Collaboration of the Health IT Policy and Standards Committees

Final Transcript
June 8, 2016

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 and Health IT Standards Committee. This is a public meeting and there will be time for public comment at the end of today's meeting. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Paul Tang?

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Paul. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kathy and Arien Malec?

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Arien and Lisa Gallagher will be joining us in a little bit. Andy Wiesenthal?

Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)
Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Andy. Angela Kennedy?

Angela Kennedy, EdD, MBA, RHIA – Head of Department & Professor of Health information Management – Louisiana Tech University
Yes, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Angela. Anjum Khurshid?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Anjum. Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Anne. Anne LeMaistre?

Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health
Present.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Anne. Aury Nagy? Brent Synder? Brian Burns? Carolyn Peterson?

Carolyn Peterson, MBI, MS – Senior Editor - Mayo Clinic Global Business Solutions
Present.

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

Carolyn Peterson, MBI, MS – Senior Editor - Mayo Clinic Global Business Solutions
Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I think Kevin Brady is in for Charles Romine?

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology
Yes.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kevin. Chesley Richards? Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine
Good morning, Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Chris. Cris Ross? Dale Nordenberg? David Kotz? Devin Mann? Donna Cryer? Liz Johnson? Eric Rose?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Eric is here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Eric. Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Floyd. Gayle Harrell?

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Good morning from sunny Florida.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Gayle. Jamie Ferguson?

Jamie Ferguson – President, Health Information Technology Strategy & Policy, Fellow, Institute for Health Policy – Kaiser Permanente Institute for Health Policy
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Jamie. Jitin Asnaani?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance
Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Jitin. John Scott?

John S. Scott, MD - Program Director, Clinical Informatics Policy, Office of the Assistant Secretary of Defense, Health Affairs - Department of Defense
I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, John. John Derr?

John F. Derr, RPh – President & Chief Executive Officer – JD & Associates Enterprises, Inc.; Founder – LTPAC Health IT Collaborative
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, John. Jon White?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology
Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Jon. Josh Mandel?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School
Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Josh. Karen van Caulil?

Karen van Caulil, PhD – President and Chief Executive Officer – Florida Health Care Coalition
Here and it's not so sunny where I am in Florida.

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

Karen van Caulil, PhD – President and Chief Executive Officer – Florida Health Care Coalition
Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Kevin Johnson? Kim Nolen is on vacation. Kim Schofield?

Kim J. Schofield – Advocacy Chair – Lupus Foundation of America
Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Kim. Leslie Kelly Hall? Lorraine Doo?

Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services – Health and Human Services
Yes, present.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Lorraine. Nancy Orvis?

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense
Present.

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

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense
Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Neal Patterson? Patty Sengstack?

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System
Good morning, I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Patty. Paul Egerman? Rich Elmore?

Richard Elmore, MA – President, Strategic Initiatives – Allscripts
Hi, Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Rich. Scott Gottlieb? Steve Brown? Troy Seagondollar?

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Troy. Wes Rishel? Okay, did anybody come in after that long list?

Brent G. Snyder, MBA, Esq. – Chief Information Officer – Adventist Health System
Brent Snyder.

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

Brent G. Snyder, MBA, Esq. – Chief Information Officer – Adventist Health System
Good morning.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Good morning. Did Vindell join us yet? Okay.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology
Vindell was just coming out of the meeting earlier, I'm sure he'll join very soon.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Okay. Well, Jon or Elise I'm going to put you on the spot if you want to make any opening remarks, but before we do that, I've been remiss, I haven't been announcing the Twitter handle on our meetings and we do have a Twitter handle for our Joint Meeting which is #HITPCSC, so HITPCSC, if folks are interesting in Tweeting today. And with that I'm going to turn it over to either Elise or Jon to make a few opening remarks.

Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Jon do you want me to start?

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology
Well, let me just say a few quick words, thank you everybody for getting on the phone today. It was really nice to see you in person last month but I look forward to having a robust discussion today, a set of interesting recommendations coming before you in draft form, so I'm looking forward to hearing the dialogue and Elise the floor is yours.

Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Thanks, Jon. So, I want to just, one I want to thank folks for their participation in our recent annual meeting, so we just had that, it seems it was a few weeks ago already, but I know for those of you who were there it was a great opportunity, we had just another opportunity and a great time to engage. We heard about our new patient engagement playbook, easy to use resources regarding patient access, having that information on hand for the patient so that they can have the information that will help them improve care and be part of that care continuum.

We also had some great breakout sessions on interoperability, MACRA, some of the work we're doing regarding the opioid abuse epidemic, PGHD and measurement, wide-spread interoperability measurement we had a session on that. So, it was really a great opportunity and we thank all those who participated. Those meetings really benefit from having so many different voices, so many different stakeholders and view-points there to discuss and help us also at ONC to learn more about what's happening on the ground so thank you so much for that.

Also, I wanted to thank the QPP Task Force and we are going to be hearing from them today as Jon mentioned and, you know, I've had the pleasure of being on the calls where they were working through these very complex pieces of kind of policy that are include in MACRA and you know that all of the behind scenes work that has happened to try to get the draft recommendations as well as the draft comments together, I really want to extend my appreciation to the chairs and to all the participants on the committee, it is pleasure to kind of work with you and to support your work in trying to help us to get to a better place and get to the best place for these regulations. So, thank you, so much. And with that that's all I have Michelle. I don't know if Vindell has joined but if he wanted to add something as well.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Well, if he does join maybe we'll have him make some closing remarks at the end of the meeting.

Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Sure thing, thanks.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Okay, so with that I'm going to turn it over to Paul to walk through the agenda and approve the minutes from last meeting.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Okay, well, thank you Michelle and welcome everyone, this is a little on the shorter side for a call but not short on content. So, we're going to open up with Vaishali Patel from ONC updating us on a couple of our favorite topics it's really interoperability, well what's the progress we've had so far, what are the barriers and how do we make sure that the information is not only getting across but used as it's received. So, that's an important update.

Then we're going to go into one of the main topics is really to start the discussion about the response to the NPRM on the QPP, the MACRA regulation and so there's been a Task Force that has been formed only two weeks ago, so we are going to see our recommendations in process very open for your feedback and then we're going to work on them again before bringing it back to you later on this month, because it's due at the end of the month.

So, that's what we have in store for today. Any other questions on the agenda or additions? If not you had the minutes from the last meeting in the face-to-face meeting for your approval. I entertain a motion to approve?

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Approve approval, this is Gayle.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Thank you and second?

John F. Derr, RPh – President & Chief Executive Officer – JD & Associates Enterprises, Inc.; Founder – LTPAC Health IT Collaborative
John Derr, second.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Okay, thank you. Any discussions or corrections? Okay, all in favor say aye please?

Multiple
Aye.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
And any abstain or object? Thank you and so we have the minutes approved from the last meeting and we're going to move onto Vaishali Patel and give us the ONC data update. Lisa is going to facilitate this discussion.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
We don't have Lisa yet so I'm going to be Lisa.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Okay, okay.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Hi, okay, wonderful, so…

W
…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Hello? We're good? Okay, so this is Vaishali and I will be, as Dr. Tang mentioned, I'll be presenting today on interoperability. The two main topics that I'll be discussing, first I'll be sharing progress related to interoperability across US non-federal acute-care hospitals and I'll be examining changes that occurred between 2014 and 2015. We presented on this topic last year and we'll be providing an update on the findings from last year. And then…

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I'm sorry Vaisahli, there's somebody that needs to mute their line, if you aren't speaking please mute your line, thank you.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Thanks and the second part will be to describe barriers to interoperability including barriers related to using information that is exchanged. And the results of this presentation are based on the 2015 American Hospital Association IT Supplement Survey which has a pretty good response rate, about 55%

or so. And the findings that I'm discussing today have been published in data briefs that are on ONC's Health IT Dashboard. They are data briefs 35 and 36 if you're interested in more of the details and findings. Next slide, please.

So, again, we'll start first with discussing progress related to interoperability. Next slide, please. So, I think first as context setting it's important to note that EHR adoption is nearly universal among hospitals, about 96% have adopted a certified EHR which largely did not change from the prior year.

There was also a significant increase in the adoption of what are called basic EHRs, about 84% of hospitals have adopted or constitutes a basic EHR which is a historical measure used to track EHR adoption prior to certified EHRs, the development of certified EHRs, so we continue to track that and it refers specifically to the adoption and use of about 10 functionalities including certain functionalities that are not part of a certified EHR and that's why you see some differences between the certified EHR adoption rate and the basic EHR adoption rate.

Now that, you know, EHR adoption is nearly universal among hospitals we really have been and need to continue assessing the extent to which information is flowing across EHRs that have been adopted. Next slide, please.

So, to that end in the interoperability roadmap we outlined a set of measures to assess progress related to interoperability in the near-term so the 2015 to 2017 timeframe. These measures include looking at the proportion of providers and in this case it would be hospitals that are sending, receiving, finding or querying and using or integrating electronic health information and not only looking at the movement of information but also looking at some of the key initial impacts of interoperability on whether that sending, receiving, finding, using for integrating of electronic health information is resulting in increased availability of outside information available at the point of care for providers and also assessing the extent to which information from these outside sources and providers that's received electronically is actually used for clinical decision-making. So, these are some of the key measures that we have decided to report on related to progress for interoperability, you know, for the purposes of the roadmap. Next slide, please.

So, the first set of measures the sending, receiving, querying or finding and then the integrating are presented here in this slide and we have both 2014 and 2015 national estimates. And as you can see here the percent of hospitals that are electronically sending, receiving and finding key clinical information from outside sources grew significantly between 2014 and 2015.

A majority of hospitals are now sending and receiving data, about 85% of hospitals are sending summary of care records, 65% of hospitals are receiving summary of care records and about half of hospitals are querying data from outside sources and providers in 2015 and 1/4, about 1/4, are engaging in all four domains of interoperability.

