health and social service agencies bringing them into the mix.

The second thing is what we characterize as the data deluge. If you solve the interoperability problem now many providers face an overwhelming waterfall of information coming in and I think that's something in an area that you all identified as well as being a potential challenge.

Having gotten the information in the other challenge we heard loud and clear is the difficulty in reporting and that's everything from performance measures to quality measures and that ranges from locating extraction and reporting the information from their systems to the relevant entities.

And finally, the tools to automate the management coordination, in a team-based care environment the preponderance or excuse me the pressure is going to be on the ability to quickly and easily, and fastly move information among a fluid group of team members and the tools that we can put in place to automate that and make that easier were seen as basically a nascent state and folks were wrestling with how best to understand what their capabilities were and also how to deploy them.

So, that speaks to the literature review and I'll pause now and if folks in the workgroup have any other thoughts on this based on the work that they've done or what they've seen.

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

So, this is Mike, if I could jump in. So, I just wanted to highlight the first item as it relates to the second item. So, in our interoperability Task Force we talked about the difference between health information exchange and interoperability with the interoperability part of course being the combination of exchange plus incorporation of data in a manner that can then be used and particularly if there is not an explicit focus on that second process the data deluge will truly be unmanageable.

I'm sitting here getting ready for clinic going through a stack of information now which is totally non-incorporate-able and I have to make a decision how much to look through and what can and can't be put in. So, we really need to make sure that this is part of the data exchange emphasis. Thanks.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Thank you.

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

This is Amy in Rhode Island and first of all I just want to mention that this is very consistent with a recent statewide data and analytic survey that the Rhode Island Quality Institute, our statewide HIE, and Regional Extension Center Organization did. Your key challenges are very consistent with what they heard.

One additional thing, and it may be out of the scope here, but to think about, is, and I'm curious to know, did you hear anything on workforce and the ability then to take the data once it is from whatever form...you know and really turn it in...know how to turn it into information and use it in care management and workflow?

So, it may be out of the scope here, but I was just wondering if that came up because we also had a lot of...that was one of another major challenge.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Amy, it did come up. So, one of the things is it takes people and process to make these tools workable and we heard that there was in some instances a lack of folks with the expertise and experience, and understanding how to use the tools and take the information.

And with respect to this particular research exercise it was identified and noted but our scope was on the technology capabilities themselves, but we heard that loud and clear that the technology was a necessary but not sufficient ingredient in order to ensure success in alternative payment models.

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

Okay, thank you, and, yeah, I mean, I knew it was probably a little bit out of scope, but making the technology as simple and easy, and to minimize what was referred to in Rhode Island as a lot of data wrangling and, you know, having to finagle with spreadsheets and stuff, you know, that will just help streamline when we move into the workforce and usability aspect of things. So, thank you.

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

Hi, this is Terry O'Malley...

Charlene Underwood, MBA – Independent Consultant

This is...

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

Just a comment on not only do you need the technology and the connection, did you guys look into sort of the vocabularies, the shared understanding, the semantic interoperability? How does a home health agency communicate with a medical behavioral health with an in home service provider? They're going to be using different vocabularies with different meanings. So, there is going to need to be, I think, sort of a core dataset that addresses the different levels of clinical sophistication and understanding to allow for and exchange of information that's meaningful to both ends.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

And Terry, we did, at the start we're thinking of the processes and functions, and business rules to be successful and alternative payment models, thinking about the technology functions and capabilities, and then when it gets down to those capabilities being tested to actually measure what they say they're capable of doing, we get into the guts of the types of vocabulary and semantic interoperability that you touched on.

So, as we go through this presentation at the conclusion we'll talk about some of the readiness of the certification approaches for each of the capabilities.

Charlene Underwood, MBA – Independent Consultant

Yeah, Terry, this is...oh, I'm sorry, Lammot, this is Charlene Underwood, just to kind of build on that question a little. One of the challenges, again, the philosophy of Meaningful Use and certification to some extent was baseline, it wasn't to reach into all the kinds of functionality and capability that you need to, you know, compete and accomplish everything.

So, to me, like, as a vendor it's like, you know, certification is that baseline and, you know, you build it additional capabilities so that you can compete and that kind of thing. So, where's the line?

I think a challenge is it's going to be really hard to certify everything and you don't want to certify everything. So, as you think through that process how are...you know how are you going to marry the current philosophy of Meaningful Use with kind of this goal, this project?

So, I would kind of see that as a challenge.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Thanks, Charlene, that's something that folks noted in terms of cordoning off and recognizing that some things needed additional tinkering, understanding of how to use it in the marketplace and potentially additional innovation in order to be ready for the kind of certification processes that you've discussed.

Charlene Underwood, MBA – Independent Consultant

Right and, you know, to what extent does certification meet that need because there is a delay process in certification.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Absolutely, okay, thank you. And I'm going to move along, we're going to have another opportunity and some of the other findings I think might stimulate some additional dialogue. So, Lonnie, if you could go to the next slide?

This gives a snapshot of the folks that we interviewed and they span three categories. We talked with providers as Kelly mentioned across a range of organizational types from large integrated delivery networks to small rural practices and we also talked with a number of vendor organizations across product categories in order to get a sense and understanding what they're finding with their clients and what they're developing and making available and how they're being utilized.

And then finally we talked to staff from the CMS Programs that are leading or involved in both or sorry the ACOs, bundled payments and advanced primary care models. So, to those three categories we explored three topics, the first is what are the key business and clinical processes that providers need to be successful and that's to ground people in the workflow and what the functions are that providers need to be successful.

Then we dove a little bit deeper and said, what are the specific health IT capabilities that present the biggest challenges either for vendors to develop or for providers to implement. And then, finally, we ended with a question, Charlene, which is to your point, was what is the impact of various certification programs to date and what are the things they think about and consider as intuitively being ready for certification at this point or potentially not and to get a sense where they thought certain capabilities needed additional maturation.

So, we used those three questions to frame our conversations with the interviewees and Lonnie if you go to the next slide. The next slide is a representation and the feedback that we got under what was identified as the top 10 business and clinical processes and these are not presented in rank order, instead they're presented in the order in which a workflow or a use case might proceed in terms of a first encounter with a patient under number one where you enroll them into specific programs and then panel them, and then moving all the way through to the collection of data, the provision of clinical care and care management capabilities and monitoring of that all the way through to reporting and communication and engagement.

So, this list we received a lot of details and information under each of them and what we wanted to do for you today is highlight two that ironically fell at the bottom of the list, number 9 and 10 that had some information that surprised us.

So, for number nine, obtaining consistent information about benefit, design and claims groupers the sense, the ability of global budgeting and tracking of cost is something of interest to many participants and alternative payment models but the tools aren't ready, the understanding of how to use those tools is emerging as a field of interest but the capabilities and getting the types of function in place still is relatively early in terms of the maturation cycle for the information technology. So, we heard that...

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

Could...

Lamot du Pont – Senior Advisor – Manatt Health Solutions

From the...

