



HIT Policy Committee Final Transcript July 8, 2014

Attendance (see below)

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good morning, everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is the 61st meeting of the Health IT Policy Committee. As a reminder, this is a public meeting and there will be time for public comment before lunch and at the end of the meeting. For those making a public comment, just a reminder that you are limited to 3 minutes. For those in the room, please remember to state your name before speaking as the meeting is being transcribed and recorded. I also...if you are tweeting today, the hashtag for today's meeting is #HITPC. And I want to welcome our three new Policy Committee members. They were on the last meeting virtually, but they are here today in person.

So, we have Neil Patterson, who is our vendor representative. And we have Chris Lehmann, who is our vulnerable populations representative and Kim Schofield, who is our consumer patient representative. So welcome to them all and with that, we'll actually do roll call and we'll start with Charles Kennedy, just going around the room.

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

Charles Kennedy, present.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

David Bates, present.

Devin M. Mann, MD, MS – Assistant Professor; Attending Physician – Boston University School of Medicine; Boston Medical Center

Devin Mann, present.

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

Neal Patterson, present.

Paul Egerman – Businessman/Software Entrepreneur

Paul Egerman.

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

Marc Probst, Intermountain Healthcare.

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

Gayle Harrell, State Representative, Florida.

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

Paul Tang, Palo Alto Medical Foundation.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Karen DeSalvo, ONC.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Jodi Daniel, ONC.

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

Terry Cullen, VA.

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

David Lansky, Pacific Business Group on Health.

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

Kim Schofield, Lupus Foundation.

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

Troy Seagondollar, Kaiser Permanent and Labor Representative.

Brian Lee – Deputy Director, Informatics Innovation Unit – Centers for Disease Control and Prevention

Brian Lee, CDC.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Health & Human Services

Joy Pritts, ONC.

Judy Murphy, RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

Judy Murphy, ONC.

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

Jacob Reider, ONC.

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

And is there anyone on the phone?

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

Scott Gottlieb.

Thomas W. Greig, MD, MPH – Chief Medical Information Officer – Department of Defense

Tom Greig, DoD.

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

Good morning Scott and Tom. And with that, I will turn it back to Karen or over to Karen.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Great. Thank you, Michelle and good morning everybody and welcome back to Washington. We hope that we made it plenty hot enough for you today, force you to want to stay inside. We have a really great agenda, which Paul is going to go over, but I'm going to yield my time this morning to Joy Pritts, who would like to make a few remarks to the group.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Health & Human Services

Thank you, Karen. As many of you have probably heard, I will be leaving ONC this Friday; it will be my last day. I've worked with you all for four and a half years now, primarily with Privacy and Security Tiger Team Workgroup. It has been a real honor working with you all, I think we've done tremendous... made tremendous progress in privacy and security. As you all know, there is a lot of work left to be done and I'm sure you all are going to have a great hand in moving that forward.

When I leave, Kathryn Marchesini of my office will be Acting Chief Privacy Officer as they search for a...somebody to step into my shoes and hopefully, that won't take them too long. So...she has a lot of experience in dealing with the FACAs, she has been staffing the Privacy and Security Workgroup along with me for the last almost year or so. She's very familiar with this process and will be very helpful to you.

So in closing, I'd like to say thank you so much, it really has been a wonderful partnership, I think, between our office and this Federal Advisory Committee in identifying new issues and working on them and moving the ball forward. And I wish you all the luck in your continued endeavors. Thanks.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you, Joy. And I'm so happy you didn't say; find someone to replace you, because that will be impossible. You are a treasure and I personally want to thank you for all that you have done for the country and always putting people first, the consumers, the folks that we are doing this for. And I want to thank you also personally for teaching me so much these last few months about what the big picture is looking like in the future, what the challenges are that lie ahead and demonstrating how with doggedness and intelligence and consensus building skills, we can really move the agenda forward. So we at ONC are going to miss you terribly and I think the country will too, but we thank you for what you have done and hope that we can get you roped back in when time allows to continue to contribute to this really important work. And I don't know if anyone else had anything they wanted to share.

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

Yes, I had the privilege and pleasure to work with Joy more than the four years and it's been...it's really been an honor to have...to work with you before ONC and then to have all your great effort put into ONC's policies. It's a substantive topic every meeting and then behind the scenes you go and make things happen and it's just really wonderful. So, appreciate your...all of your help and best of wishes and we'll be seeing you, for sure.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

We have to make you cry every day this week, that's the goal.

Joy Pritts, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology – Health & Human Services

So far, you're succeeding, thank you very much.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Great. Go on.

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

Okay, we'll go over the rest of the agenda, as Karen mentioned, we do have a full agenda. We have our usual update with ONC and CMS. And last time Karen said that in addition to just having some stats, we ought to have some real people talking about their experiences, so we do have some real people here to talk about what it's been like preparing for Stage 2. Speaking of the Stage 2, we're going to report out on a couple of listening sessions that we have, it's experience with Stage 1 and 2 moving towards Stage 3.

Then the Quality Measures Workgroup, in their final report as a workgroup, they're going to be merged in with some other workgroups, will be presenting a recommendation...sort of a package recommendations that talk about the overall context for Stage 3 quality measures and beyond. And then the Accountable Care Workgroup also will be merging in with another workgroup, and so they've been working on what it means to have HIT support for these new models of care, and Charles Kennedy and Grace Terrell will be talking about that.