However, what you can also see here is that the rates of integrating summary of care records into EHRs didn't significantly change, about 4 in 10 hospitals, report both in 2014 and 2015 that they're able to integrate a summary of care record into their EHRs. Next slide, please.

So, in terms of examining some of the initial impacts of that movement of information of sending, receiving, finding and the integration of information, this slide here focuses on one of the first initial impacts which is looking at the availability of electronical health information from outside sources or providers at the point of care.

And what you can see here is about 1/2 of hospitals, about 46%, had information available electronically from sources or providers outside their health system at the point of care. And in comparison, about 9 out of 10 hospitals that engaged in all four domains of interoperability had information available at the point of care and that's about twice the national average.

So, this shows that there is some dramatic benefit associated with engaging in all four domains of interoperability. The 1/4 of hospitals that are engaging in all four domains, so are sending, receiving, finding and integrating information from outside sources, are substantially more likely to have information from outside sources available for their providers at the point of care.

One other note that I just wanted to point out is that the rate of information being available at the point of care did increase significantly from 2014 to 2015 although only by five percentage points. Next slide, please.

So, the other key impact of interoperability that we outlined in the roadmap, and I mentioned earlier, is looking at the usage of information that is received electronically from outside sources or providers and what we found was that about 1/2 of hospitals report their providers either often or sometimes use patient health information that is received electronically from an outside source or provider. About 1 out of 5 use it often and a little bit over 1/3 or 36% rarely or never use information that they received from outside sources. And we actually examined that in further depth. Next slide, please.

And, yes, thank you…we further examined this. We asked hospitals amongst the 1/3 of hospitals that reported that they rarely or never use information that they received from outside sources, we asked some of the reasons behind that and what we found was that the top reasons related to information not available to view within their EHR either because it wasn't part of their clinical workflow or they experienced difficulty with integrating the data in their EHR and again that relates back to the finding that I discussed earlier which was the flat rates or levels of being able to integrate summary of care records amongst hospitals. So, again this had some downstream impacts on providers being able to use the information at the point of care.

Interestedly, the least cited reason for not using the information related to not trusting the data. So, it seems that primarily the reasons relate to the information not being available at the right time, at the right place for providers to be able to take advantage of the information, rather than a lack of trust of the data from an outside source. Next slide, please.

And we also examined, and this is something that we reported on last year, was just more broadly speaking, looking at barriers to interoperability in exchanging data and again, similar to last year what we found was the lack of exchange partner's capabilities to receive data either because they lacked an the EHR or their exchange partner's EHR lacked a capability to receive the data really remained the most frequently identified barrier to interoperability.

I should note that these two barriers that relate to exchange partners, lack of capability to receive data, did decline significantly from the prior year but it still remained, amongst, one of the top barriers.

Other reasons that were cited as issues related to interoperability included greater challenges with exchanging data across different vendor platforms and finding provider's addresses. About half of hospitals reported each of those barriers.

In addition, difficulty with patient matching increased significantly by 9 percentage points and that was higher than any other barrier in terms of, you know, significant increase so that is an issue that has emerged as a greater problem in comparison to 2014.

And about 3 in 10 cited limited utility of summary of care records as a potential barrier and cost continued to remain as a barrier for about 1/4 of hospitals that did not change significantly from the prior-year.

And finally, hospitals reported, you know, less than 1 in 10 hospitals reported that they don't typically share patient data with outside providers and that declined significantly from the prior-year as well and that has implications for information blocking. Next slide, please.

So, in summary some of the key takeaways as it relates to interoperability, the proportions of hospitals that are sending, receiving and querying or finding key clinical information from outside sources significantly increased between 2014 and 2015 whereas integrating information, summary of care records specifically, remained flat.

About half of hospitals are able to query or are actively querying data from outside sources and a majority of hospitals, about 85% of hospitals, are sending data and about greater than 60% of hospitals are receiving data from outside sources and providers.

And nationwide, in terms of the impacts of that, nationwide about half of hospitals report that they have information available at the point of care from outside sources. And amongst the 1/4 of hospitals that report that they're engaging in all four domains of interoperability, about 9 out of 10 of those hospitals report that they have information available at the point of care.

And with regard to using information, that hospitals receive electronically from outside their hospital system, about half of hospitals report that their providers either often or sometimes use that information. Next slide, please.

And with regard to some of the key takeaways related to barriers to either exchanging or using the information, what we found was that the most common reason for not using information electronically received, which was reported by about 1/3 of hospitals, relates to information not being available at the right time or place so it's not available to view within the EHR either because of clinical workflow or the data not being integrated within the EHR, or not being timely.

And common barriers to interoperability really relate to, you know, about half of hospitals reported that they had difficulty exchanging data or greater challenges exchanging data across different EHR platforms, difficulty locating provider's addresses and difficulty with patient matching.

And finally, although lack of exchange partners with the ability to electronically receive information continues to be the top barrier reported by hospitals to interoperability it did decline significantly from the prior-year. Next slide, please.

Some of the implications of all of this, so hospital interoperability continues to increase particularly as it relates to the components of sending, receiving and finding key clinical information from outside sources but integration of data within EHRs remains flat, that remains kind of a sticking point.

The impact of these increases in interoperability on improved availability of information and the subsequent use of information really still needs to be fully realized. About 1/4 of hospitals, 26%, are

engaging in all four domains of interoperability and those hospitals have information, almost 9 out of 10, almost all of those hospitals, have information available at the point of care and that's really where we want to see all hospitals, you know, reach those goals so that's not fully realized as of yet.

And common barriers to the exchange and use of information really relate to technical, primarily relate to technical issues so issues that relate to cross vendor exchange, patient matching, the lack of provider directories, as well as issues related to clinical workflow the fact that data is not being pushed or available within the EHR for viewing at the right time.

The other frequently reported barriers relate to the limited health IT and health information exchange capability of exchange partners so the capability specifically to receive information from hospitals and the future provisions of MACRA and the Medicaid funding for health information exchange, Tom Novak I believe presented to the committee about the state Medicaid Director's letter that will be offering funding to support health information exchange among non-MU eligible providers who are exchanging with any eligible providers and so one would imagine that over time we should be seeing greater progress in this domain. And, next slide, please.

So, I'll end there and would welcome comments or questions as it relates to the findings that I've presented on hospital interoperability and also would welcome comments on how we can refine our measures as it relates to interoperability and looking at the barriers as well. So, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thanks, Vaishali. We have a few new members on the phone so I just want to let them know and remind folks if you have questions there is a little man on the top of your screen that has his hand raised, if you could use the hand raising feature to put yourself in the queue to ask a question. And the first person I saw with their hand raised was Paul Tang, but I think he put it down, but let me know Paul?

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Oh, no, sorry, thanks Vaishali. I have a question on…so the main focus is really we have to send, receive basically use this information and so the measure that you had was to use or integrate. I wonder if you could you define the criteria for receiving…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right, yeah, so…

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Use or anything like that.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah, I should have mentioned that earlier a little as a clarification. So, the send receive, find, find refers to, you know, querying largely of information, and the term "use" in the context of send, receive, find and use refers to integrating or incorporating data within the EHR.

Whereas the subsequent measure, which I described, which was looking at the actual usage for clinical decision-making of information of data that's received from outside sources is different, it's talking about, you know, when data is received from an outside source are providers actually, you know, do

they value that information, are they using it, you know, are they using the information to inform their clinical decision making. Does that help clarify?

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
It does and so a follow-up question.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Sure.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
In the graph about using all four I noticed that if you were able to do all four you still only had 90% and I guess the definition of the 90% versus 100% is just in 10% of the cases you don't have information from the outside? What makes up…why isn't it 100% if you're all the way to integrate is I guess the question?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Well, we asked the question, I mean, that 10% difference and that's a good question, that 10% difference why it might not be 100% there are a couple of things it could be that they're missing, you know, missing responses or do not knows and then also we asked about routine, you know, is information available routinely and so maybe if information is not available routinely, you know, the hospital might respond "no" to that.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Okay so that…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
That would be my kind of interpretation of why it might not be 100%.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
And to clarify then, the people answering these, it might be somebody in IT or something; it's not really getting down to the actual clinical user at the point of care is that…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yes, so, yeah, that's a good question I should have mentioned that earlier, that the respondents of this survey are hospital CIOs. So, with regard to…particularly with regard to the usage question I think, you know, this is a…we're not directly asking all the providers or physician and staff members at the hospital about their usage, we're asking the hospital CIOs. So, it's an indicator I would say of what's going on, but it's not the same thing as, you know, asking all the providers within the hospital whether they're specifically using the information or not.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Are there any plans, even if you're not asking all the providers, are there any plans to try and understand the end goal more clearly, that is, you know, is it being used, have we provided them one, access and two, useful information?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
You mean different…like a different data source for measuring that?

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Yes or…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah, so, you know, we are in the process of…I mean that is certainly a goal with regard to measurement is that I think the survey data certainly provides a lot of great qualitative information. So, for example, the barriers related to interoperability it's…you know if we don't ask the hospital CIOs there's not like a really…other great data sources for that that's, you know, consistent across all hospitals.

But one can imagine, and this is something that we are interested in pursuing, is, you know, developing more system generated measures of interoperability ideally that would not be burdensome for providers to be able to report on, we don't want to add to provider reporting with regard to reporting, but not relying totally on self-report or survey data for that, but, you know, also looking at some complimentary data sources. That's something that we are looking into…

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Thank you.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
And pursuing. Thank you.

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

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Thank you. Two questions, so first of all this is fabulous data, super useful and, you know, I think the summary is pretty obvious that we're doing a good job of moving data around but not as a good job about incorporating it into workflow.