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

This is Norma, could I ask a question here that really goes back to the previous slide as well for your informants or the people who or the groups that you interviewed, I'm concerned because I was going to support Terry's concern previously that when you asked these big integrated or these systems did you get somebody who represented other than hospital and primary care? Because that's where all of our experience is in even Meaningful Use and when we try to bring in those things that even make it more complex they sort of get not as much attention as they should such as long-term care post-acute, hospice, behavioral health and home care. And I don't see necessarily these folks and necessarily these vendors being able to offer what's needed to move that part forward.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Norma it was a challenge, we recognized having a limited number of folks that we could interview and also limited timeframe was trying to get that mix and we were conscious of making sure that we didn't inadvertently orphan the markets that you spoke about.

So, we also in collecting the information wanted to focus on providers who are working in Accountable Care Organization or bundled payments that have relationships with those long-term care facilities and others and non-traditional care settings.

So, we're hoping that we scratched the surface and identified some issues and considerations but to your point, this is in no means a comprehensive look and that we think this starts the conversation that will continue as people become aware of what's required by these new payment models both from a practical stand-point and also the coming payment based on the law.

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

Okay, but I just...I guess there are a couple of us probably that sound like broken records and it's just hard to keep saying because those are so difficult and so complex to bring into an already difficult and complex, but more experienced environment. So, I guess maybe I'll just push the button periodically.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Oh, please keep pushing. I think that one of the things we wanted to acknowledge is complexity shouldn't have a shy away from the challenge and what we wanted to do is be cognizant of the tools and capabilities that would address that complexity and make it easier, as Charlene said, and sorry, Amy and others, to bring the full complement of stakeholders and institutions and entities that are going to be needed for success in these payment models. Thank you.

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

So, this is Amy, I have another question looking at this list. Was there any...on this list...and it may even precede this, was there any discussion about sort of the ability to identify sort of the high cost, high utilizer groups?

Because, you know, we have a lot of discussions about these things sort of...maybe that's under patient risk stratification I can't really tell if that's where it is or if that's sort of risk adjusting under the payment model.

So, sort of the ability...I just don't know if that got raised at all, because I know that our providers here, you know, are getting multiple lists from multiple different payers in addition to us trying to think about a more streamlined way even for Medicaid at the state level to try to figure out who to hone in on in some areas and whether any of the technology components can help with that, you know, we've got some tools we're developing here off our HIE and other things to sort of...it goes to the ADT notification but it also goes to sort of a history of data to say, you know, how many hospitalizations or how much usage and what period of time to then sort of link those folks into the rest of the care team whether...and a lot of them are behavioral health. So, I just didn't know if there was any discussion or if it is embed in any one of these functions?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Amy, it is embedded in these functions. So, to start at the top of the list with respect to risk stratification that includes this notion of how do you define risk and then one of the things we heard from providers that often times they're exposed to multiple methodologies for defining risks, so they'll not only get a list of patients from different payers but they'll also get different risk stratification methodologies...

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

Right.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

That attenuate them to populations and they said what they would like is tools and risk stratification tools that allow flexibility because their patient panels are mixing across these different payers and at some point they're not quite sure which risk methodology they need to apply.

So, we heard that this is a challenge, it's well intentioned that people advance these types of risk methodologies with their payment programs but on the receiving side of the providers managing those multiple approaches if they had tools and technologies that allowed them to do that this was indicated as something.

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

Yeah...

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, each of these...

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

Yeah, no, I agree with you or some standardization and I would argue that attribution is another one that falls in that bucket.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Yes and you also touched on a number of ones, behavioral health and each of...this is a very crude construct these 10 processes embed quite a number of different functionalities.

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

Okay, thank you.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, one, before I forget it's at the bottom of the page, communicating and engaging patients and family members it surprised us a bit in terms of the relative lack of enthusiasm for patient engagement and it wasn't because people didn't believe that it was an ingredient for success, it was more to the idea that folks are still at an early stage of developing effective payment engagement strategies so understanding on the heels of how to deal with view, download and transmit for Meaningful Use, other types of patient engagement tools, there was a sense that this was important but there was still a lot of area in which folks were still exploring and learning.

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

This is Mark with a...

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

Hi, this is...

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

Oh, go ahead?

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

No, go ahead Mark, I'll follow; this is Terry.

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

So, I don't know if this is folded into to say your last item communicating and engaging but we see increasing movement toward patient generated health data, it seems like it's going to be...I mean, it's already...it's been there in terms of family history for a long time but increasingly patients are going to involved I'm wondering if that's a process that's either folded into some of these things or even if it is I'm wondering, given the way things are going, if it shouldn't be listed separately if that makes sense within what you're trying to do.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Well...

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

So, both the patient generated health data and data from other non-clinical settings I should say.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Yeah, it was integrated and feathered across this. So, the arch of that movement for the data of those types both patient generated and from non-traditional settings the volume of that is increasing and the velocity is as well and providers recognize that and I think what they've indicated there is, at this point, still the sense of learning of how to deal with it and untangle it and it's an area where they didn't have a lot of patented solutions, they had some best practices and some lessons but there wasn't an overall sense of a playbook that applied across all those.

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

So, this is a list of processes that are currently in use not necessarily ones that are expected in the near future?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

It's a bit of both, a microscope of what's currently in use and then in probing them we asked them which ones were emerging and, as we'll talk about in a bit, are those emerging ones able to address the challenges that they're facing.

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

Well, that still strikes me that it's something that's going to be big and should be on the list for what that's worth.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Okay.

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

Yes.

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

This is Terry O'Malley just to follow-up on that comment from Mark, and I think the other piece is going to need to be bidirectional.

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

Yes.

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

Most of our experience now is sort of unidirectional, you know, through portals, through whatever, but it's not only the volume but it's going to be the bidirectional volume and then making sure, again, that each, the recipient and sender, understand a common vocabulary.

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

Right.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Okay, thanks, that's helpful.

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

If...this is...this is Norma, I'd like to, if I could, just speak as a consumer for a moment especially when one gets to payment models and I'd just like to make a plea that if any of you haven't taken a look at bills that are given to consumers lately you might want to take a look at that, it's almost unintelligible to get consumer or patient involvement in that because of all of the complexities of cost versus charges, versus payments and co-payments and somehow along the line we have to think of the consumer.

And I considered myself sort of an intelligent consumer or an experienced consumer, I don't know what sometimes other people do with these, but somehow in our moving forward that has to be more transparent and more able to be understood by people who have to share now in decision-making about "am I going to do this or not if I have to pay 20% or 30%" I've got to understand of what.

So, I just make that plea because this is still so much dominated by the people who think they pay and do pay most of the bills but we also want the patient engagement and the consumer engagement. So, that's a plea.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Thanks, Norma. I think that's a helpful transition of the challenges we face with the billing process to slip and move to the next slide Lonnie which is the most frequently cited challenges. So, recognizing and given our limitations on time what you have is a high-level list here organized under the CCHIT Accountable Care Framework of the most frequently cited challenges and we wanted to spend and focus some time on the ones highlighted in blue because they emerged consistently across the folks that we spoke with as being challenges.

So, the first one under care coordination, managing referrals including the tracking of status appointments and being able to close the loop on the referral. One thing that we did note is that often time's folks in integrated delivery networks and providers will tell us that this is less of a challenge and that's primarily due to the fact that they are working on a common health IT platform either from a constellation of vendors or perhaps even a single vendor.