After lunch, David Bates is going to update us on the policy or provide some recommendations for approval for our response to the FDASIA report that came out earlier. And then finally we'll be concluding with an update from the Certification and Adoption Workgroup on both workforce issues related to health informatics, including coding of some of the workforce in this area. Any additions to the...and then Karen's going to finish up with some...a charge to a new task force, a Governance Task Force and announcement of workgroup chairs. Any other additions to the agenda? If not, you also had a draft summary of last meeting and I'll entertain a motion to approve that. I submitted some editorial comments earlier.

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

So moved.

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

Thank you. And second...people are catching up on it. Do I hear a second; we have to have a second to move on.

M

Second.

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

Thank you. Any other corrections? All in favor?

Multiple speakers

Aye.

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

Any opposed or abstain? Thank you for that. Okay, we'll begin with data update with Jennifer King from ONC and Elisabeth Myers from CMS.

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

We're going to do a quick switch on the agenda and have Elisabeth Myers go first and then Jen.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Hi, this is Elisabeth Myers...can you hear me?

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

We can hear you.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Great, thank you. And Michelle, are my slides able to get loaded?

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

Yup, Altarum is working on it now.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Thank you so much. I'm sorry about that delay.

Caitlin Collins – Junior Project Manager – Altarum Institute

We'll be just another minute. Sorry about that.

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

Beth, you might want to go ahead because we have a shorter amount of time this week or month.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Okay, but I really only have a very few quick updates that lead sort of directly into what Jen is doing, so if it's only going to take a minute for the slides to load, I think that would be preferable.

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

So far they're still caucusing.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Okay. So let me pull it up on my end so I can at least get...make sure that I'm accurate. Oh, never mind, there we go. Okay, so if we can...thank you, just go to this first slide. So today, rather than dive in on all of the total numbers that have accumulated over the course of the past few years over time, I'm going to...incremental shift in those percentages. I think that these are the numbers that everyone is most concerned about, so these are what I wanted to put up.

But I also wanted to take a minute to make sure that we're all understanding what these numbers do and do not mean, because I think there's been a lot of questions over the...both through these presentations and from the media interest and as well as just individual conversations. When we take a look at these numbers of what we're seeing for 2014, questions like, well how does this compare to past years? And is this representative of the full population of potential participants for this year? And what does this mean in terms of trends and is this indicator of success or a lack of success? And I think it's actually a little bit dangerous to try and apply those types of interpretations to these particular numbers because they don't necessarily mean that. They are meaningful and they do provide us with some information, but they don't...but as far as data sets go, there is some difficulty comparing these in those types of ways.

So I did want to just highlight these numbers and then explain a little bit about what we can't get from these numbers in terms of a comparative sense. And then Jennifer has some really great data to share with you on what we can get from these numbers. So what we're looking at is that through July 1, we have had 2823 eligible professionals attest for the 2014 reporting year, 143 of those are new participants and 972 have attested to Stage 2. We have 128 eligible hospitals who have attested for the 2014 reporting year, 70 our new participants and 10 have attested to Stage 2. Next slide, please.

So June 1 to July 1 shows that the numbers have nearly doubled; however, this month-to-month increase is only a change in the total attestations, it doesn't actually represent an increase in the number of people who have successfully completed an EHR reporting period. Because you need to remember that when we're talking about eligible professionals, there have now been two, but really the last one only ended on July 1, so since our data is through that date, as of that date, there has only been one potential reporting period, and that's that first quarter. For eligible hospitals, there have only been two potential reporting periods and those are the first or second quarter reporting period. So yes, new providers can do any 90 days, but when we're looking at the bulk of the potential universe, we're really talking about people who are returning; who have to do a full quarter that is tied to the quarter. So the numbers don't really show us from June 1 to July 1 an increase in the total number of people who have done a reporting period, it's simply the number of people who have attested to the data, that's very important.

And when you look at the number itself and it is very low, so it's not really representative of the actual total universe that could potentially participate or that may be currently participating. We're looking at that number, 2823, it's only about 1% of eligible professionals have currently attested for the data that they reported during the first quarter. And we're looking at about 3% of eligible hospitals have currently attested. Next slide, please.

So, what that means, what that data actually is saying, and I'm using eligible professional because I'll get...I'll show you why in just a second, it's actually a slide that stole from Jennifer's previous presentation. So I'm using the eligible professionals here and just showing you a quick timeline. This is just to illustrate what we're really talking about. What we're talking about, that number, that 1%, is the number of people who have done the following things: On January 1, they had 2014 certified EHR technology available and fully implemented and they began reporting their EHR reporting period for a quarter. By April 1, they had successfully captured their Meaningful Use data for a full quarter and sometime between April 1 and July 1, they attested to Meaningful Use for 2014 and that attestation was accepted or upheld, pending the submission of their electronic clinical quality measurement data. So that's who...this is, that's who that 1% really is. It doesn't actually tell us if that's everyone that did the first quarter. It doesn't actually tell us if that's everyone in the entire population, how they're doing. We don't have that data because this is what that number really represents. Next slide, please.