Did the survey have questions that would tease out relative to the lack of counter party support for exchange that was cited as a reason the setting of care? So, in acute care I know that in many cases the barrier is discharged to alternate settings of care, an LTPAC, as opposed to discharged to ambulatory care, so did the survey…was the survey able to get at that or did you not ask that question?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yes we did and we are in the process of basically reporting out on that and, you know, maybe at a subsequent meeting be able to discuss that, but, yes, there are survey questions that relate to looking at exchange of summary of care records so the sending of summary of care records to different types of providers that are outside the hospital system, so looking at long-term care facilities, behavioral healthcare providers, as well as outside ambulatory care providers so providers that they're not affiliated with, as well as outside hospitals. So, we'll be sharing that.

But I think, you know, overall what I can say is that the results are consistent with what I…with the barrier which is that, you know, they're lower…providers such as…those that are not eligible for Meaningful Use and we know this from other surveys that the behavioral healthcare providers as well as long-term care providers have lower rates of EHR adoption and exchange capabilities so it's consistent with that the fact that they have more limited capabilities to receive information from providers, from hospitals rather.

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Super helpful, thank you. And then the second question is, you know, relative to use, meaning incorporate into the chart, did you ask the question about use relative to being able to see the summary and, you know, at least provide context to the clinician to read the information even if that information is not incorporated into the chart?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
We did not ask about like view only access is that what you're kind of…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Yeah that's exactly right, yes.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah, view only access. I'm just trying to think. I mean, we did ask about what…we asked about querying, the ability to query and I don't know if that would necessarily cover the view only access. So, this would be a question to you would be, do you think querying would be sufficient to cover the view only access or should we be looking at that, you know, separately as a separate measure?

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Yeah, what I'm getting at…yeah, what I'm getting at is for example in transition of care and in a view there is sometimes the behavior of clinicians to visually inspect the summary and in particular to look at the clinical narrative on the summary as a prelude to intake even if the data is not actually incorporated into the chart, it may be incorporated textually but not incorporated as structured information and, you know, asking the question whether the information that's viewed or received is useful, it may be useful even if it's not incorporated and of course it could be that it's not useful in either case in which case we've…you know each of those things is a slightly different problem that we'd need to understand and solve.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right, I mean, we do ask about the availability of information from outside sources…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Great, okay that might get at it.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Whether they receive it and then the usage question is, you know, whether they are using information that they receive from outside sources.

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Understood.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
So…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Understood, so that gap between receive and use at least presumably in that gap is information that is received as view only or functionally view only by the clinician. It would be interesting to ask the question about whether that information that's received is useful independent of it being used in the definition of the survey if you know what I mean.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Okay, so asking about the utility of the information.

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Even if…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Just…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Even if it's not incorporated.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right even…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Correct.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
If it's not incorporated and even if it's not used.

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
That's right.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
I mean, I think we could add that as…not to get into the nitty-gritty here, but we could add that as a reason, you know, there was…if we go back a few slides to the barrier section, if we could put that up real quick, yes, right here, so if we added the…well the information not presented in a useful format about…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
I see that…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Three in 10 hospitals reported that, but I mean, I don't know…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Yeah that…

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
I mean…

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Probably gets at…that probably gets at exactly what I'm asking. My hypothesis here, just to be clear, is that even in cases…in cases where the data are not incorporated they are also not terribly useful in terms of clinical utility because they're not displayed in a way that clinicians understand and get to their workflow in general. So, you're right those questions kind of get at that supposition that I had so I'll go with that one.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Okay.

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Thank you, this is super, super helpful and incredibly, you know, as I said it indicates we solve one problem we've got another one which I think is the progress in interoperability is going to be continually knocking down barriers until we get where we're going and it's good to know that we're making progress and also bad to know that we're not where we need to be but I think that's to be expected. Thank you.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Thanks.

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

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thanks so much I really appreciate it and very, very interesting survey. I have a couple of questions though that really delve a little deeper in really getting to what is going on and if we have any indication from the information you've gathered, what the different hospitals look like? The characteristics of those hospitals that are doing everything, they're receiving, sending, integrating the information from electronic health records and seem to be moving along rapidly, what are the characteristics of those hospitals? Are they large integrated healthcare systems? Are they urban, rural? Are they, you know, suburban hospitals? So, that we can see…get a little more in-depth look at what's happening across the country. Could you speak to that?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

So, that's a great question and we have started examining that and are hoping, in conjunction with…so those analyses are in progress I should say and so I think it's a great question and something that we want to understand too, what are the factors, whether it's characteristics or engagement with like HIOs or the use of specific HIE vendors, what are the factors that enable hospitals to do all four components sending, receiving, finding and integrating data, and who is farther ahead and who is lagging behind. Those are questions that we're examining right now and will be hoping to share.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Yeah.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
That is critical because if we're going to really move the bar let's find out why certain people are successful, what they're doing right and then start to replicate that and if there are things that are working that we can use in other areas to help spread that ability would be very, very informative, I would think. So, I thank you for pursuing that and I hope that at some point we hear the rest of this conversation in one of our meetings. But I have a second question, if you don't mind?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Sure.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Since these questions were to CIOs and not directly to providers I really have some concern about the question of whether or not the information, what are the barriers, is the usefulness and the…working them into workflow and do you have any future anticipation of doing a survey directly to the people who are the hands on users? The users, whether it is the nurses on the floor, the providers, the physicians who are actually at the patient at the site of care because that is really where the rubber meets the road.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah, I mean, I think, you know, certainly as I mentioned earlier, I would consider these as…the measures that relate to, particularly as it relates to usage, we're gauging provider's usage for clinical decision making as an indicator…

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Yes.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
As opposed to, you know, it is a crude measure but that's kind of what we have, this is a survey that we have and that's what we're limited with. I should say though that, you know, also have a national survey that we do of physicians that we partner with the CDC's National Center for Health Statistics on an annual basis and we are asking very similar questions on that survey and that survey is directly of, you know, office-based physicians.

So, we will be getting, I would say, a more true assessment or complete assessment I should say of the utility of information and, you know, the availability and usage piece from that survey. You know whether that…that's office-based physicians so it's not within the hospital setting but we are at least, you know, in terms of broadly speaking, you know, interoperability measurement, you know, we will be getting a sense of the utility of the information from provider's perspectives.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Yeah.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
But, yeah, we don't…right now we don't have any plans to do, you know, a survey of providers within the hospitals themselves.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Okay. And one more kind of technical question. When I'm looking at the information on the difficulty in finding provider's addresses and also in looking at patient matching, you know, it's problematic that we had 45% in 2014 and a greater number, 49%, who are having difficulty providing provider's addresses. Do you have any insight as to why that is and what we can do? I think this is a conversation that our committees need to really address along with the, you know, increase in numbers on patient matching, you know, these are technical questions but still a lot of policy involved in how you establish systems for doing that and do you have any insight from the survey as to what is actually happening out there?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right, can we move it to the next slide, please, because then we can have the barriers table up, okay, great. So, yeah, as I mentioned, you know, these…interestingly it's, you know, I guess what we're labeling as technical issues, so, you know, issues related to the fact that there is not a, you know, uniform provider directory that's available, you know, patient matching algorithms, you know, we haven't been able to develop the perfect algorithm out there, you know, to help match patients are two very common issues.

Now these are issues that are the focus of the interoperability roadmap and we do have efforts underway to try to address them and I think, you know, having…I'd invite, you know, others on the call to kind of discuss, you know, have that broader conversation about, you know, the progress that we need to make with regard to provider directories and patient matching, but, you know, what these findings show is that those are critical sticking points and we do need to come up with solutions to enable interoperability on those fronts and those are the focus of efforts and ONC is focusing on them, but, you know, that's…I guess that's all I can comment on from…the survey itself didn't dive any deeper into those specific issues other than, you know, what we can see is that those are significant issues and, you know, we do have efforts underway to try to address them but they are complicated areas and issues.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you, thank you very much, appreciate it.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Vindell did you have a comment you wanted to share before we go onto the next question?

Vindell Washington, MD – Principal Deputy National Coordinator – Office of the National Coordinator for Health Information Technology
It was just a minor comment I was just going to share that in my previous work environment for those AHA surveys that the different executives would perform certain portions of the surveys if the expertise was deemed that way as a CMIO I did fill out some of those surveys on the clinician responsiveness.

I say it's a minor comment because I don't think it takes away from the overall position which I actually firmly believe in that we should make an effort where possible to get closer to the front line if the survey is going to measure the true value of the interoperability that occurs. So, it was just a minor point. Thank you.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
Hi, this is Anne do you see my hand raised?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yeah, there's a lot of people in the queue but you actually are next Anne.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
Oh, awesome timing. I just have a quick question, what is the definition of an outside source for a hospital?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
So, yeah, so we wanted to…in the survey we wanted to not just ask about information that hospitals are either sending, receiving, querying or integrating data to and from outside providers. We also wanted…we used this term outside sources as well as a kind of a catchall to include say public health agencies or, you know, other sources that are not necessarily providers and we wanted to include that term because as interoperability expands and evolves we are expecting that, you know, hospitals and other providers will be exchanging data not only with other clinicians or other providers, types of providers, but also non-healthcare settings as well, such as social services and EMS, and, you know, other I'll call them sources. So, we wanted to create this…we used this term to try to capture, you know, go beyond just providers.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
So, my thought would be that it would be helpful to know what some major category of sources are as we move into MACRA especially maybe with payers and APMs.

And I also had a thought that some hospitals own a lot of primary care physicians and I don't know if they consider, especially if it's a CIO answering the question, whether they were consider interoperability with their own physicians as outside sources or inside sources that it kind of muddies the water in terms of being able to grade them on that and I know that that's part of the scores in MACRA moving forward. So, just to plant a seed of maybe some differentiation on that, that would be helpful so that we know a little more about, you know, where we need to work a little harder on that.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Well, we do ask in the survey, and this is something we are in the process of analyzing and reporting on, is differing rates of exchange with providers that are outside the hospital system versus inside the hospital system so trying to get at that point that you're raising.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
But what does that mean the system? So, you know, we even have a hard time discussing that when we're talking to our hospital systems as well. You know because, you know, distinct NPIs, different business setups, so just pointing out just a technicality and the fact that you are talking to the CIOs.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
But the interoperability, you know, being such an important issue with so many different constituents or different entities that's the future is now essentially it's not just hospitals with other providers. It's with the organizations that quality data is reported to that's now, it's with the payers or other APMs that's now. So, I just would ask for a little more specificity in that direction? Does that make sense?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Yeah that's a great suggestion.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina
Thank you that's it.