When you move outside of that closed and walled garden environment and have to manage referrals in a more heterogeneous environment with multiple technologies and more partners outside of your contractual arrangements this was identified as a significant amount of pressure. So, being able to track and manage the paper chase was something that providers spoke to loud and clear.

The second area identified under patient and caregiver relationship was the notion particularly from hospitals and provider practices that had established some sense of the portal strategy is one that's fraught with complications that taking on the consumer perspective of having to manage access to multiple portals was found to be a constraint and then looking for solutions that would be able to proffer data to patients in alternative ways was thought to be a more attractive solution than the current proliferation of portals.

And the third area, which under clinician engagement was mentioning, again, the integration of risk stratification information, again, the notion that even though the providers have the tools and products available the difficulty getting the risk analysis embedded into the workflow and then being able to modify and adjust that based on a population and/or a specific individual moving from one category to the other.

So, these were some of the challenges that were identified and it hints at some of the possible technology solutions that could address these challenges. I'll pause here if folks want to have some questions or comments.

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

This is Mark, I'll just jump in and point to the one about patient frustration as illustrating how it might have been helpful to have a patient representative, consumer representative involved in these discussions as well.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Yes.

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

And this is Terry O'Malley, I'd comment on the managing referrals, it's not only an issue of sort of tracking but this is a huge patient safety issue because referral management is a series of feedback loops that may not occur and so you really want to be able to track a referral from its inception to actually the results of the referral being acknowledged and acted upon. And there are probably 10 or 12 steps in between.

So, maybe broadening this to take on the safety issue component of referral management might be helpful.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Yes, thank you and we'll talk about that as we move along into some more detail.

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

This is Amy and I would just echo that these challenges have clearly, you know, again, this is very consistent with what we hear and see in our state and the patient/caregiver relationship management and multiple portals is an ongoing, I mean, all of these are ongoing big issues, you know, again, maybe off the topic a little bit but sort of the role of HIEs in helping to try to deal with some of this and how they can get folded in on a number of these issues I think is something we might at some point want to think about.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Okay, thank you, Amy. Okay, with that I'm going to turn the microphone over to my colleague Mark Falcone who is going to describe our technical expert panel.

Marc Falcone – Manager – Audacious Inquiry, LLC

Thanks, Lammot, if we could go to the next slide, please? So, now we're going to talk a little bit about our TEP, our Technical Expert Panel, focus and methodology as Lammot said. Next slide, please.

So, the TEP members consisted of providers from a variety of organizations both large and small, rural or urban who have experience or firsthand knowledge of the requirements and challenges of participating in various alternative payment models be that ACOs, bundled payments or PCMH. We invited those individuals who could provide both a clinical and technological perspective inform and direct the TEP discussion. Next slide.

And so our process included three steps. In step one we created a list of capabilities which were earmarked as necessary for success in APM as identified by our literature review and interview findings.

In step two we asked the TEP to take our list of health IT capabilities and rate each capability through a process that we're going to walk through in detail in an upcoming slide.

And then our third and final step, the TEP ranked the list of those capabilities which led to the prioritization which would then help inform next steps regarding certification. Next slide, please.

So, when creating a list we decided to start with the CCHIT list of 270+ capabilities which were published in 2013 and work down from there. Our first priority was to review and interpret the entire list of capabilities and apply a first pass filter to remove those that should not be considered by the TEP.

The three filters that were applied were for starters administrative functions. Because our focus was on the clinical functions and capabilities we wanted to remove those that were administrative in nature. Capabilities like the ability for patients to schedule primary care using on-line and mobile devices, that's certainly a helpful capability but, again, administrative in nature.

We then removed those capabilities that were not identified from our literature review and interviews as being critical to providers participating in APMs.

And then finally, those capabilities that were included in the 2014 and 2015 final rule editions were also removed from consideration. And so what we were left with was a list of 20 capabilities that were identified as being critical for success in an alternative payment model and we used this list as a foundation to begin our discussion with TEP members. Throughout the process panelists were encouraged to recommend any additional functions and capabilities that should be considered or reconsidered in addition to these 20. Next slide, please.

And so for reference purposes here is the list of the 20 capabilities that were identified and now I'm going to turn it back over to Lammot who is going to walk us through the process that we used to rate and rank each of these capabilities.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Thanks Marc. Before we go on I want folks to know that we did encourage at multiple points that the technical expert panel gave us feedback and add to this list so that we'd also encourage you to think about this as well if there are capabilities that we have inadvertently left off for consideration.

Again, as Marc described, there was a filtration process so we recognize that some things were important but where either administrative in scope or also already being addressed in existing certification.

So, for a number of those that you would consider important they were removed for those two purposes. So, Lonnie, if you could go to the next slide I will talk about...

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

Can we pause for just a quick question? Can you...

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Sure.

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

Because I'm trying to read quickly, so let me just ask the question it may be here. How does patient and family caregiver engagement fit into these functions?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, patient and caregiver engagement if you look through the functions we had on the left-hand side engage...I'm trying to go through. It was not specifically called out I'm trying to...I apologize scratching my head which one would...in terms of a specific item, one of the thought processes was that the 2015 certification mentioning APIs and other types of methodologies for view, download and transmit was a first stab at addressing this and so...

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

Well, I'm seeing under engage preferred providers and clinicians, and care teams there is the second line identify patient authorized family caregivers. We just did a webinar on the 2015 edition yesterday that transitions of care are starting to include patient goals, care team members, patient health concerns, the PGHD point as well you're going to start getting uses there. It seems like I would have expected it to be more integrated throughout this list than I'm seeing, which is the reason for my question.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Okay so that...

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

So, Mark just in response, this is Kelly. I would say, I mean, if you look along the function list...

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

Yes.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Several of these do actually...they do actually relate to the consumer. So, I think...while I don't know if it's a semantics issue the shared care plan monitoring patient goals, well-defined care teams, I mean, they all have a patient engagement component to them.

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

Thank you.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

And...

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

And I'm just checking on the...sort of the patient's active integration, the shared...sort of the shared decision making component of this so that monitoring I recognize the conversation is also the kind of thing I was looking for.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, I mean, I think it's a good note for us to go back and look to see from the original 270 functions what was taken out around sort of shared decision making or the shared care plan. The shared care plan management and all those concepts around that we had extensive discussion of but we could go back to see if there is anything around SDM specific that was taken out because it wasn't applicable to a health IT capability that could be certified.

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

All right.

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

This is Terry O'Malley, just a comment, I can't help myself, but looking at this through the lens of a person-centered care plan rather than a patient-centered plan, you know, the patient lives in the context of healthcare system, the person, the healthcare system lives within their context. So, just a slightly different frame on these issues because it's got to be much broader than patient, it's going to be a person and their interaction with social determinants of health and all of the slew of agencies and institutions that we've alluded to that aren't included on this list.

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

Kelly, this is Amy and in that context were there discussions around advanced care planning documentation sharing or is that embedded in other things here in general?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, there was a lot of discussion of that and I think in the next few slides we're going to get into a more detailed sort of separation of the care plan related to capabilities that were then sort of further ranked and considered.