So this is a slide capture...screen capture, stolen from Jennifer's presentation. This was from the June HRT Policy Committee presentation. And it's a little hard to see but what you are looking here is the April estimates of how many providers were how far along on getting their 2014 CEHRT. So remember that last slide was showing that this number, this 2823 who've done 2014 so far, is really people who on January 1 had 2014 certified EHR technology in place and fully implemented. So what this shows us, if you look at the first section under physician, you can see that below that bar is where we're talking about people who may still be struggling to get their 2014 CEHRT in place and this was as of April 1. So there was a big shift between that January 1 time and this slide, and that was demonstrated throughout Jennifer's previous presentation. But I did want to highlight that what we're looking at here is April 1. So April 1 is the beginning of the second quarter, which takes us to July 1, which is the attestation that we'll start seeing coming in over the next few months. Next slide, please.

The other thing that I want to highlight is that we can't easily compare this to past years because we haven't had a year quite like this. So the last slide not only demonstrated what that scale looks like for...in terms of timing to actually get the 2014 software installed, but it also mentioned that we're talking about an upgrade for 375,000 providers at the same time. So there's going to be some difficulty in capturing where each one of those providers is along the standpoint, but that estimate kind of gives us an idea of how that is progressing.

But the difference between this year and other years doesn't just go with what's the software and what is this upgrade that's required. We've never actually had a reporting period that was structured in this way, which makes it incredibly difficult to try and compare it in terms of a rate of attestation. Is this the normal rate? We honestly just don't know because we'd be comparing apples and oranges. So when looking at in 2011, we had a reporting period that was any 90 days. In 2012, we had a reporting period that was any 90 days for new providers, plus one full year for returning provider. In 2013, we had the same, in 2014 we have this massive upgrade that's been required and part of the reason that we moved to quarters was in order to accommodate that.

But what that's done is essentially made five different reporting periods that occur during the 2014 EHR reporting year, and that's just for one of the types of providers. If you then offset everything by a quarter, between hospitals and eligible professionals, it becomes a more complicated set of data to try and compare. So we...our 2014, have any 90 days plus Q1, Q2, Q3 and Q4. So again, taking these individual numbers and trying to compare them as a rate to a past year also that doesn't give us a whole lot of useful information. Next slide, please.

The other thing that we have found in trends over the course of the past few years is that whether you're looking at January to January as your potential period of time to complete your reporting period or whether, as for 2014, you're looking at each of these individual quarters. The majority of our attestations come in after the close of the reporting year, and that does include even those new providers who can attest during...to any 90 days and immediately attest as soon as they've completed their EHR reporting period. Even last year we had over two thirds of our attestations for new providers that occurred during the January and February time period, so that's sort of the trend that we've been seeing. So it would probably be difficult again to go back and look at these in comparison to another year. But what we can do and what Jennifer is going to be leading us through, is try and understand a little bit more about what are the factors that are in common among this particular group. Next slide, please.

So we can look at these 2823 eligible professionals who have attested and we can see that 443 are new participants, which is a pretty significant number if you compare it to the total that have attested. And then we look at the number that have attested this Stage 2, which again, we have concern over the overall, not just those who have attested to the Stage 2. And the same thing for eligible hospitals, even though the numbers are lower, they do represent 3% of the eligible hospital population that could potentially participate who have at this point attested. But again, these numbers are very low and very difficult to compare. So what I think we'll see from Jennifer's presentation and it think it's...I've gotten to see it ahead of time, but it's pretty interesting. It shows us some trends about who these providers are and what those success rates are on individual measures for the 2014 reporting period. So at this point I'll pass it over to Jennifer.

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

Thanks, Beth. So if I advance here...okay. Great. Well that was a great lead-in to the content here that I'm going to talk about, which is, digging in a little bit to understand what these very early data can tell us about who has been attesting so far.

So wanted to take a look at those providers that have been able to attest so far in 2014, look at the characteristics of the providers that have attested how they're performing on the Stage 2 objectives so far and a quick look at some of the vendors that they're using.

So just to piggyback on Beth's presentation, wanted to highlight at the outset here that this is based on very early data. So Beth went through some of the details about the uniqueness of this provider group that we're looking at now, but just wanted to highlight again that this is an early slice of folks who have attested so far in 2014. And we can't really say if they're going to be representative of the entire group of people that will attest by the end of 2014, but important to start taking a look at the data as soon as it starts coming in here. And also wanted to highlight, as Beth did, that although there are some differences in 2014 compared to previous years, we have seen in all of the past years that the vast majority of attestations have been in the later parts of the year and we expect that to continue in 2014, even probably to a greater degree.

But first, taking a look at eligible professionals and what we're seeing so far among those folks who have attested in 2014. So this slide shows characteristics of those professionals who have attested to Stage 2 so far in 2014 and compares them to the entire cohort of professionals who attested to Stage 1 in 2011 or 2012. So that's the whole group of people who are eligible to attest to Stage 2 in 2014. So we can see that there aren't any major differences at this point; however, urban professionals and physician professionals are slightly overrepresented in that group of the early Stage 2 attestors compared to professionals in rural areas or non-physician professionals. And in terms of practice size, we actually see fairly consistent patterns with a good representation of physicians in smaller practices and larger practices and in sort of proportion to what we saw in Stage 1 cohort that would be eligible to go to Stage 2.