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

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System
Hello, so, my question is back to the integration piece again since that seems to be the biggest hurdle that we have here and being somebody that interacts with nurses and physicians on a daily basis I totally get it. They do not want to have to go to a second place in the record to look for information. If it's not there during their workflow there's a good chance they're not going to take a look at it. So, I'm not really surprised by that.

So, I'm just curious, in the survey did any of the respondents share any pearls of wisdom or examples of how they are doing this or doing this well? Because I'm looking at the questions and I'm wondering if we need to provide a clearer definition on what exactly integration is to get some more, maybe some more granular data, you know, the question says, does your EHR integrate any type of clinical information received electronically from providers or sources outside your hospital system, organization without the need for manual entry, and then it says, this could be done using software to convert scanned documents and the indexed discrete data that can be integrated into the EHR.

So, you know, I'm kind of wondering if people responding to that have a clear understanding of, you know, yes we have integration or no we don't have integration, would they think that a scanned document is considered integration or is it truly the only definition of integration is it has to be indexed and put into discrete data elements that fed into the screens that they look at during their workflow.

I don't know, I just feel like if I were answering this as a CIO I might be a little bit vague on what exactly integration means. So, you know, maybe in future surveys we could spell that out or clarify that a little

bit better. But I'm curious did anyone share any success stories on the survey in the comment section or anything?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Not that I am aware of. I don't think we have a kind of open ended question in the survey as of right now as it relates to, you know, what you're talking about.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System
Yeah.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
But I know the AHA has done in the past kind of a more qualitative work with the hospitals on issues related to interoperability and that's something that we could kind of follow-up with them about.

Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System
Yeah and great job, really good information, thank you for sharing it today.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
You're welcome.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Okay, so we have five people left in the queue, we have Chris Lehmann, Troy Seagondollar, Kathy Blake, John Derr and Josh Mandel. And so we have 12 minutes left, so if folks can try and be efficient so that everyone has an opportunity to ask their questions it would be appreciated. So, Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine
Thank you, Michelle. So, I very much appreciated this report it was very interesting data and I wanted to alert the committee a little bit to the other side, outside the hospitals to the private practitioners when it comes to the exchange issue.

As you know Meaningful Use has the requirement and transitions of care providers are required to submit in 10% of cases a CDA and the American Academy of Pediatrics has been over the last several months been receiving reports across the nation from all kinds of states about pediatricians having some serious challenges finding people willing to take that information off their hands. So, they are eager and willing to send their CDAs but they can't find tertiary children's centers for their referrals to specialty care or for inpatient admissions that are willing to take it.

So, the complaints that we are hearing is that children's hospitals don't have Direct messaging turned on, that children's hospitals don't publish Direct messaging addresses, that children's hospitals rely on HIEs as opposed to Direct messaging in the first place and we've gotten an increasing number of complaints, this is an issue that is truly is a problem for pediatricians. And that in our mind it is truly is a challenge with interoperability.

So, you know, for us the lack of this infrastructure that allow people to get rid of the information that they're willing to send is a real concern and I think further queries with your hospital should focus on who you're actually interacting with, who are the people that you get data from, are there any people that you're excluding because their modalities of messaging is not something that you support and try to get a feel for how open these hospitals are indeed to receive messages from all people who want to participate in the process.

So, I think these numbers of interoperability kind of paint a little bit of an overinflated picture unless you really know how many people that want to exchange with that hospital actually can. So, again, thank you for the report it was quite fantastic but I think we should not pat ourselves on the back too much at this point. Thank you.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

So, Chris, you bring up a really good point which is…and this is something that we are very interested in doing is not just looking at measuring interoperability across hospitals which have, generally speaking, pretty high EHR adoption rates than physicians, but we're also seeking to expand the measurement of interoperability across providers and settings that were not eligible for Meaningful Use incentives so behavioral health care providers, long-term care providers and the like.

And so, we should be getting a portrait of their abilities to, you know, exchange data. So, you know, in terms of the exchange partners, so getting a broader picture of exchange capabilities across the care continuum.

And additionally, as I mentioned earlier, we do have measures on the survey that speak to hospital's rates of exchanging data, sending and receiving data from different type of providers which paints…it shows the variation.

So, overall, yes, 85% of hospitals are sending data but then, you know, we'll be able to look at, you know, the variation in that when you break it down by, you know, rates are likely to be lower amongst behavioral health providers and long-term care providers because, you know, they have lower EHR adoption rates or exchange capabilities.

The other point that you raised with regard to children's hospitals in particular, so in our physician adoption, EHR adoption data brief, we did examine variation in EHR adoption rates and looked at children's hospitals and we found that about 84%, as I mentioned, overall across hospitals have adopted a basic EHR, in comparison about 55% of hospitals of children's hospitals have adopted a basic EHR in 2015 and, you know, that represents a pretty large difference or disparity there.

Certainly the rates of EHR adoption amongst children's hospitals has grown significantly since 2008. In 2008 it was about 10% and it has grown fivefold since then but there is still children's hospitals are behind kind of general medicine in terms of general medicine hospitals so that might be another issue as well with regard to infrastructure.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Thank you and I appreciate your answer and I just wanted to add, you know, but even, you know, the complaints that we are hearing and even if the children's hospitals have EHRs oftentimes pediatricians are blocked from sending information because, you know, they want to use Direct that the vendors have

installed in their software and unfortunately the children's hospitals are incapable of taking those Direct messages.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Right so I think that's something that we could examine. I think that's a great suggestion is to look at the interoperability of children's hospitals as well to break…you know similar to what we did with the adoption data brief is looking at rates of EHR adoption amongst, actually psychiatric hospitals as well as children's hospitals to look at that with regard to interoperability.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Troy did you put your hand down?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Yeah, I did, Patty actually…we must have been mind-melding because I really wanted to get greater definition on what integration means. And I think from the point-of-view of a CIO, if you pull in a C-CDA and you put it into a media tab somewhere that is one form of integration but when you look at the use of that data and true integration into the EHR, you know, looking at all of our clinical decision support systems things like that, what is the level of integration switching back and forth much like Patty pointed out, you know, going to a C-CDA document and trying to sift through it to find relevant and pertinent information is totally different from it truly being integrated into the record and allowing the system to actually data mine that and incorporate into our workflow and our process and really doing much better…which higher grade quality work along the continuum. So, that was it, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
Yes, thanks, Michelle, and mine is more a comment than a question and it is to go back some to Gayle Harrell's questions and bringing forward the issue of how do we go from the hospital level to the individuals who are actually providing care.

And as I look at the proposed…the notice of proposed rulemaking for implementation of MACRA into the physician fee schedule it is contemplated that not for the first year but subsequent years that physicians will have an option of reporting for quality measurement as well as for resource use, calculations, which are done automatically by CMS, that they will be able to do that if they are hospital-based through their hospital.

And so I think that what we should forecast, and again, think about whether it's an issue for this committee to review is the implication in terms of physician's use of electronic health record systems and our access to information about their use and their experience as more of them go into reporting modalities that are essentially one and the same with the hospitals.

So, hopefully I'm making that clear that I think that line between the physician and other clinicians experience and the hospital's experience is going to become blurred as the reporting out is done using the hospital mechanisms. Thanks.

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

John F. Derr, RPh – President & Chief Executive Officer – JD & Associates Enterprises, Inc.; Founder – LTPAC Health IT Collaborative
Yes, thank you it's John Derr, just a couple of comments, thanks for the study. FYI, the collaborative, the LTPAC Collaborative, just submitted the comments on the RFI and it's from providers, vendors, nurses, physician's organizations and it gives you a lot of information on the LTPAC and what we would need.

And just two other comments, I hear in all my work with LTPAC and the providers and vendors and that, that I have no quantifiable information to verify this, but I would like, under the…one of the barriers was timeliness. We are still receiving patients in SNFs at 4:30 in the afternoon on a Friday and we get the paper record on the gurney and we do not get the electronics until Monday or Tuesday of the following week where it's irrelevant because the first 48 hours when they're in one of our facilities with home care are the most important to get things started.

And also, and I've mentioned this before in Standards Committee meetings, we do get sometimes…when we do have people who are really good at electronics, which our vendors now are very robust in their capabilities, but because of the lack of funding we are not upgrading our people in the field. The providers…but when somebody does have electronic capability the hospital sometimes has trouble receiving it and I have also heard things like, well, we don't really need it. And I know Meaningful Use doesn't have as much on receiving information criteria to meet their Meaningful Use criteria as it is for sending. Thanks.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology
Thank you. I think in the survey we found that, and this is, you know, amongst the…about 4 in 10 hospitals reported that information was not always available when needed and that was, you know, one of the reasons cited for not using patient health information received electronically from outside providers or sources. So, that, I think, speaks to the point, one of the points that you were raising.

John F. Derr, RPh – President & Chief Executive Officer – JD & Associates Enterprises, Inc.; Founder – LTPAC Health IT Collaborative
Thank you.

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

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School
Thanks very much and I know we're at time so I'll keep this to under a minute. I have a quick question and a quick comment. The question is about the first bar graph that you showed in particular with the numbers about how many hospital CIOs reported the ability to send and to receive and just to clarify on those two, was it routine sending and receiving or do they receive or what was the precise wording there?

And then the comment which I'll just run into now before I pause, was when it comes to barriers, and this is just to say that asking users and CIOs what the barriers are is interesting and relevant but it doesn't mean that they're right.