And also, I just don't want to dismiss the shared decision making concept and generally speaking we really want your input on gaps. So, person-centered planning and how that's different from what we're talking about that's more clinically oriented here and also the things around shared decision making if they're missing or even missing from the initial list of 270 that CCHIT had...we used as a starting point, we need to go back to it and consider it.

So, please continue to raise these gaps. I don't mean to dismiss them in any way, but I think if we let the next couple of slides...as Lammot goes through them you're going to see sort of how this was further delineated.

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

Yeah.

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

Kelly, this is Joe, so one of the things that maybe...I mean, it seems pretty consistent coming up from the workgroup is because this was...and you guys were working on a fast timeline here too, it is specifically pretty provider centric along those lines and so as this process narrows and as this list narrows, and as you get into more details of vetting each one of these capabilities I think that viewpoint is what's reflected in this report going forward but I think you're recognizing from the workgroup's perspective sort of the acknowledgement of that limitation of these lists and sort of the concept of it being comprehensive or it's a...and I know Lammot you said sort of it's a starting place but I think acknowledging it's limitations given who was involved and the frame that you had to take in order to move quickly through it is one of the areas that needs to get expanded and probably should be reflected in the report too.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Okay, thank you, Joe. Okay, so I'm going to move through the process keeping an eye on the clock and so Lonnie the next slide was a way for us to talk about each individual capability. We asked the panelists to rate and rank each of the health IT capabilities across three dimensions and using a Likert scale the panel rated each capability as follows, the first dimension was the criticality of the health IT function capabilities for providers successful performance in APMs ranking from five being very important to a one unimportant.

The second dimension was the gap between the ideal state and the current level of availability and use in the market and asking the TEP to acknowledge or identify a gap as either very large as a five down to no gap as a one.

And then the third dimension was the likelihood that the market absent a certification regimen would be able to cure and close the gap by 2019 with again looking at a crystal ball as that potential very likely and high as rated a five or very unlikely low rated a one.

So, we're going to walk through the sort of the ratings across each of these screens and pause and talk a little bit about what we found and then at the end of the discussion of each of the screens I'll talk about how we integrated and pulled it all back together and some takeaways from that process.

So, to begin with let's start with the criticality ranking. Now on slide 21, Lonnie if you go there, and I apologize for the inscrutably small font and as a reference point this could be something to take away and digest but give you all a sense of where the technical expert panel landed. This shows you the 20 capabilities ranked by the percentage of the expert panel who rated the capability as either important, which was a four or very important that was a five.

So, at the top of the list you can see those that where every member, all eight, indicated that the capability of care plan accessibility by patient designated providers and specified health plans and case managers all eight of them designated as either important or very important. And that moves all the way down the list to the one that ranked 20th at the bottom.

So, the key takeaway for this, at least from our perspective, is that all of the ones were important with the exception of the last one down at the bottom which was the management and presentation of data in multiple formats, graphs, charts, etcetera in the sense turning those Excel spreadsheets into nice pie charts and trend lines was identified as not being very important or important.

So, this gives you a list in a sense that of the 20 there was a good feel that all of them had some importance and a role to play in success for alternative payment models.

Going to the next dimension which is understanding there criticality what is the gap in the current marketplace. So, on slide 22 you see that the experts rank for the existing gap and the use of the health IT capability by providers, in a sense, how prevalent is the capability in the marketplace and if not what is the size of that gap?

As you look to this, again, sorted from the top with being the biggest gap to the lowest being the smallest gap, what arises and the key takeaway for us is the preponderance of capabilities that align with supporting the care plan.

So, if you look at numbers one, two, five and six these all address specific dimensions on either making the care plan accessible, having it formatted to be readily used in the accountable organization or being able to monitor the care plans milestones and goals. And looking at this constellation of care plan activities they seem to rise to the top which I think Joe was consistent as we went through this.

The next dimension, the slide, our third screen, was the ability of the market to close the gap by 2019, in the absence of any certification just the natural harmony of both the purchasers and developers of these tools coming together and being able to get what's needed and have it widely used in the market. So, this is an inversely ranked list that identifies those capabilities whose current gap would be least likely to be cured by the market at the top.

And here again we see that the health IT capabilities around the care plan are perched quite frequently in the numbers one through ten slots in terms of ranking of where they stand in terms of the market's ability to close the gap. So, that's a very high-level overview of the three dimensions that we screened and ran the capabilities through.

If we go to the next slide I'll talk about bringing the data and information together and what we did was having splintered them across these three dimensions we pulled them back together into the eight groups that you see listed here and they're ranked in the order of collective importance in terms of the IT capabilities that, again, aren't covered by the 2014 and 2015 editions, and this was the panels prioritized rank of what to focus on.

As indicated previously, at the top of the list there was a cluster of 11 capabilities around the care plan and as Joe and others mentioned it was interesting that the discrete capabilities of the care plan may enhance the functionality care plan but even then there was a question as to how do we ensure that this is a dynamic living care plan that has the ability to be updated and accessible, and monitored and acted upon in real-time so that being the top constellation of capabilities moving down the next one was referral management two specific discrete capabilities around referral management in terms of identifying the individuals responsible for the task and then integrating the provider list into the referral process. And there are other dimensions of that but those were the two capabilities of the 20 that fell within the referral management category.

Moving down is the multiple communication modalities, sense of us moving to the mobile platforms and using texts and other types of communication was important and it was actually being used in the marketplace, there was significant caution regarding the potential misinterpretation of messages and that impacts on patient safety. So, that was one that was also identified and flagged.

Moving down is notification of tests and intervention results. Not only to alert the ordering provider but also this notion of with split responsibility and accountability across individuals what are the ability of these tools to ensure that people that do have accountability are getting information that they need to act appropriately.

Number five, getting the data extracted in a standardized format really speaks to the fundamental notion of interoperability that at the edges of these systems they need to be able to communicate in a common manner so that they can be digested and understood by receiving systems. And then down through the list, risk stratification we've talked about that a bit.

Number seven was quality performance measures and I want to emphasize that it fell to number seven on the list not because it was unimportant or because there weren't challenges but the particular capability that made it through the screening process was just anchored on the storing of the quality metric and that particular capability writ large to all the other things that have to happen with quality performance wasn't deemed as important or a big gap as some of the things that were higher up on the list.

And then as I mentioned the one that fell to the bottom of all three filtered lists was the data visualization. So, this was the overall rank of the capabilities and I'll pause here for people to have comments or questions.

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

This is Norma, I have a question about number one, the care plan, you know, we debated that in our group several times depending on what's really in that depends on what is missing. And what is important to some groups is clutter to another. How did you deal with what is a care plan or did you not deal with that? What is a dynamic care plan? What does it look like? What is it made of and how far does it go?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, we...

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

So, I can jump...

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Go ahead.

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

Norma, this is Joe, so I think we had a lot of debate on this because that...

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

Right.

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

Precise point came up a lot and initially there was a lot of discussion around how can you sort of certify or say that there are certain functions of the care plan that need to be there when you're not really sure what makes an effective care plan to advance sort of the health of a patient or a population along those lines and because there is so many designs that were out there and discussed.