And then taking a look at how this early group has performed so far on the Stage 2 objectives. So this slide shows all of the core Stage 2 objectives and the shading here represents the distribution of the objective scores that professionals reported when they attested. So the green cells highlight the cells where a larger number of professionals fell, in terms of their objective score, compared to yellow cells where there were fewer professionals in that score category. So for example, the top line there is CPOE for medication orders and you can see that the green is on the far right end, so the majority of professionals are falling well beyond the threshold there, in the above the 90% range, several in the 100% category. And that's the case for a lot of those objectives towards the top of the slide, the CPOE objectives, recording key patient information, etcetera. But as we move down to the bottom of the slide we see some of that green shifted over to the left, so more professionals clustered closer to the thresholds for some of the objectives, like sending patient reminders, the view download transmit objectives and the transitions of care, summary of care record measures.

And finally here on the professional side, just taking a quick look at the types of vendors that have been used to attest so far in 2014. We see that as of May 2014, 37 different vendors had been used for attesting to Stage 1 among professionals and eight had been used to attest to Stage 2. So these are vendors that have their 2014 addition certified products being used to attest. And the table here on the right shows the distribution of those Stage 2 attestations by vendor. So you can see that a couple of vendors athenahealth and Practice Fusion have a higher share of attestations for Stage 2 so far compared to the share of attestations they had in that Stage 1 cohort. Again, this is very early data, so these are the folks who were able to attest right away and it's likely that this will shift over time as more professionals start attesting to Stage 2.

So then shifting to hospitals, taking a look at some of those same questions for the hospitals that have attested so far in 2014. Here in terms of characteristics of hospitals that have been able to attest so far, the bar on the far right here shows all hospitals that had attested to Stage 1 between 2011 and 2013, as sort of a reference point. And in the middle here we see that the hospitals that have attested so far to Stage 1, that group contains a slightly larger number of medium and large hospitals compared to the overall group of hospitals that had attested to Stage 1 so far. And of the hospitals that have attested to Stage 2, a couple have been small rural hospitals, but most of them have been medium-sized hospitals.

And again, taking a look at the objective score distributions for those hospitals that have attested to Stage 2 so far, this is a small number of hospitals, so 8 hospitals, so it's important to keep that in mind as we're looking at these distributions. But there's a little bit more variation across the board for the hospitals than we saw for the eligible professionals. But we do see the similar patterns where some of the objectives, like view download transmit and the summary of care record provided electronically, we see hospitals clustered closer to the threshold values there than we do for some of the other objectives.

And finally, taking look at the vendors, for hospitals we see that 13 vendors have been used to attest to Stage 1 as of May 2014 and five different vendors have been used to attest to Stage 2. So again, these are vendors whose 2014 edition technology has been used to attest so far. And we do see some variation in terms of the specific vendors and their share of the Stage 2 attestations, but the differences aren't nearly as large as we saw on the professional side.

So just to sum up again, highlighting that this is very early data, so we can't draw many definitive conclusions here about what this tells us about how things are going to be going over the rest of the year. But it does highlight that there are some areas in terms of the types of providers that are attesting that will be important to monitor over time, to ensure that we have even progress and that the group of people who have attested by the end of the year represents that full universe of folks who could attest. And also highlights that the quantitative data is pretty consistent with some of the qualitative information we've been hearing about the types of objectives that are most challenging for providers to meet so far for Stage 2. I'm happy to take any questions.

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

Okay, so we'll open up for questions. I have a need to sort of try to summarize what we heard in these past two presentations. So one is, I think we're hearing this amount of data, even on small numbers and there's a danger in presenting that because the committees asking for that kind of information because they're concerned. So that's a valid concern, but we've got to be careful not to over interpret information statistics on a very small number.

And the second part, I think, is the biggest uptake from...my biggest conclusion from Beth's presentation is there's...each year has been so different. And part of that's been a reaction to the need for more flexibility, so there's been...going back to the 90 days, and that caused it to be difficult to compare from one year to another because they're all really different. We do know that people tend to attest, just like any parts of our lives, in the latter part of the year than the former part of the year and so that's sort of the overarching conclusion, I think, from presentation one. So comments and questions, David Bates?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

So I just wanted to ask, was that list of the inpatient vendors an inclusive list, in other words, are there other...for example, EPIC was conspicuously absent. Are there any hospitals who have EPIC that have attested?

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

At this point, for Stage 2, that's the inclusive list, again, it's the small "n" of 8 hospitals that had attested at this point...

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Oh, I've gotcha, okay.

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

Chris?

Christoph U. Lehmann, MD, FACMI, FAAP – Director, Clinical Information Technology – Johns Hopkins Children’s Medical and Surgical Center; AMIA

Chris Lehmann. I have a question regarding your slide on the characteristics of eligible professionals. I noticed your categorization into rural and urban, not as a suburban category that is rather different than urban, so you have either no suburban people reporting or you didn’t tease that out. I would strongly advise, especially because there are different needs when it comes to the care of patients that you change that category to include suburban.

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

Thank you. Yeah, we can definitely take a look at more detailed categories than in terms of the urban/rural breakout. This is based on the...whether or not the county is classified as a Metropolitan statistical area, which is a common rural/urban definition, but there are many others that break it into more nuance, so we can do that in the future.

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

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Yes, thank you, Jennifer and Beth as usual very good presentation. I have first a very technical question. You said verbally that there are 10 hospitals, but on some of the slides it says the data’s on 8 hospitals. So...are all slides on eight and what happened to the other two?