And so when I see the reinforcement between the roadmap objectives and the questions that are asked and then the interpretations of those answers, I think it's a good thing that there's a consistent story but I'm also slightly concerned if we can't tie this back to real-world demonstrations that eliminating these barriers actually makes a difference.

So, when it comes to, you know, better algorithms for patient matching for example it's not clear to me, you know, either how achievable it is or whether that's the real barrier or just that it's easy to check off when you're going through a list of potential reasons why things aren't working. So, I think this kind of survey data is helpful but we need to somehow tie back to real-world observations and studies of real systems in work.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

So, I agree with you. I mean, this is certainly not a substitute for looking at the impact of say improvement in patient algorithms or looking at the availability of provider directories. I mean, we would hopefully see reductions in those reported barriers over time with, you know, improvements in those areas through the survey but that wouldn't substitute looking at kind of more granular measures that might look at the impact of improvement in the patient algorithms for patient matching and in terms of, you know, look up match rates and things like that. But this is a broad measure that we have across hospitals and it provides us, again, as an indicator of some of the issues that hospitals are experiencing.

With regard to the more specific question, so the…and I would encourage you all, in the interest of time, we do have data briefs posted to the interoperability data brief it's data brief #36 and it's on the Health IT Dashboard, and the rates that are reported with regard to sending, receiving, finding refer to…it doesn't refer to capability it actually refers to whether hospitals are actually engaging in those specific activities so just to clarify that.

And with regard to how we measure rates that are electronically sending and receiving we asked about routine, you know, methods or routinely sending and receiving a summary of care record and that's what the rates are based on. So, if they indicate that they are routinely for example, sending information via a secure message such as via Direct or other secure protocol, posting it to a portal or downloading from a portal using a health information exchange or other third-party, you know, that would be considered electronically sending it and, you know, we asked them to report it on a routine basis so the actual questions themselves are in the appendix table in the data briefs and I would encourage you to take a look at that.

One final thing that I will mention is that, you know, I was alluding to the fact that we are in the midst of other analysis and will be planning to share findings related to those. I believe that we are planning to post another data brief on interoperability that will do more of a deeper dive into some of issues that we raised today and that will be posted on the 23rd of June and that will be data brief #37. So, you know, once that comes out, you know, I'd be happy to again talk to you all about any other additional questions you might have related to those findings.

But it points…the findings relate to some of the issues that we discussed today which is a variation in rates of sending and receiving across non-MU eligible providers such as behavioral health, long-term care providers looking at the specific mechanisms of exchanging data that hospitals are using. So, using HIOs and HIE vendors and the like, and looking at the variations in interoperability across different types of hospitals. So, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you, Vaishali. Okay, so thank you everyone for that in-depth discussion. I think we're ready to turn it over to the Quality Payment Program Task Force. I think Cris Ross is now in. I just want to check. Cris are you on?

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
I'm here, Michelle, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Cris. So, I think Kathy is going to help walk us through this discussion.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
Right.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
So, Kathy I'm the one who sees the hand so I'll really just defer to you if you have any questions or comments that you want to make to introduce Paul and Cris and then I'll help walk through the questions at the end of their presentation.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
So, I think…thank you, Michelle, this is Kathy and I think in the interest of time I'll limit my comments to first of thanking the members of the Task Force for assuming this large task just in the last two weeks and that this is a chance for the members of the two committees to be able to provide comments with the expectation that this will come back to us at the meeting that we have scheduled I believe for June 23rd so that the deadline is met for submitting this group's recommendations as formal comments to CMS in time to meet the deadline for comments on the proposed rule. So, with that I'll turn it over to Paul and to Cris.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Thank you, Kathy. So, as we've mentioned before it's a short timeline so I want to start out by thanking the group for bearing with us in the really fast turnaround which includes the weekend and also to thank the staff and especially Gretchen for all of her help in preparing this.

So, this is our initial look at things and it's open for your feedback to guide us in the next couple of calls before we come back to you in a couple of weeks with our proposed final recommendations.

So, the task and I'm not going to read this to you, but really is to say, how can we use certified HIT to support the value-based quality focused care under the QPP? And they're seeking comments on the policy approaches they've proposed for the Merit-Based Payment System, i.e., MIPS, and Alternative Payment Model, i.e., APMs and we also did have some specific questions sent our way by ONC and those were handled by subgroups. So, we're only going to talk about the overarching themes today to get your comments. And then I think we're going to make available some of the comments we have for the individual questions for you to also look at and provide feedback. Next slide, please.

This is the illustrious group and thanks to Cris for co-chairing this Task Force and we broke up into a couple different subgroups to manage the work and make it concurrent, but we have diverse representation from everything from the quality measure side to the HIT, to the ACOs or the APM kind of view-point so a really nice mix of opinions, backgrounds and expertise to contribute to what you're going to see. Next slide, please.

This is where we are, we've had a few calls to put together what you see today and then we will take your feedback over the next couple of weeks and massage that and refine the recommendations to bring that back to you in a couple of weeks. Next slide, please.

Okay, so we're going to start off with comments and Cris and I are going to tag team this. We'll start out with comments and then some recommendations.

So, first, on the comment side, so, overall everyone is in agreement with the…and somebody might need to mute the furniture moves…but we started out with, you know, everyone agrees with the objectives for MACRA. This really is a turning point in our country's health care delivery system, the environment in which it serves and everybody wants to move toward measuring and improving outcomes so everybody is totally in agreement with that.

We also heard loud and clear how well CMS and ONC heard the concerns around the level of effort required to both understand and to implement some of the payment related programs. I think both the burden in doing the reporting for example, and the need to increase the flexibility because we find that one size doesn't fit all whether you're a primary care versus specialty or across all the continuum it's really darn hard to have one size fit all but it's also really hard to make sure you have a program that is flexible enough to accommodate the various perspectives.

So, in the process we sort of found ourselves in sort of the sausage kind of results, we talked about how well intentioned legislation or regulation can often at the end of the day be a bit like sausage in the sense when you step back and look, gosh, we tried to address all of the concerns and then you end up with something that's fairly complex and that's sort of where the Task Force found itself in this regard.

We found that it was hard to understand because most of it is…most of it is composed of words and it's really hard to get the big picture so to speak. And we found that if you were able to understand it that there's so many bits and pieces and complexities to what's described that it would be hard to implement especially for smaller practices. Next slide, please.

Okay, so as a result, I sort of foreshadowed what we said, this would be pretty tough to implement and implement quickly because at first it's actually hard to understand just because there's so much going on. An example is, in the provider space is something called variation reduction and as the name implies you're trying to reduce the amount of variability you either use in diagnosing a problem that a patient has or in treating that.

But we found that once you provide credible data in front of let's say clinicians then they really engage because they understand now more clearly what's the problem to solve and how can they go about helping to solve that. We think the same would apply to the NPRM on the QPP.

If we made it really clear how the ultimate level of effort that is going to be required for providers to implement it actually do produce better outcomes and better care that would go a long way to truly engaging everybody in participating and that buy-in is so successful to…I mean, so important to a successful program versus people treating it as sort of a check the box kind of program and that's what's

we're trying to balance in terms of giving CMS and ONC feedback, how can we achieve that balance so people really, truly engage because they understand how things link up so that they don't look at it as a check the box kind of program.

So, we're trying to engage everyone and one of the pieces is to gauge everybody on the payer side so this is coming from CMS, really the large public payer, but from the provider perspective we have to deal with everybody and it's a very heterogeneous world now that's a big source of the burden for any of these programs related to reporting.

And so if there's some way that we can align the public and the commercial payers in the same program or at least in programs that align very well, and for example in the quality or performance measures, that would go a long way to reducing the burden and simplifying the overall program.

So, in terms of addressing the high priority goals and they've certainly been elucidated in multiple occasions, interoperability probably being at the top and the patient engagement is also extremely important. So, in particular people are interested in how do the requirements of the Quality Payment Program take us closer to interoperability and patient engagement and you'll see in our recommendations we're trying to say, and if we focus on that perhaps we can drop some of the other things that may not be as closely in line with these really high-priority goals.

So with all of these comments it's probably going to be magnified, at least the impact and the challenge is going to be magnified, for the smaller providers, the folks that don't have as many resources of literally hiring people to understand these rules in addition to implementing them. So, we want to make sure that we see sort of a twofold win of not only does simplification make it easier for everybody to engage in it also sort of levels the playing field for those who don't have as many resources such as the smaller providers and practices. Next slide, please.

From a timing point-of-view, as you can imagine, because of the complexity and the amount of time that's going to be spent in digesting this and then in reacting to it there's…it's really important to give us enough time or to reduce the amount of time needed to digest it all and act on it.

So, in the process of creating the flexibility there have been a lot of choices created, this is sort of very analogous to the EHR situation where you have…the more choices you have actually the longer it takes to configure those choices to get what you need and sometimes people sort of give up in the middle and actually don't configure them and sort of don't take advantage of the flexibility that's the kind of feeling we're having right now but there are so many choices offered that sometimes just even trying to decide can be very paralyzing.

And so the concern is when the final rule comes out in the fall will there be enough time for the providers to even make the choices before the start of the measurement year on January 1, 2017. That's driving a lot the concern.

And we need to know…so the providers would need to know how they're being measured, what they're being compared against, i.e., the benchmark, in time for the start of the measurement period and deciding whether they apply as an individual or as a group, and what part of their EHR systems do they have to configure and turn on or do they need additional capabilities all of those things affect the timing and create some concern because of the short-term amount of time.

We understand that for the adjustment year to be 2019 CMS is asking for a two year lead time because of just all the processing that has to go on. We're trying to find the best way to operate within those constraints.