So, there was actually a hearty amount of debate I think on the concept of care plans and I think that's part of how it was put into these three elements where we're talking about sort of whatever that care plan is it needs to be accessible to the people that are supposed to be responsible for whatever those tasks are. So, it got a little genericized to that level fully acknowledging the fact that we still didn't know what made, what are the true components of a truly effective care plan and to your point it's different from different perspectives so it may not just be one care plan.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

So, this is Ginny Meadows and I would absolutely agree with what Norma said and then your comments Joe and I think I would really caution any attempts to actually overlay some kind of certification criteria to a concept that's not really well-defined and is not truly sharable if we don't have a common understanding of what this is. So, I would be very cautious on how we would proceed with that first comment.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

I think that probably...this Kelly, I think it might be helpful to just bring people up-to-speed a little bit because for the last three years we've actually done some extensive work with the clinical community and technology experts that actually Terry O'Malley could best describe because he was part of it all.

So, we had a standards development process that yielded the C-CDA care plan template, which is not necessarily trying to prescribe everything that has to go into a care plan, but it is providing a structure to share a care plan and there is wide recognition that the clinical community and various disciplines need to come together to better define the care processes and how all this will get implemented and used more broadly particularly in the context of these alternative payment models.

But in terms of, you know, a consensus on what should be the data elements in a care plan and how might that be consistently transported from one provider to another there has been a lot of work over three years, there is a balloted standard that's been implemented and it's now in our final certification rule and I invite Terry to offer any input on his involvement in that and just other...there's really extensive collaboration done in recent years to sort of get us to the point we are now.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

And you know what I agree that there has been extensive work done and it is part of the Consolidated CDA but to me that's a very episodic and care setting based care plan. I felt like we were talking about a different type of care plan and I know we've had discussions amongst our workgroup around what that would be. So, I guess I feel like we're still talking about potentially two different ways of defining something that some people think is very clear.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, no, and I think everyone noted and Joe and others can speak to this, everyone knows that this is a...you know where we're going to be more dynamic and more of a shared construct we are not there yet but we are along a continuum of change and to just get some progress in the market I think there's been broader recognition that we need to start where we are today to be able to support at least for the care management vendors and care teams that do want to be embracing the use of where we are today with what we understand today as being sort of a document-based care plan not dynamic, not shared, you know, in a virtual or wiki-like way. But we are looking at where do we go over the next five years we have to build from what we have today.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

And that's why...

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

But I think...

Ginny Meadows, RN – Executive Director – Program Office – McKesson

It's really important to set those standards and figure out what it is we're building before we certify it.

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

Yes, I...you know I totally agree, I think it's too easy to pass over it and I think you're asking for our input and we're saying don't move so, you know, rapidly and leave the field out think that this is kind of a subtle thing we maybe went a step one on a ten step process and then all of a sudden we tied payment to it before we even say "hey, there's a whole lot missing here." And I think, I wouldn't want that to just go so smoothly in that direction.

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

This is Joe, Terry can we ask...you participated in all the discussions we had in this workgroup too over the spring as well on this topic what are your thoughts?

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

Yeah, no, I think we're early on the journey and I think the work to date has been an attempt to define at least some minimal components of what would be in a care plan but in no way define how they're combined or how they're transported or how they evolve, or how we track all that.

So, I mean, these are all issues that are going to be critical in creating the ultimate dynamic widely shared continuously updated care plan but we started with some basic pieces that appeared to be common to all plans, care plans, plans of care, treatment plans, you name it, HL7 said a plan is a plan, is a plan so treat it like one.

So, I think we've got the basics in place but I agree wholeheartedly that we have a lot more work to do to not only refine what the content might be but more importantly how that content continually evolves and how we reflect that and how we manage it. There are a whole host of issues.

So, I don't think this is subtle by any means and certainly the work that's been done in no way tries to imply that any of this is settled other than some of the, you know, the basic Legos are in place but not the whole structure.

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

So, this is Amy...

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

This is Mark, can I...

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

This is Amy and I was going to actually, if we're done on the care plan, I had a question and comment around four, the notification of test and intervention results but I don't know if we're done with care plan yet.

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

This is Mark with one thought on the care plan which is to actually harken back to what Terry was saying about that it's not just care it's health planning and with the whole goal of improving outcomes with alternative payment models hopefully lifts that up even further. So, I just flag how does that get factored into this cluster or into the thinking across all of these?

The second thing I wanted to share...to point out is that I think both the care planning and the multiple communication modalities, if I'm understanding it correctly, are places where patients, family caregivers and so forth are front and center. So, once again, top of the list getting that perspective is important. Thank you.

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

All right, so this is Amy, and then if I don't hear anyone else butt in I'll go onto the notification of test and intervention results. So, my sort of comment/question is, as I read this it's about the need to alert not just the ordering provider but whoever the patient is attributed to in terms of both notifying them about some sort of an event or test or admission and then whatever the results are.

My question is, one of the things we're wrestling with is as we move to advanced payment models multiple entities are putting care management systems, nurse care managers in place and who ultimately responds and deals with the family and then how that gets transmitted to the other providers, I don't know if that's sort of embed back into the care plan conversation but, you know, if you're doing alerts and notifications on either admissions or whatever, you know, we've talked about the potential at least our plans have nurse care managers, our PCMHs have them, we're setting up community health teams, you know, is the patient going to get barraged actually by too many people trying to care manage them?

Where does that coordination of care management then come into play with some capability to notify who is doing what and does that go...and again, my question is, is that embedded back in the care plan with the actual ability to say, this is the entity or organization that's actually doing work to take responsibility to try to make an impact on that patient.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, this is Lammot, I think it lies in two places, it is back in the care plan so the establishment and tracking of goals as part of care in process but also separately we also heard strong sentiment that we don't want to overload the care plan, become the artifact that is responsible for collecting everything that we may have orders for specific discrete types of tests and others that can exist outside but inform a care plan so that's an important distinction and to have a registry of providers that then would be able to have certain characteristics so that they would be known as to where they fall in the continuum of the care management team and then also, as one of the TEP panelist describe it, as an escalation path that is also helpful to understand which of these providers of the care team are responsible or better served to doing certain things.

We talked about using a microscope, we talked about trying to figure out where we are, a crystal ball where we're going, I would attribute this almost to a magic wand, if we had a system that would be able to pull all those pieces together and show the appropriate escalation path an individual responsible is something that folks said would be incredibly helpful in terms of helping them navigate the environment that they anticipate.

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

Well, yeah, I think it is kind of a magic wand to get there quite honestly because I see the potential for everyone wanting to sort of grab on and manage this high risk high utilizer patient and people bumping into each other in the care management space around the patient and that's only going to frustrate the patients and their family.

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

Yeah.

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

So, if we're ready to switch topics, this is Paul Tang, can I ask a question?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Sure.

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

I apologize for joining late but I noticed the quality performance measure being ranked low and you said that it was because the only thing that went through the process was storing of the quality metric data so I may have missed why that was the only one of all the things that were mentioned in the reporting, it was under the reporting column in the framework.