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

Yeah, thanks for asking that question. So we have...we use data from different points in time...slightly different points in time for some of these slides. So Beth...what Beth presented this earlier was the very latest numbers as of, I think, Beth correct me if I’m wrong, but I think July 1.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Yeah. Yes.

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

And so, that’s...as of July 1, they were 10 hospitals that had attested to Stage 2. For some of the analyses that we presented here, we used some earlier cuts of data to give us time to do the analyses before today. So eight hospitals had attested as of May 31 and then one additional slide here we have data from a little bit later, which included nine hospitals. So, a little bit confusing that we’re using slightly different time points of data, but wanted to use the most up-to-date whenever we could that would give us the time to present here.

Paul Egerman – Businessman/Software Entrepreneur

So the other eight is through the end of May, the number 10 is through end of June, roughly.

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

Correct.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

Correct.

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

So in effect, the number of hospitals increased from the month of June from 8 to 10, which is 25%. So, that's evaluation. But another way of looking at it is...as I look at this is, well over 99% of the hospitals and eligible professionals are still on Stage 1. Is that a fair way to look at these numbers?

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

So as Beth pointed out, yes at this point, the small percent of hospitals that have so far attested to Stage 2 of those who are eligible to do so in 2014.

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

So the other thing to sort of...on to that question, a lot of hospitals and eligible professionals should be on Stage 1. So that's the...year that they are in. So I think that there's that additional layer of complexity that the total universe is not the total universe of everyone who should be doing Stage 2, only providers who are scheduled to begin Stage 2 this year should be doing Stage 2. So a number of them should be doing Stage 1.

And then also the caveat on the increase of 25%, it actually doesn't increase at all. It's not an increase in the number of participants, which is what I tried to make clear with the...the reporting period is, the period that we're in that we're talking about is an increase in how many people actually attested. So that doesn't mean that that's a new group of people who did a reporting period, the reporting periods are static, they are the first quarter for eligible professionals or the first or second quarter for eligible hospitals. So it's just that some of them attested the day they were done and some of them attested three or four weeks later, some attested six weeks later. So it's still the same group who completed those reporting periods and I think that's important to understand as well that we haven't even seen people who did a reporting period between April and July yet.

Paul Egerman – Businessman/Software Entrepreneur

Thank you for that clarification.

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

Okay, thank you. Gayle?

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

Thank you very much. I would just like a little further clarification because with those that are at the point where they should be moving to Stage 2, do we have that exact number that this 10 hospitals represent 10 of 100, 10 of 500, 10 of 1000? How many do we actually have who should be attesting to Stage 2?

Elisabeth Myers – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services

I should get that number for you and I can do that.

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

Thank you.

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

Oh, Terry.

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

This is Terry. I'm just wondering do you have specialty data on the EPs that have certified.

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

We do, we didn't present that here today because we had some issues analyzing it for this go around, but we're hoping to be able to present that in the future.

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

I just think that would be helpful. Thanks.

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

Yeah, thank you.

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

Good, well thank you Beth and thank you Jen for the update. To bring some real experience to the table, we're going to have Tom Johnson and Paul Merrywell talk to us about their implementations and attestation, I believe for Stage 2, if I'm not correct. Okay, and so Paul, in your context, Paul Egerman in your context, this would represent either 10% or 12% of the entire experience. But, after saying that, I want to make sure everybody...these are low numbers so we're just trying to get some personal experience here. Tom, do you want to go ahead? I think you're on the phone.

Thomas Johnson, MBA – Chief Information Officer – Dubois Regional Medical Center

Yes, I am. Thank you. Good morning everyone, my name is Tom Johnson. I am the CIO for Dubois Regional Medical Center. We're a 200-bed community hospital in rural Western Pennsylvania. I believe we were the first hospital to attest for Stage 2. And before I can really dig into Stage 2, I have to tell you a little bit about how we positioned ourselves with Stage 1. So, when we started with Stage 1, our whole focus was to go all in and really exceed every measure. So we didn't ask our physicians to do 5% of this or 10% of that, we really strived to do 100% of every measure, including all the menu items, to really get the real value out of our investment and the value out of the system.

We started off working on the first three population health-reporting measures with the State of Pennsylvania right away, which took well over two years to get everything set. We were in the first group to attest for Stage 1 and it really did transform our organization. We integrated Meaningful Use into everything we did, every committee; every process and we spent a lot of time with our physicians transforming their workflows, building in the quality measures, but building and all the Meaningful Use measures. It was not optional for them. So positioning ourselves for Stage 2 began at Stage 1. We really did stay very focused on Stage 1 and we had a very strong relationship with our vendor, which was Cerner, that I believe was very key in getting us where we're at today. They have a very strong regulatory team that helped us through the whole process.

So for Stage 2, we were very well positioned going in. So from the get go, the first thing we had to focus on was the Meaningful Use code, the certified code for 2014. So we used Cerner's upgrade center, got that done very quickly. And then spent all of our time, effort, and focus on the two what I would consider major hurdles for Stage 2, which is the patient engagement portion, really engaging patients and their families in care, which is a very hard thing to do, we're not used to doing that in healthcare, and the HIE portion, the health information exchange. So that was our two focus areas.