And the final point does have…does relate to something I mentioned before in terms of deciding about your HIT system. Will the eligible clinician both those who are new to Meaningful Use and those who are even already under Meaningful Use will they have the right tools in place in time to start the measurement year that's a big concern. Next slide, please. I'm going to turn it over to Cris to continue with the next three comment areas.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Thank you, Paul. So, the next area relates to Advancing Care Information scoring and we're going to begin to get into a little bit more detail below the level of the overall goals. And in this particular area we noted comments about requiring participants to meet the scoring and reporting for the Advancing Care Information category mainly that the bar is so high that they may not be able to participate in QPP.

Since the purpose of this legislation was really to combine three different things, the physician quality reporting system, the physician value-based payment modifier and the Medicare Eligible or excuse me Electronic Health Record Incentive Program the intent to try to do all three maybe laudable as noted in Paul's first comment but here's a specific area where trying to fit all three of them together results in something like this Advancing Care Information category may make it difficult for clinicians to participate in QPP.

The second comment relates a little bit to the ones that were remarked upon earlier around diversity of choices and this specifically is around the diversity of choices in 2017 during this transition period and you can see the notes here between the 2014, 2015 edition rules and the modified EHR Stage 2 and Stage 3 objectives.

Given that diversity of choice there may be a negative impact on the ability of technology developers to support their customers and these program participants, especially in these new categories of eligible clinicians, that the other attribute of this legislation that extends beyond eligible professionals to eligible clinicians and several new classes of clinicians are included in the program which had not included previously under Meaningful Use.

So in general lots of choices expose to new participants and then we note particularly the problems of these new eligible clinicians but also smaller practices and rural practices and those in underserved areas and so on. Next slide, please.

We'll just put a little circle around the issue around small provider and small provider here could mean both, one entity practice in terms of number of providers, it might mean those that are financially strapped as well or those that are in areas non-metropolitan areas where they don't have access to rich resources.

So for these small providers we note that it would be especially difficult for them to understand the rule and ensure that their practices and use of health IT comply with the requirements, we'll have some recommendations about how that might be mitigated and then the issue around complexity being a barrier to eligible clinicians to decide how do they want to move towards the Advanced Payment Model participation. Next slide, please.

And Paul I forget how we divvied this out, does this come back to you?

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
No that's on your side.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Yes, all right, I'll keep going with the group reporting, thanks. So, under the category of group reporting we've got the question that practices will have to decide whether to report as a group or as individuals for MIPS. We had a robust conversation about the complexity and issues involved in that and we teased out a couple of different factors that might be deciding factors and you can read what those are around, you know, timing required, around basic processes including the selection on reporting mechanisms, how does it affect clinical workflow, measure selection and determining which providers in a multi-group practice should fit under the Advanced Payment Model or in MIPS.

There is…because this legislation is intended to be rather neutral there will be increased compensation for those with exemplary performance and some reduction in payments for those eligible clinicians who don't meet the goals. This is a really meaningful choice. There is a more potentially significant implication on reimbursement then maybe had existed under the three previous programs prior.

We note that these would have significant impacts in practice…and there's a need to help practices have a clear understanding of the requirement timelines and the technology availability and we are going to, in the recommendation section, make some specific recommendations about how that might work.

Now, next slide, please and I think at this point Paul I turn it back to you.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Right, thanks, Cris. Okay, so we have four sort of themes of recommendations so far and as I said these are more overarching at the moment to get your feedback. One is going to really drill heavily on the clarity in terms of the complexity. There are a lot of words in this 962 pages and we think that to help people digest this and just understand the program pictures would help a lot just the number of components, the number of choices, all motivated by good intentions, are a bit overwhelming.

So, we've made a few suggestions. One, just understanding how the overarching goals of MACRA, this whole shift to pay for better outcomes, how do all those components fit into that overarching goal that would help people understand it to see all the moving parts.

The other is how do we get from here to there? The mapping in people's minds, I mean they've got…they've, you know, settled in on PQRS and Meaningful Use and VM, how do we go from where we are to where CMS would like to take us and they have these two sort of…it's sort of a trajectory from MIPS to APMs.

If there was a graphical diagram that showed how we migrate from one program, the programs that we're in, into the new programs and what changes does that mean for us, the providers, the clinicians and the hospitals. How do people start planning for that migration especially if it's coming so quickly?

And along the way it would be nice to see how CMS did meet the goals of reducing the burden. As I say, sometimes it's not actually the flexibility but the choices actually may increase the level of burden. So, this picture may help us all better understand what's required but also uncover some areas where we could simplify the program. So, we think that would be very useful.

When we were asked at some point along the way is it a problem with understanding it or is it a problem with implementing it and our answer was "yes" so that's what we're trying to focus on.

And then the ultimate goal is clearly to move people into the new way of thinking it's not just another program it's a way of thinking in terms of how is everybody accountable for and continuously improve the outcomes of the people they serve not just the people that show up but really a community-based or population-based view.

So, how can we get more and more clinicians and providers like clinicians and hospitals into the APM is the objective. So, graphically representing how it's in your, that's addressing provider groups, in your best interest to move into APMs that would really help and it possibly could uncover, as I said before, ways that we could simplify the program and make it easier for people to go from where they are to MIPS, to APMs. Next slide, please.

So, another overarching theme and this carries over from previous programs but we thought that with MACRA we have an opportunity to really nail this and really work on outcomes and not processes. So, we want to try to elucidate and make explicit the direct connection between what are we…what the current programs are and where we want to go and especially try to reduce the number of process requirements.

So, we want to focus on achieving the goal of measuring and improving outcomes and, you know, we always thought actually in Meaningful Use, the Meaningful Use Program, that sort of swish from Stage 1 to Stage 3, in Stage 1 it was about process and it was somewhat of a push by Stage 3 we were hoping something like MACRA would come along that says, actually now it's going to be a pull, a pull from performance measures that focus on outcomes and now that we have this opportunity we are suggesting that we really try to highly leverage that and promote the…so set the goals of these outcomes and how you incrementally improve your own outcomes and relax the focus on processes so that individual providers and provider organizations like hospitals would be able to create innovative processes that do a much better job rather than just incremental improvements.

So, we talk about what we called HIE sensitive performance measures that's a holdover from the Advanced Health Model Workgroup under the Policy Committee, HIE stands for, you know, health information exchange, if we focused on performance measures that reward meaningful and that's really a topic that was just discussed under the presentation Vaishali led, I think the overarching comments that came through this morning is that we're really not only interested in how many data elements flow across, but how do we instrument the final pathway which is are the data actually used and are they useful to care.

So one way that we threw out in the Advanced Health Model Workgroup was to say, hey, what if there was a payment policy that says you're not going to reimburse anybody for medically unnecessary duplicate testing well all of a sudden everybody would need to interoperate and be able to know what else has gone on. So, that's just thrown out as an example but it shows that there are ways that you can design performance measures that cause the motivation for interoperability to be palpable and then let the market innovate in a way that creates the changes that you are looking for.

So, the focus on outcomes, the other point is that if we're going to shed our fee-for-service sort of mentality that measures processes and transition over to the outcomes we also want to make sure we aren't dragging the same biases we had which is to focus in on what happens on the provider's side at a time we're transitioning so let's not take that same bias let's move it over to what's important to consumers and individuals and communities.

So, if the outcome measures that we're going to drive the providers to achieve are more focused on the individual and the person this would really I think change the orientation of our whole health delivery system to serving the consumers.

And finally, this notion of being able to focus clearly and definitively on outcomes would also go a long way in empowering the providers to find the best possible way and that's the innovation process.

So how do we make…how do we make it in their best interest to figure out to rethink the current processes in ways that would deliver on the outcomes that they're being measured against. That's sort of the position we want to make this program we think and we'd like to make prescribing processes something we've dealt with in previous programs to be a last resort rather than the first result.

So, you are going to hear that some of the kinds of…the components of the program proposed do have some of the legacy in the process oriented approach so we're trying to advocate for a more outcomes and a lessening up of the emphasis on processes. Next slide, please and I'll turn it over to Cris.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Thank you Paul so just a few more recommendations. The third that we had was a category of "tell a compelling story" which really is meaning to say that the intention here is to move several hundred thousand clinicians and their associate health systems and the vendors who support them, and the rest of ecosystem from one set of models to some new ones and in order to do that the recommendation is that CMS ought to emphasize how to convincingly explain how will you be benchmarked as a clinician, and how exactly will payment incentives and adjustments be applied with an emphasis on clear policy and a scoring methodology that's easy to understand.

Even if this is done as beautifully as possible this is really complicated stuff to move our industry sort of from the current position to an improve position and in order to do that will require as much clarity and as much simplicity as possible. We have several sub-recommendations associated with this.

The first is probably the most important or arguably the most important, which is a recommendation to focus the advanced care information on health IT functionality that is clearly connected with these three priorities of interoperability, care coordination and patient engagement.

There are many other areas of health IT functionality, quality and outcomes that could be made priorities. We've used these three as the ones that will have the most overriding advantage to CMS, to providers and to patients.

The second is a proposal of the final rule should more strongly reward opportunities for innovation. We specifically, in comments from the group, pulled out things like expanding access to care such as through telehealth, incentives for rural providers to participate in the program and for those in underserved areas.

A third recommendation is to…which fits in congruently with the topics that Paul just covered, is to simplify the glide path for participation in Advanced Payment Models. So make the scoring standard simpler so that an eligible clinician doesn't have to go through a substantial education process to understand exactly what am I doing, when I enter this program how is it going to affect me, what are the things that I can do to manage my participation in APM to the advantage of my patients and for the viability of the practice. The standard scoring approach could be made simpler.

As a sub-point to that we suggested, particularly for interest of smaller rural underserved areas, the possibility of creating an education and explanation similar to happened with the Regional Extension Centers under HITECH.

And then finally, identify some additional pathways for small and rural providers to better engage in the program and to meet their priority goals. Can we go to the next slide, please?