So, two comments, one, why only that store quality metric data made it through this process and two, this reporting column doesn't...it really is reporting and it's not using our measures to help motivate change on the front lines every day. So, I'm wondering where we've lost...is that a gap that we have in the current way of looking at things?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, Paul, in terms of why that fell through the screening process one of the things we did was impose a discipline for items that were addressed in the 2014 and 2015 edition in terms of quality measures and the like there was a sense that this was already being addressed and to some of the dimensions. So, we can revisit that and I think as people get a sense of what is actually in the final rule in the 2015 edition that may color their interpretation of specific capabilities but when we were doing this we were just at the cusp of the Notice of Proposed Rulemaking going into final rule and so we were very careful to screen out things that could potentially be included and as a result this one was the one we asked the expert panel to review and rate.

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

Yeah, Paul, this is...

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

One more...

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

Kevin from ONC, we had some intense discussions around this. The very specific item here was the fact that once you've calculated quality scores could you store those in your system so you could go back and prove that this was what your score was on a certain day and many people reported their systems can't do that now, they can't recreate what their score was last month or the month before.

The data visualization sort of got put into this overall data visualization but to the points we made earlier in the call we were very open to other things that weren't included here and other ideas and this is the start of a conversation at the end of one.

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

Okay, so let me expand on that then, so thanks for kind of, you know, reviewing the part about the certification rule but I think we're looking at quality measure very narrowly in this case, one it's looking at it as only a respective report and I think we really want, especially in the context of APM, I mean, really front and center which is why I'm really disappointed how it fell off the chart essentially is to have quality...one, a better sense of what quality is, two, using better data than what's been by necessity driving quality measures right now and three, getting the impact and insolvency into the frontline at the point of care, I think that is something that really is glaringly missing from today's systems in order to do care coordination in the context of an alternative payment model and just like...that's almost the front and center and I certainly support the care, shared care plan because that's how you do improve and coordinate all of the activities around the patient.

So, I'm rather dismayed that this has essentially fallen off the plate when I think it's actually one of the top two things in the context of APMs. And I worry that we drove it from looking at where we've been and the things we've done from a data up to reports point-of-view rather than looking at how do we assess our performance and continuously improve it which I would think would sort of be more the skating to the puck and that's my view of looking at this. How do we support APMs because we're already skating to the puck or where the puck is going.

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

This is Amy and I would support what Paul is saying and talking about the feedback and benchmarking relative to the cycle of quality improvement.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Okay. Kevin did you want to have any other final thoughts before I move onto quality?

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

Yeah, no, just to say that, you know, in part because of the timing of this TEP discussion. We couldn't fully lay out what was in the final rule because it wasn't out yet and therefore I think a richer discussion now that we know exactly what's in the final rule and to talk about what's there and the gaps that would be helpful for APMs would be terrific.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Okay, I'm also cognizant of the clock, so I'll move us through, and the next slide, Lonnie. So, in addition to the items that were noted and then you all have offered two other considerations arose and that's the inclusion and ability to address usability as a concept, an important construct that is in light of the challenges, I think Amy as you described it, about being able to access the information and actually be able to use it. So, that was something as we looked back and are going to work into final recommendations considerations around usability.

Another item that was raised by the panelists was around the challenges for accurate patient identification. I know that's something that this group worked on this spring and summer in terms of identifying the capabilities that would be needed for success in advanced health models so that was also identified and will be recognized in the culmination of what we deliver.

A dimension that the panelists also asked us to consider was the extent to which the capability was included in the clinical and care process workflow. So, this notion of the technology being existent and the capability are available in products get a little better sense of how it interplays with the workflow was another dimension that we added a rating scheme to. So, we're still digesting that information as well.

And finally, the point that Kevin made is that there was a lot of conversation about the readiness of certification standards and functions, and understanding that the TEP in terms of thinking about the trajectory for each capability that being informed by what was the current knowledge of certification around functions, capabilities and standards was going to need to be brought to bear in order to determine final recommendations.

So, having still a little bit of work to do with the technical expert panel on the clinical and care process workflow what we've done is organized in the following slides discrete information on the readiness of certification capabilities.

So, I'm going to move through and probably given the amount of time Joe is be able to talk at a very high-level and then turn it over to you to address any final comments, considerations and then advance recommendations to the HIT Policy Committee.

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

Okay.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Thank you, Joe. So, Lonnie, if you go to next slide and one more slide we'll dive right into the certification categories. So, as I mentioned it's important to understand the discrete and often complex undergirding of each capability in terms of how it ties to specific standards and certification components and in order to do that we organized each of the 20 capabilities into five different buckets and these categories are identified on slide 27.

The first category, Category A, would be those capabilities that require a new certification criterion and that criterion is mature and ready to go in terms of its being implemented into a certification process. So, if you're thinking about whether a particular capability could be certified capabilities that fell into this category we would characterize as the easiest ones to include because there's something to point to it's ready to go and as we'll go through and show you that 4 of the 20 capabilities fell into this first category.

Moving down the list, Category B, capabilities that require changes to existing certification criteria. So, like the first one there is a viable standard to certify it against but in the current certification regimen it's optional and we could switch it's optionality to a requirement and 3 of the 20 capabilities fell into this second category of a change from optional to required could advance its inclusion in certification.

Category C, are those capabilities that require maturation of a potential standard or an aspect of their functionality. We looked at this by, again, thinking of a timeframe if capabilities need to be widely expressed in the marketplace by 2019 certification in other types of approaches are going to need to be in place earlier than 2019. So, in thinking about the various levels of maturation understanding that there is the Interoperability Standards Advisory we put out as a timeframe what of the relative maturation could we anticipate by October of 2016 of this year?

So, all of the capabilities that fell into Category C are those that there is a preliminary standard to function to certify against and we could point to but some additional work needs to be done relative to our assessment for inclusion. And the bulk of our capabilities fell into this category 9 out of the 20.

So, if you're going down and moving through the list that's 16 of the 20 capabilities fall into this level of readiness for certification in the first three categories.

The last two categories speak to capabilities that require development of a potential standard and in these instances there is nothing available in the process and maybe just starting to be piloted but it's not going to be ready by October 2016, it could be ready by October 2017, we're not prejudicing that we're just saying, what does it state now and what can we anticipate by October 2016. Three of the 20 capabilities fell there.

And then finally, we created a fifth category where we recognize that there were some certification criteria that are ready to go and they're mature but they would have to be applied to other entities beyond the Medicare providers that would be eligible for the payment mechanism. So, for example, the one that fell into this is the data exports from non-EHR users, the ability to get data from payers in a standardized format would require something outside of certification for provider's use of a health IT module or tool.

So, what we did is using the schema, as I mentioned, is we ran the 20 capabilities through and slotted them into these various buckets and what follows is a description of where each of the criteria fall and some discussion of what it would take to be included in a certification process. So, given the amount of time that we have walking through all 20 of these could be days of conversation for each one and what we'd like to do, recognizing that we're still in the process of formalizing the findings and recommendations is give you a hint of how we organized this and additional information will be forthcoming. So, Lonnie, if you could go to the next slide.