So we hired a full-time LPN for the patient engagement piece that really went around to every patient that was admitted into the hospital, worked with them and their families to try to encourage them to log in and sign up for our patient portal, which we were able to do successfully. And then the other major hurdle was the HIE piece, which we already had a relatively well-connected community. We did a lot of remote access to our independent physician offices, nursing homes, free clinics, so we were already pretty well connected, so it was pretty difficult for us to do HIE in a rural area when we're already connected with everybody. So we had to get very creative, develop a lot of interfaces, work with some independent physicians to overcome that measure. But it really didn't add a lot of value for us in our community, which we're already, like I said, relatively connected. So that was probably one of the bigger challenges.

Again, just the regulatory challenges, trying to navigate all of the language and just make sure we had clear interpretations. We did lean a lot on Cerner for that one, which was very valuable for us to get over that hurdle. So that was basically the key for us for Stage 2.

And basically my recommendation is do not lower the standards, just maybe give some more time and some flexibility. I am concerned about some backsliding, even with our own organization, if we don't keep the pressure on the physicians, keep the focus going, it's too easy to get distracted with health system building, ACOs, and population health. I do appreciate the ICD-10 delay, but it's still looming out there and it's still going to be a distraction as we move forward. All the health insurance exchanges and the ACA, there are just so many moving parts and pieces that we have to worry about and focus on and just keeping our reimbursement strong and healthy, that it is very hard to focus on Meaningful Use with all of the initiatives. But our key to success has been we're small, we're nimble, we're flexible and we're able to put our resources behind Meaningful Use and truly integrate it into everything we've done. So, those are my comments and thank you, Michelle, for inviting me for the second time to share my experiences with Meaningful Use. Thank you.

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

Thank you, Tom. Is Paul Merrywell on the phone as well, or...?

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance

Yes.

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

Great. Thank you, Paul. Why don't you go ahead and then we'll take questions for both of you.

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance

Well much like Tom, the...a lot of Tom's comments I would echo that the Mountain States is a different type of organization. It's a health system of about 14 hospitals scattered across two states, which presents some problems, as you can imagine. But the...our experiences were, as a said, similar to Toms. We struggled a great deal with the pace of the rate of change that Meaningful Use poses. Of course we...our vendor is not EPIC and not Cerner, it's Soarian it's a Siemens product. Their delivery of Meaningful Use Stage 2 software was probably like everyone else's, just in time and it created kind of a time crunch for us.

We just did finish on June 30 our Meaningful Use attestation for Stage 2 or the collection of that data for attestation for two of our hospitals and we'll begin attestation on October 1 for the remaining eight hospitals. We do have one hospital that began on July 1, so as you can see, it's kind of a, I called it here a rat race that we're in to manage all of the various moving parts of this. But, it's gone pretty well. Again, the pace of the Meaningful Use Program is a problem for us, probably because of our size. Resources, not only personally in our organization, but the vendor is prob...the vendor community probably struggles managing Meaningful Use command centers and various other things like that, which were very helpful for us.

My comments are going to kind of focus on some challenges that I think this committee, which I am eternally grateful and appreciative of the group that has gathered to listen to my comments today. Because I know that without a broad industry type group working on this, we'll never get to where virtually every other industry in the world is at from an interoperability perspective.

I sense a true lack of readiness by the vendor community, as well as the vendor's customers, the eligible providers and eligible hospitals. There is still kind of a sense in my mind that this is temporary and I know that it's not, but, again, underlying current of what are you doing to us. We have a very strong promotional activity that promotes Meaningful Use, bakes it into processes, much like Tom talked about. However, we have a fair number of physicians...we have over 90 clinics, about 450 physicians and we had some really superstar, early adopters who I appreciate every day when I go home. We have some on the opposite end of the spectrum who feel like every day, me and the federal government are victimizing them in some way.

So I think that timing of the requirements created some pressure for us, Meaningful Use Stage 2 requirements came out I think in September 2012. If they could have come out earlier, it would have given vendors more time, which would have in turn given us more time to get on board and get that accomplished. I believe that there is variation in the certification process, which I again, I don't know that for sure because I'm not involved; however, I know that the way for example patient portals and the enrollment processes in the patient portals work is different. And so I would recommend that somebody kind of tighten that up, because we're never going to get to interoperability until we have standards that can be universally applied.

I'm encouraged by the ONCs recent interoperability vision. I'm encouraged because of everything that I read, a little bit discouraged by the pace that they think it'll take, it'll take 10 years, which interestingly enough is how long it took us to put somebody on the moon. I think there are barriers that the government and other folks need to work on and that a lack of profit motive in the healthcare environment, especially the not-for profit side, which is the side I'm in. I mentioned that practitioners feel like victims. There's no clear ROI for the enormous expense of rolling these products out and continuing to roll them out. It's very difficult for me to continue to make a case for additional, more and more capital expenditure to shore up some of these...shore up these health systems in a fairly short amount of time.

There seems to be multiple government agencies that working at this and from my perspective, they don't seem to be on the same page so I wonder if they're actually working at cross-purposes. I know that having multiple agencies is better than having one or no agency, however, there's probably work that could be done there.

And the other...the last comment that I would make is that it seems like all the focus is on the EMR technology. And of course I think much of the focus belongs there; however, there's an awful lot of downstream technology that when it comes right down to it, creates a problem for EMRs. Because there are all of these disparate systems not...with their own unique or proprietary input that create problems, not only for me as a CIO of a fairly large health system, but it's got to create problems for everybody who has interoperability as a vision within healthcare. With that, I will tell you I'm proud to be maybe the 11th or 12th eligible hospital to attest and it would...and that will be coming to...we'll be doing our attestation in a couple of days.