Related to this is what we can do to improve the CPIA category. The overall recommendation is that the CPIA should avoid becoming prescriptive since it's a process requirement and that this could serve as a testbed for innovation for activities which might later be incorporated in the APM. We suggested a couple of flexible options.

One is to explore opportunities to allow specialty specific quality improvement activities that might be related to maintenance of certification requirements that could be used as a deeming method to get to partial satisfaction in the CPIA requirement.

The second might be to test health IT use that supports innovation and care within the CPIA category, HHS might identify high impact functionalities for consideration at future certification requirements. The goal here is to try to create some clear pathway as well as signals to the market so that the QPP Program in the marketplace would have the ability to incorporate innovation and scientific advancement.

If we are overly prescriptive it may make it very difficult to take advantage of that innovation and scientific advancement. This is all obviously congruent with focusing on outcomes rather than processes as well. And can we go to the final slide, please?

Our fourth recommendation relates to interoperability. We viewed that as one of the major objectives of this regulation. MACRA offers an outstanding opportunity to promote widespread interoperability through multiple stakeholders. As Paul noted at the beginning we had a diverse group of participants in this Task Force. We had obviously representatives of ONC but also private payers, vendors and so on and I think there was a large amount of congruence that if we can create clear enough signals around interoperability all of those stakeholders may be able to align along methods to improve interoperability.

We want to encourage private payers to construct value-based programs in addition that align with the QPP Program and to build in incentives to submit electronic clinical data so all three parts of the program related to the original component.

The sub-points here, that QPP could facility greater partnership amongst providers and public and private payers to reward information sharing. So a concrete a suggestion is, could there be ways to build common infrastructure for data submission that could be used by any payer not just CMS.

A second would be to simplify and standardize the quality measures so that the reporting is made more common and simple across multiple payers in multiple programs.

The second sub-recommendation is to create a pathway for providers to move towards completely electronic information collection that would allow for equivalent information to be distributed to any entity that request it. So, this is highly aspirational but one that we should aim towards which is that as providers simply do their work of care that this might be sufficient to collect the information required and that it could be distributed in the same way.

And then finally, make sure that the most important information for quality measurement and improvement is submitted in the QCDRs even if it's not imported electronically. So despite the fact that we're looking at pathways to get to solely electronic collection and submission recognize that at least initially we ought to focus on the information and then perfect the process over time.

This is complicated stuff, we're moving from a series of regimens to hopefully a more simplified regimen but it's not something that's going to happen overnight. And the multiple stakeholders who are involved in QCDR activities will need time to adjust to the information required.

That concludes our comments based on our initial pass through the work. We welcome your input and comments which we'll take back to our workgroups for final recommendation on the 23rd.

Michelle I'm not sure who is going to facilitate the Q&A but turning it back to you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
I will start calling on the people in the queue, before I do that, Kathy did you want to make any comments? I will let you go first Kathy.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
All right thank you Michelle. And thank you both to Paul and to Cris and to the members of this Task Force. I think everyone feels very much the sense of urgency that you've conveyed here. I think that the Task Force got it absolutely right in terms of pointing out the challenges that we all expect to face with a very, very rapid implementation schedule.

So, if the proposed rule comes out sometime in October, the rule to which we are responding, and the first day of the year, January 1st, is when eligible providers are expected to start to embark upon, I think most will be MIPS providers, I'm anticipating that there will be some bottlenecks of how quickly can all of the necessary testing tools get out to the vendors so that the vendors can test and make sure that their systems that their customers are using are going to be able to respond to the demands of this rule.

And then secondly, as you've highlighted, and thank you for that also, the challenges of having really brand-new participants who will also be facing that very short window of two months to be up and running and ready to report. So thank you to you and your Task Force.

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

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you so very much and I just want to reiterate the timing aspect for this and really be a voice for the small practices. I'm kind of the bottom of the funnel when it comes to complaints both as a state representative and on this committee but I can tell you I have heard overwhelmingly from providers out there, small groups and even medium-sized groups and individual practitioners, who are saying this is such a complex rule and that they are overwhelmed by it. There needs to be an education process and explanation and it needs to be…they really need to understand the benefits of it in the long run. So, timing is absolutely key.

And I would suggest we even make specific recommendations that we delay the implementation at least for six months, possibly even put it off another whole year because this is just going to be so overwhelming to the system. I don't know how we're going to get the information out there to get some buy-in that's going to be needed and also to make sure people understand what they have to do. Of course then you have the technical components making sure you have the ability within your system to comply. So I can't tell you how much I appreciate these recommendations. Thank you for doing such a great job.

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

Paul Egerman – Businessman/Software Entrepreneur
Yes, thank you and thank you Paul and Chris, you know, as has been said, this is really spectacularly good work so I really appreciate it. The comment I have is I first just want to certainly agree with your call for simplification. I also want to agree with your call that there should be greater focus on outcomes rather than process.

And I wanted to particularly comment on, I think it was your last slide, slide 15, where you talked a little bit about the commercial payers because it's really important to realize that the CMS activity doesn't exist as an island by itself providers still have to deal with current payers, commercial payers, in a process that's entirely fee-for-service so this new MACRA approach really layers on top of that.

And I thought that your call on the last slide that perhaps CMS could show…the way I interpreted it, show a leadership role in trying to get commercial providers to use the same quality metrics and reporting that CMS uses that would help with simplifying and sort of get on board with the program. I think that's very important. I didn't quite understand why all of that was a sub-bullet to interoperability however it seemed to me that this might be a recommendation by itself.

But with that minor process comment or format comment I would just say that this is really excellent work and I'm really pleased with it.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Paul, this is Chris. Thank you for your comment. We were trying to lump these together as best possible, but your point that it might be a separate recommendation is a good one and if it helps us, you know, make sure we don't lose something in the mix we'll take that into account. Thank you.

Paul Egerman – Businessman/Software Entrepreneur
And my comment there is, I mean, CMS obviously can't tell payers what to do but CMS can sort of ask them and set a standard and if for example CMS were to ever say, here is what we want to have happen in 2017 or 2018 we want to work on these specific quality issues on a national basis and we would like to ask payers to voluntarily do the same thing. Not every payer would, but some would and the fact that some would may just help.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Yes.

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

Richard Elmore, MA – President, Strategic Initiatives – Allscripts
So, just seconding all the positive comments about the great work that's been done here. As it relates to interoperability I think congresses intent with MACRA, and CMS's intent with the Quality Payment Program, was to accelerate and try to really get interoperability at national scale. I think to do that well we need to make sure that part of our recommendations focus on specifically what it is we're trying to do in a very short period of time with, you know, existing systems and infrastructure to improve and make those better.

As an industry, I think we suffer from ADD and we tend to get onto the next bright shiny object before we finish the job moving from version 1 to version 2 and 3 and really making sure that what we have out there is going to work and work well.

Not that we shouldn't be moving ahead onto new frontiers but I would encourage the Task Force to make specific recommendations about some of the deliberate work that's going on to improve existing specifications and implementation specifications around Consolidated CDA and Direct and so on that could contribute to the original intent for the interoperability requirements and the law and in the regulation. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Kathy, we're back to you.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
Wow, thank you. So, I'm really responding to two comments ago that has to do with the role that CMS is able to play with respect to how reporting is done to non-federal payers and just highlighting for the group that the proposed rule does have language that to participate in MIPS there are thresholds of reporting for all reporting mechanisms except for if one is using Part B Medicare claims that require that the all patients for whom a measure applies whether they be covered by CMS or in a private plan that their data is also submitted. And the threshold I believe is 90%, 80 or 90%, so de facto actually, there will be reporting to CMS of all of those non-CMS covered patients. Implication meaning it is even more important that there be harmonization of what is reported to CMS for patients with particular conditions and what is reported to the private plan.

So I have some cautious optimism I would say with regards to the work that CMS is doing with AHIP and also the work that CMS is doing with the learning action network or the LAN but I think this committee should continue to see what the outcomes are of those efforts and see if it helps lessen the burden by harmonizing the reporting requirements. Thanks.

Paul Egerman – Businessman/Software Entrepreneur
This is Paul, can I just respond to that quickly?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
Sure, please.

Paul Egerman – Businessman/Software Entrepreneur
Yeah, I hear what you said but when I made my comment about CMS and leadership there is still the issue that private payers have requirements for quality reporting that has to be submitted to them in order to get paid by them and it would be great if those quality reports were the same that you're

submitting to CMS because the private payers sometimes I feel like they can help themselves they have to tweak those reports or make them different and that is adding a huge amount of complexity, it has an upstream impact you have to ask the same question three times or 10 times about a patient's smoking status because it's reported differently to different payers.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
So this is Kathy, I couldn't agree with you more and I think that again making suggestions back to the Task Force I think that having within the report some language to the effect of how the goal of reducing burden should be viewed broadly in terms of the burden not just for reporting to CMS but also the reporting across the payer landscape and the justification for being able to make that kind of comment is the fact that CMS is requiring submission of patients whose care it is not currently paying for. So I think we do have, shall we say, standing to make that kind of an observation.

Paul Egerman – Businessman/Software Entrepreneur
Sounds right to me.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
And this is Paul Tang, along those lines, CMS does do contracting, as you know Kathy, for measures and if they were to contract for more of these measures that matter to individuals and get them through the endorsement process then one of the ways of shaping the field is to have available common outcomes oriented measures that matter to individuals and they could become de facto for private payers. But that's an example of how CMS's actions can affect the whole field.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association
So I would agree, but I think that it is a step-by-step process and the Core Measures Collaborative, which I'm involved with on behalf of the AMA, is certainly taking a step at a time of trying to have common measures that are agreed upon and that the payers will use and that CMS will also propose in the rule. So, definitely an incremental type of process.