What we've done is organize all the capabilities that fell under that first bucket that's the bucket that there is a certification criterion or standard that's mature and ready to be pointed to. There were four of the capabilities that fell into this category. The first at the top of the list is to facilitate communication among team members using multiple modalities conforming to security standards and what we've done has shown that this ended up being ranked overall number 10 where it fell in terms of its criticality 100% of the panelists felt it was important and critical or very important. There was a gap in the marketplace identified as being significant by half the panelists and then the likelihood that the market would correct was relatively high. That being said, if this was to be...if this was to be included in a certification process that the notion or idea would be that we could require forms of communication like texting and instance messaging adhere to existing security and privacy criteria.

So, again, the theme of everything that falls on this page is there is something that exists and it's just a matter of pointing to the criteria. And it's a methodology that there were some areas and we worked hard with Kevin and others who are deep experts in the certification process and recognize that some of the capabilities would touch on multiple standards and elements of certification so that complexity is something that was difficult to represent here in the timeframe that we have but it's something that we are factoring into the process for arriving at recommendations vis-à-vis certification.

So, Joe, I think I can pause here and turn it back to you. The next steps for us are to finalize your output from the last rating filter that we created and then develop recommendations that we'll turn over to the Office of National Coordinator for Health IT later in November and I think we wanted to leave some time for you for discussion in preparation for the HIT Policy Committee.

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

Thank you, Lammot and Marc. Do you want...is there any sort of general comment or feedback on the five categories and how that got laid out? Does that make sense?

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

This is Norma, just a question, are you still...are we still limited to the existing law of the eligible providers including most of these people meaning hospitals or physicians and physician offices?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, that's interesting because the statute in MACRA focuses on a Medicaid sorry Medicare providers and those are eligible Part B payments. It gets a little interesting in that candidates for alternative payment models are envisioned to include commercial entities and also Medicaid. So, while the scope of this may be Medicare eligible providers for payments there is a recognition and understanding that this spans multiple stakeholders. So, how that all gets addressed I think is a complexity that is going to be determined and I'd turn to others...

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

So, we...

Lammot du Pont – Senior Advisor – Manatt Health Solutions

To weigh in.

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

So, you're sort of suggesting we keep thinking more broadly?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

I think it's helpful to think broadly and we again, in mentioning and showing that there are levers that need to be expressed to entities outside the traditional concept of Meaningful Use is something that we identified that's that 5th category, Category E. So, at this point because there is nothing eminent we have an opportunity to think broadly and then narrow as we go along as we're required to.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, Lammot, I would just add beyond MACRA and the provisions in 101(e) which I think are really more geared at sort of how, you know, clinicians that are impacted by MIPS largely eligible professionals would be transitioning into these alternative payment models so it primarily impacts them.

ACO networks, as we know, are broader and more broadly when we look at the interoperability roadmap we've laid out sort of a strategy that goes beyond hospitals and doctor's offices and clearly would like to use, you know, our authority as appropriate in terms of certification of health IT products and services and try to drive, you know, interoperability across the care continuum and beyond.

So, we're not, I mean our certification program is not restricted by, you know, what's in, you know, prior statutes around Meaningful Use and HITECH or MACRA. So, you know, and we're looking increasingly to collaborate with states and our Medicaid colleagues in making sure that their policies are reinforcing certification and standards, and private payers as well.

So, I think we can be looking a little more holistically across the universe it's just that as it pertains to MACRA it could be argued, you know, just from a strict legal perspective that it might be a little bit more narrow.

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

I have a question, this is Paul Tang again, I have a question on...in terms of going forward, it sounded like the report is due at the end of this month. What I heard, and again, I'm sorry I joined late, what I heard from the comments of the workgroup it seemed like one an observation I think the process looked good but there is some concern about the input feeding into the process and some of the gaps we talked about whether it's surrounding patient engagement or shared care plan sounds like the function came through but, you know, our readiness is still uncertain and then this whole notion of quality, doing more than just reporting on quality measures and having it be much more of an influence or in care.

If we look at the goal of this, the charge for getting the systems ready for 2019 alternative payment models I don't know that we can miss let's say these three things that possibly haven't been vetted enough from being input to the process. I think they're just missing so they never even got scored in a sense. How can we deal with this?

Lammot du Pont – Senior Advisor – Manatt Health Solutions

So, I'm going to defer Paul to Kelly in terms of next steps for inclusion in the discussion process. I know that there is currently an RFI that's available and that the final rule contemplates comments and as I mentioned at the outset that this is a discussion that's going to proceed in the future so Kelly or Kevin anything about next steps?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Next steps in terms of public input or...

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

Well, this is Joe too, so to Paul's question I think if the charge was for our workgroup too to think about how...what things are critical in terms of helping provider's systems be successful in APMs in the future, I think this report takes a fantastic swag at it, but there are some things that the workgroup has identified in terms of, well we could probably look at it in maybe a couple of different ways as well too that could fill this out and make it robust.

What, in terms of next steps of...if the workgroup recommended that, what...is that tenable or is that the type of things that helpful or are we at a time crunch where we're just narrowing down and we have to get more focused rather than expanding out?

It sounded like we wanted to expand out, but I'm not clear.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, I mean, it sounds like there is an opportunity to do that. I think it might be helpful to hear what the full committee says next week and then we can regroup and figure out what would a good actionable agenda be either looking more expansively at some of the issues we don't feel are adequate...you all feel that we're not adequately addressed, you know, some of the gaps that were noted or also just more clearly defining the orientation around being person-centered and what does that mean in the context of some of those gaps.

So, yeah, I mean, I think, because this is sort of the start of the conversation there is a lot of room to sort of carve out what's next and I think also, you know, there is a recognition that it's not that everything has to be perfect or is anticipated to be anywhere close to perfect January 2019 this is going to be a multi-year process and we're also not trying to be, you know, overly ambitious in the way we're looking at certification there is going to be a lot of things that will drive innovation and market development.

We're really trying to hone in on what are some of the critical things that, you know, over the next four years providers are going to have to rely on and, you know, often we hear from ACO leaders that, you know, things like access to the care plan and being able to do better referral management are core functions that they are not being...and they're just not being served by the current marketing products.

So, we have to I think just come...to where do we...what's the starting point, you know, what do we need to push and plan for January 2019 and then, you know, what do we see evolving over a longer period of time that you all want to opine on and inform.

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

Okay. Paul, what do you think about then next week's meeting and sort of from the workgroup's perspective? Do we need sort of a list of top three recommendations on how to build on this report? What do you think would be helpful for the committee?

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

I think that's useful and then also to get...so this group has...which was formed to look at the advanced health models and has tracked a number of things and there is an important piece is how do we...what are the critical things we can have our systems do to support the advanced health models.

So, clearly hearing what this group's reaction has been to this report is useful but obviously getting further feedback from the Policy Committee is another source of input that would be helpful.

I guess with respect to...so, the 2019...on the good hand 2019 still does give us three years so it's not that we can't get anything done and I think it's a balance of what we can do and a lot of the...what was brought up is process measures but it's sort of how do we both catch up, so the payment system and the market are going in a rather dramatic new direction over a fairly short timeline and I think in some sense we have to catch up, re-equip some of our systems to serve the needs of the new payment model and the new way of delivering team-based care to people.