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

Good, thank you Paul and thank you Tom. Let me open it up for comments or questions from the committee. Okay. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Great, I just want to thank you both, Paul and Tom, for sharing your observations about the entire process. I'm interested, Tom, in your comments about the patient engagement piece where you said you hired a full-time individual to work with people who are admitted, as part of the process. Can you tell me a little bit more? There's this concept of view download, transmit, are your patients using that or are they using the view concept, the download and the transmit capabilities?

Thomas Johnson, MBA, CPA – Chief Information Officer – Dubois Regional Medical Center

Basically we tried to initially incorporated it in with our nurses, so that having...when you admit a patient, have the nurses walk through that with them with everything else they do. They just didn't have the time to focus on it, they didn't feel comfortable with it, it was too technical for them. So really we could train hundreds of nurses on our portal or we could just hire one nurse that was very well trained in the portal, so we went with the one nurse just to get over the hurdle. We only got 7% of our patients enrolled and interested in it. And basically, we get the view download transmit credit when we sign them up and have them go in and look at labs, while they're here in the hospital.

So, I don't know that there is a lot of usage ongoing. But certainly the people that signed up for it were very happy to see their labs and it seemed like it's something they're going to be continuing to use, but...so view and downloads happening, I don't know how much transmitting is happening. And the reason being is we're a small community. I mean pretty much everyone that needs information has it already electronically, so there's not a huge amount of people moving in and out of our community, so there's not a lot of value to the transmit portion.

Paul Egerman – Businessman/Software Entrepreneur

And that's helpful. So what I understand is then you have one full-time person that goes around to the inpatients, enrolls them and tries to get them to look at their lab results while they're an inpatient in order to meet Meaningful Use criteria?

Thomas Johnson, MBA, CPA – Chief Information Officer – Dubois Regional Medical Center

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Great, thank you.

Thomas Johnson, MBA, CPA – Chief Information Officer – Dubois Regional Medical Center

You're welcome.

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

Karen?

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Tom and Paul, this is Karen DeSalvo, I just want to thank you for your hard work on the front lines and for taking the time today to give us some feedback. I know you guys are sharing with us your most precious resource. Just specifically to Paul, I want to thank you for your very thoughtful comments about ways that we at the federal level can be more helpful and in particular. Just respond to your query about alignment of the federal departments and agencies around policies and expectations for technology and make certain that you're aware, part of our process here is to renew the federal HIT Strategic Plan. And we are well underway with our internal processes for doing so and that involves a set of some 36 or more departments and agencies ranging from NASA to FTC back to agencies at HHS like the Indian Health Service and CMS and of course, ONC.

It's one of our expectations at ONC and I couldn't agree with you more, it's really important that we at the federal level are aligned in the array of expectations from policy all the way through to technology and then to standards, privacy, security, you know the list. And so we're working on that and hope that that's going to help provide some clarity, not only around interoperability, which you raised as a top priority, and it remains one for us, but for other areas of technology.

And let me also underscore what you said about the importance of creating an infrastructure that is supportive of different types of data than perhaps we have been considering historically. And I hope we brought that out in the vision document and that we continue to have that conversation with the Policy Committee that there are types of data, whether that is the genomics, proteomics, at that end or patient reported outcomes, quantified self-data, community level data, about where people live, learn, work, and play. I think we need to be thinking very broadly about how we can inform health and healthcare. And so please stay engaged because we would love to work with you all on that as we go forward. Thank you.

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

All right, that exhausts the questions we have from the committee. So thanks again to Tom Johnson and Paul Merrywell for taking the time out of your day to share your experience with us.

Thomas Johnson, MBA, CPA – Chief Information Officer – Dubois Regional Medical Center

You're welcome.

Paul Merrywell, MS – Vice President/Chief Information Officer – Mountain States Health Alliance

My pleasure, thanks.

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

And their comments foreshadows what you're about to hear from the listening session George and I are going to try to summarize for you.

Okay, on May 20 and 27, we held two listening sessions and the context of this is we had given our recommendations from the Policy Committee to ONC and CMS and they are in the rulemaking process. They're expected to release their NPRM later on this calendar year and we wanted to build up, as we have in the past, additional feedback so that we can prepare to react to be NPRM and provide our official response in time for when that comes out, in preparation for the final rulemaking. So we held two listening stations to hear from providers in the field, this is the Meaningful Use Workgroup members. This is probably our final official function as the Meaningful Use Workgroup, as we all change into the new workgroup structure.

As I said, we had two listening sessions, the first at two panels, one of eligible professionals, another panel for eligible hospitals. And the second listening session talked a lot about HIT support of advanced models of care. And then panel four was the vendor's response. So George is going to summarize the overall findings from the panelists and then I'll go over the suggestions from the panelists.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Thank you, Paul. So the first finding was a feeling across the panels, I think, that Meaningful Use Stage 1 was a success and not unduly burdensome. And a generally feeling that Meaningful Use Stage 2 has been challenging, and we'll go into those details. Of course, you have to realize that if we had asked them three years ago how Stage 1 was going, would they say it's useful and not unduly burdensome, I'm not sure. It's hard when you're in the middle of things.