Paul Egerman – Businessman/Software Entrepreneur
Yes, and in some ways the situation is reminiscent of the early days of automating claim forms where every payer had their own format for their own claim form and we went through a whole series of iterations where we basically standardized claim forms and got payers to use the same claim form and then eventually got, you know, the electronic aspects of all of that standardized but that was also a very slow and painful process and I see some of that being repeated with some this quality reporting.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic
Paul, this is Cris Ross. I think your comments are right on the money. I would not want to speak for the members of our workgroup who came from the payers much less speaking for all the commercial payers that would be highly hubris but I think in our conversations it was pretty clear that the representatives on this group had a strong interest of trying to find cases where the private payers could, where possible, adopt processes, methods and so on that CMS might propose that they saw it in their interests to try to become more standard and more simplified and that can surely only be a good thing.

Paul Egerman – Businessman/Software Entrepreneur
Right.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Paul I think you raise your hand to respond to Kathy but I just want to make sure that you don't have another comment?

Paul Egerman – Businessman/Software Entrepreneur
No I'm all set, thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you. Arien Malec?

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Hello, so, I very much agree with the Task Force's comments. The piece that I'm sort of mentally struggling with kind of putting myself in CMS's position is I'm pretty sure that the Task Force's comments are well in line with CMS's particularly the comments relating to simplification and getting more outcome oriented are in line with what CMS has stated they were trying to do. Likewise with respect to aligning quality measures with commercial payers. That's very much in line with what CMS at least has stated and acted as trying to do.

So I think it would be helpful, to CMS at least, for the Task Force to try to, in future iterations of the recommendations at the end of the month, see if we can draw out examples where the intent and the proposed rule aren't in harmony.

With respect to the recommendations relating to timing and simplification, you know, I'd comment that the NPRM itself, if you read all the details, a lot of the complexity stems from CMS's I think laudable attempt to make, as you know, it flexible and also make this applicable to the widest number of providers. For example there are sections, sub-sections in each of the sections relating to providers who aren't patient-facing and how do you tailor messaging.

The thought process that I had in listening to your comments is, you know, there a simplified MACRA-lite that kind of strips this down and says "okay, if you are a patient-facing, you know, primary care provider here's what MACRA means for you" and that kind of simplifies by subtraction instead of simplifying by changes, that is one of the things I'm hearing you say is the complexity and the flexibility lead to a great deal of complexity, maybe one of the ways of addressing that complexity is to show a version of MACRA that is tailored and highlighted to specific provider groups and orientations that strips it down and says if you're a patient-facing physician in internal medicine MACRA means "x" for you and that might help people wrap their heads around what this is all about.

And then finally, I'd like to, you know, endorse again the notion of providing a softer on-ramp particularly for 2017. I'd also note that relative to adoption of APMs and Advanced APMs I think we're putting providers in a strange position of asking them to do a hard and fast New Jersey Turnpike on-ramp and we probably should be looking for mechanisms to provide more California style long merges so with respect for example to MIPS to give flexibility in 2017 and more time to achieve IT changes, more time to achieve process changes.

And with respect to APMs in particular, some level of flexibility of APM, recognizing there is an APM adoption period and potentially contemplating considering that participating in non-advanced APMs with the intent to transition to Advanced APMs may well be qualifying for the Advanced APM track.

So for example, if I have an intent to participate in Track 2 MSSP I might start in Track 1 just to get my bearings and get my footing. I think there is some level of flexibility that CMS should contemplate relative to providing particularly the IT adoption that goes along with the level of outcomes that are associated with Track 2 that gives people credit for the hard effort that's required in the early years of adoption, but as I said, I otherwise firmly endorse the comments of the Task Force.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
This is Paul Tang, and maybe I'll respond to couple things that Arien brought up. So, without commenting on what may or may not happen with the bridges in New Jersey, one, actually a couple of the ideas you threw out were just not included in the summary slides, one is we also suggested that there be a by perspective kind of table or diagram that shows how...probably not down to the individual provider group but specialty versus primary care and so on and so forth, we agree with you that would help.

And the second thing we also agree on and we see in the responses to individual questions is if we have to by constraints start the measurement in 2017 maybe holding other things constant like EHR capabilities, try not to introduce new things, would be helpful. So, we have to live under the constraints that exist in the current law and it will be tough to change the law but within that how can we simplify and make that on ramp easier?

Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation
Right, thank you.

Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health
Well, if there are no other questions, certainly on behalf of the group and Cris and I, we really appreciate your support of some of our initial thoughts. You seem to agree with the organizing concepts. We'll flesh out some more of the details along the lines of what Arien suggested and maybe make those a little bit more visible in our next go around with you towards the end of the month, but it sounds like we should proceed in trying to flesh out these points and come up with some more concrete recommendations that can hopefully help the rulemaking finalization.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Are there any additional comments from the group? Okay, well, thank you again to Paul and Cris for leading this effort it has been a lot of work but we greatly appreciate all the time that you've put into it and we look forward to hearing your updated recommendations or more detailed recommendations on June 23rd. So, I guess with that I just want to check first with Vindell because we weren't able to hear any opening remarks you may have had. Vindell, is there anything you want to say in closing?

Okay, well not hearing Vindell we're going to go ahead and open up to public comment. As a reminder, public comment is limited to three minutes. If you could please state your name and your organization before presenting your comments it would be appreciated. And Lonnie I'll turn it to you.

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute
Okay, thank you. If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the queue. If you are on the telephone and would like to make a public comment, please press *1 at this time. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thanks, Lonnie. We received a few comments via the chat that we'll distribute around to the group and David Tao has a comment.

David Tao, MS, DSc – Technical Advisor – ICSA Labs
Hi, thanks, Michelle, this is David Tao from ICSA Labs. The difficulty of integrating external information was said many times today and in other FACA meetings too. Up until now the problem has generally been associated with C-CDA summary of care records because those are the main vehicle for exchanging information through Meaningful Use Stage 2. However, I'd like to suggest that the same difficulties in integration may continue even with APIs such as FHIR since the data values coming from external EHRs or external sources will be the same data just in a different format.

EHRs have challenges incorporating, de-duplicating, translating and reconciling data today. And widespread progress needs to be made in algorithms and best practices to automate the integration and also to help clinicians quickly and easily review the most relevant external data.

So, I recommend that research and pilots be funded to stimulate a major leap forward in integration and reconciliation of external data and that the research not be limited to medications, allergies and problem lists. Thanks for listening.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thanks, David and it looks like we have no other public comment so you all will get a little bit of time back in your day which I'm sure you all will appreciate, just a reminder that our next meeting is June 23rd and it is in person. There is a large conference going on so that meeting will actually be in Arlington, Virginia at the Hyatt Regency Crystal City Hotel so we look forward to seeing you all then and thank you very much to everyone.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you.

M
Thank you.

W
Thank you.

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

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Thank you.

Public Comment received during the meeting

1. Vindell Washington: Vindell Washington ONCAt my former organization the AHA survey was not a single individual effort. Leadership with different responsibilities filled out the survey portions

that were deemed within their area of expertise. Still believe that we should try to engage more providers directly, though.

2. David Tao: This is David Tao, from ICSA Labs. The difficulty "integrating" external information was said many times. and other FACA meetings. Up till now, the problem has been associated with summary of care records (C-CDA) because those are the main vehicle for exchanging information, through Meaningful Use Stage 2. However, the same difficulties in integration may continue even with APIs such as FHIR, since the data values coming from external EHRs will be the same, just in a different format. EHRs have challenges incorporating, deduplicating, translating, and reconciling data today. Widespread progress needs to be made in algorithms and best practices to automate integration AND to help clinicians quickly and easily review the most relevant external data. I recommend that research and pilots be funded to stimulate a major leap forward in integration and reconciliation of external data, and that the research not be limited to medications, allergies, and problem lists.
3. Stanley Nachimson, Nachimson Advisors - there is a long time period between when information is collected and when providers actually get feedback. This causes a disconnect between provider actions and risk/reward. CMS should look at ways to provide ongoing feedback to providers, or encourage vendors to create products to help them moniitor their performance on a more current basis.

Meeting Attendance

Name	06/08/16	05/17/16	04/19/16	03/10/16	01/20/16
Andrew M. Wiesenthal	X	X		X	X
Angela Kennedy	X	X			X
Anjum Khurshid	X	X	X	X	X
Anne Castro	X			X	X
Anne LeMaistre	X	X	X	X	X
Arien Malec	X	X	X	X	X
Aury Nagy					
Brent Snyder	X		X		
Brian Burns				X	
Carolyn Petersen	X	X			
Charles H. Romine	X	X	X	X	
Chesley Richards					
Christoph U. Lehmann	X	X		X	X
Christopher Ross	X		X		X
Dale Nordenberg		X	X	X	
David F. Kotz		X		X	X
Devin M. Mann					
Donna Cryer		X	X	X	X
Elizabeth Johnson		X		X	X
Eric Rose	X	X			X
Floyd Eisenberg	X	X	X	X	X
Gayle B. Harrell	X	X	X	X	
James Ferguson	X				
Jitin Asnaani	X	X		X	X
John Halamka					X
John Scott	X	X		X	X

Name	06/08/16	05/17/16	04/19/16	03/10/16	01/20/16
John F. Derr	X	X	X	X	
Jon White	X	X		X	X
Josh C. Mandel	X	X	X	X	X
Karen Desalvo	X		X		X
Karen van Caulil	X	X			
Kathleen Blake	X	X	X	X	X
Kevin B. Johnson			X	X	
Kim Nolen		X	X	X	
Kim Schofield	X			X	X
Leslie Kelly Hall		X	X	X	X
Lisa Gallagher	X		X	X	X
Lorraine Doo	X	X	X	X	X
Nancy J. Orvis	X		X	X	X
Neal Patterson			X	X	
Patricia P. Sengstack	X		X	X	X
Paul Egerman	X	X	X	X	X
Paul Tang	X	X	X	X	X
Richard Elmore	X			X	X
Scott Gottlieb		X		X	X
Steve H. Brown					
Troy Seagondollar	X		X	X	X
Wes Rishel		X	X	X	X