So there is a bit of this catchup but I think it will be...it seems like it would be a shame to waste the opportunity, again, three years is a decent amount of time, to not also skate to where the puck is going from a...we really are going to involve...just as the financing system, in other words, the cost people are bearing on their own now, it really requires people to be equal partners in this that's where I think we're getting the shared care plan and the people, the person-centered health and the engagement.

And then since it is going to be pay for value, which is another way of saying, pay for some kind of performance score I think we need to give people a better chance at the frontlines of knowing how they're doing every day so they can affect the decisions they make, but these seem to be things that are going to be crucial in this world that is changing very, very quickly. So, wouldn't...as we catch up with some of the process improvements it seems like we also have to work on the new functionality we haven't had but are instantly going to be important.

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

So, when I hear that Paul, and to Marc and Lammot too there, so the framing that Paul just put out there is not sort of antithetical but it sort of is a slightly different cut than the CCHIT framework that we started with in this work here too. So, I think integrating that, that viewpoint that is sort of the tenets that Paul just articulated may help us get to a place where you start to have that, these are things that are tangible big levers that help systems become successful in those future models.

Lammot du Pont – Senior Advisor – Manatt Health Solutions

Okay.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

So, Paul, what I...I just want to make sure I understand what you were just saying though, I mean, the new capabilities in some ways were not all...we need to go back and double check the list but let's assume that in the 270 capabilities from the accountable care framework they were not delineated, it was done a couple of years ago, things are changing they may not have been as person-centered as they needed to be, we're in a different place today.

So do we...we need to be looking at this sort of in a new framework where there could be new capabilities that need to be developed and considered in addition to making refinements on other things that have been sort of part of the historical framework. Is that right?

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

I think that's true. CCHIT of course was pre-AC, pre-era and pre-ACA and it's just a different world and no one...I don't think five years ago we would have dreamed we would be going this fast, you know, certainly in the timeframe the Secretary has announced, but I think we can get there but only if we have the system support to do that. So, that asks us to both help with the process and help with the new view of things.

So, I'm saying, yes, to what you just said, which is we had input which was sort of this...the past conceptualization of what would a comprehensive EHR look like, I think, like you said, even in the past two years the view and people change, people's behavior changed a lot because of the first dollar going to the consumer is really making a need and wanting to do more with the team fully developing and engaging people as equal partners and then using quality measures, which we all recognize, which were retrospective in a very different way to guide...it's along the way of precision medicine, use data, so that would be my proxy for "quality measures" use of data that we have, now have in our system to help guide each and every decision we make prospectively with an individual.

It's possible and I'd hate for us to miss this opportunity. So, three years is sort of just enough time, I know it is fast, but it's just enough time, it's not one year, it's not two years, just didn't want to miss the opportunity.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

So, Paul, this is Ginny Meadows and I just wanted to clarify something too about the timing, because we keep talking about having three years, but my understanding is that many of these things would need to be in place in 2017 for reporting purposes in order to actually calculate the participation bonuses in 2019.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

So, I think what we were originally...just to clarify that...this is less focused on MIPS which those timeframes do apply to. What we are trying to prepare for is the January 2019 deadline in MACRA 101(e) which is having to do with alternative payment models. So, those qualifications of what you need to do in an alternative payment model are what we're planning for. So, there is a little bit more time with respect to that and that's also eligible alternative payment models so it involves, you know, some downside risk or more of the nominal risk.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

All...

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

This will be, you know, specified in future regulation.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yeah.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

But we're just trying to...

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Right.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

You do everything we can to inform what might be proposed.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

And I think it's important to really think about the timelines because my understanding when I look at the way some of the ones that would qualify how they're structured is that they would have some components that would be required for reporting in 2017. Quality measures would be one example.

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

So, maybe I looked at our charge a little bit more broadly, one level up, saying, hey if health systems need to change the way they do business then we need the systems to do that sort of irrespective of regulatory timeline. It's more consistent with I think what Kelly was saying. It's not a specific program, it's now do we reorient our delivery systems, we just need systems to support that and getting the functionality in place by let's say 2019 is the goal. Is that consistent with what your thought for this effort was Kelly?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Yeah, I mean, I understand that a lot of people are so focused on the MIPS timeline and that will effect an awful lot of people as the law gets implemented. We were originally just thinking more along the lines of what's going to be needed in these alternative payment models recognizing that's going to be a continuum between who is in MIPS in 2019 with a performance year based in 2017 and that they'll be continuing between that MIPS and then who is going to end up being in an APM with downside risk that will be eligible. So, not everyone will clearly fall in, you know, one extreme end of that continuum but we do need to be supporting sort of, you know, evolution of all of these products and services much of which, hopefully the market will demand and everyone will be responsive to those demands.

But for the things that require, you know, really consistent standards to move the data around and to meet a lot of these needs we are going to need to think about this more broadly and more broadly meaning a larger continuum of providers and the products that they use and, you know, increasingly we're hearing, obviously from many of you and from many others, that community-based service providers are a key part of that too.

So, I think it is broader continuum, it's not all going to be done by January 2019 but we're trying to sort of break this down to figure out what can we get done over the next say 5-7 years that is consistent with what's realistic, you know, to be done across the standards development community and, you know, our regulatory timeline and constraints.

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

Okay, it's coming up to 1:25 here and I know we need to be open to public comment as well too. Is there, on the workgroup, are there any other sort of final comments and I know we're probably going to pick this up Kelly and Paul too right on Tuesday, so final inputs from the workgroup and potentially I think we should open up the lines, right?

Public Comment

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

Hearing no comments, Lonnie, 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 telephone and would like to make a public comment, please press *1 at this time. Thank you.

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

As we're waiting Paul, Kelly in terms of structure and other things we've got a lot that we can share, we can organize that and bring that to the committee. Is this sufficient at this point in time or is there some off line work you'd like to do between now and Tuesday?

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

Well, I think we were going to try to capture some of the key points that were raised today and some slides that you would have to refer to when you report out on Tuesday.

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

Yes.

Kelly Cronin, MS, MPH – Director, Office of Transformation – Office of the National Coordinator for Health Information Technology – Health & Human Services

And we can circle back with Lammot and Marc and make sure that that's, you know, synthesized and then give that to you for you to review and give us feedback on. So, I think we'll just have to do that in quick order given that the meeting is next Tuesday.

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

Yes.

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

And Paul is not presenting anything else so he'll be fine. The whole meeting is going to be Paul, anyway. Well, thank you very much everybody and thank you to Marc and Lamot.

Marc Falcone – Manager – Audacious Inquiry, LLC

Thank you.

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

We have not public comment so thank you everyone and have a great day.

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

Thanks.

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

Thanks everyone.

Lamot du Pont – Senior Advisor – Manatt Health Solutions

Thanks, Joe.

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

Yes.

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

Bye.

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

Bye.

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

Thank you.

Public Comment Received During the Meeting

1. Sherry Reynolds: Great question - patient engagement is an outcome of patient centered design and clinical process happen outside of the clinic in patient's homes as well.. What is missing are professional consumer centered design experts (in addition to the voice of actual patients) Sherry Reynolds Alliance4Health (former ONC staffer responsible for provider adoption of patient centered health IT)