The scope and pace of change causes vendors and providers to focus on meeting the letter of Meaningful Use and less on the spirit, so that was something that was expressed. For example, sometimes in quality improvement it's more work to document to measure the thing than it is to actually improve it. And so this actually dovetails the Meaningful Use workgroup's desire to retire measures, as we think that the nation has gotten to a certain point to get rid of that burden assuming that people will not step back from that and the comment that fear due to audits is often a factor driving implementation. And I'm going to come back to this theme on the next slide.

Probably the most challenging thing, transitions of care. The problem here is not automating an existing process, we're creating a new process and we're using the Meaningful Use regulation as a driver. So the requirements of transition of care is not well defined because in fact we are defining it going forward and it requires changes in the workflow. This is not just asking someone to measure and new thing, it's asking them to change the way they do their work and in a way, that we're still figuring out what's the ideal way to do it. However, if we don't push it forward, we won't...we haven't been getting there in the last 30 years, so that's the trade-off.

Like being the first person in your town to have a telephone, it's difficult to identify electronic recipients to accept information. So you need to start somewhere and get everyone on board so that there's someone to communicate with. And also, express that there's a need to exchange useful information, not just more data. If someone's been in the ICU for three months and you get a dump of their health records for a referral for an eye checkup, that's not a useful lump of information. It needs to be more nuanced that what you get is appropriate for your purpose.

There was a comment, actually a couple of comments that Direct is not working as planned, let me give the two examples from the hearing. One was that in one case they had to step backward, they had been sending information in automated fashion using HL7 with the primary data, and that had been going on for many years. And then because of Meaningful Use, they had to turn it into a CC document, which is kind of derived data and then send that using basically synchronous secure e-mail, which is a step back from HL7. Whether that's an exception or not, you can discuss, but I would...and the other was that doctors don't have access to its...or providers in general, in some cases hospitals have set up Direct accounts for clinicians that they work with. And then the challenge is, will those clinicians check their accounts, if that's their third e-mail like account. So those are two things that were expressed about Direct.

Health information exchange remains...which is related, remains a challenge, proprietary business interest and legacy technologies are part of the problem. They expressed that we should not just look at exchange in abstract, but say okay, it's for the purpose of care coordination and patient engagement and focus on that. They expressed that the key to exchange is not sending data across the country, but in local community. So it's really getting the local competitors working together and exchanging information. And expressed the need for policies, for example, across state boundaries. Remember, we just heard that even though it's a local community, it can still cross state boundaries. So that is, in fact, important and patient matching has always been a challenge.

Timelines need to be aligned. We talk about aligning the quality measures for one thing but in addition, those programs say Meaningful Use and other quality measurement and other CMS quality measurement, the timelines of those things should be aligned so that you're collecting data on one set of quality measures at one given point in time. Also they noted that in some cases, the difference between EPs and EHs, and they understand the difference in fiscal years, but that three-month difference has been a challenge. Timing in general, the late delivery of final rules and guidance, they say has impeded delivery of certified products. And so therefore, providers and vendors are overwhelmed by the current pace and scope. And more time is needed to prepare for Stage 3, learning from Stage 2. And that was the overwhelming opinion from the hearing, although one vendor expressed that, in fact, they didn't find it overly difficult and were wishing that it could not only not slow down, but go faster because of their business model works well with this paradigm.

Patients in general...it was expressed that patients are thrilled...remain thrilled with electronic health record as a potential for their providers using them as well as them being able to use them to get to information and get to services like making appointments. Two concerns that were expressed is each patient has many doctors, because the Meaningful Use regulations each doc...each professional is setting up a portal, therefore giving...a patient may have many portals and that leads to possible fragmenting of care and confusion. They're actually seeing firsthand, in effect, our lack of health information exchange. They're seeing on different portals what each person knows about them. And second, just the issue of health literacy, we need to recognize that and work with that as they try to get to their data over these portals.

There was expressed the challenges of being measured on things that are not in their full control, therefore, either we don't measure them or if we measure them, to set the level...the threshold appropriately.

Certification, my institution here at Presbyterian just certified a product, so we know what it's like and the hearing expressed that it was rigid and complex and that it could affect usability the way you have to go through the process. And it is a hard process, I know that firsthand. One of the big things was communication though that could improve it without changing other things that you need high-quality, unambiguous specifications with an opportunity to ask questions at in a rapid manner to get answers back so you don't need to try out certification, fail and try again.

Again talking about redundant reporting requirements we've talked about. In general the panelists were thrilled to be there, to be able to express their experience and basically express appreciation that the Meaningful Use Program remains a big, open process. Paul?

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

And speaking of being thrilled, they were also thrilled to share some of their suggestions. We call it suggestions for improvement because this is a listening session, so they are providing suggestions and we're listening and incorporating their thoughts as we await the NPRM and react to it. So, among the suggestions for improvement, really there's the...they really like the idea that the Meaningful Use Program has made it possible for so many to have adopted these systems and to begin to use them meaningfully. And now as we move in...later in the stages, need to step back and make sure we are tackling only the challenges that government can solve in trying to allow the market to continue to innovate.

So some of the things that the government, as a public servant looking out for the public good can do, one is help with interoperability infrastructure, sort of the highway in that metaphor. So just like the saying, there are so many standards to choose from, pick a standard so that they can operate off of one. In the highway situation, lanes have to be a certain width and they can't be different in every state, for example. So pick standards and help set those so that information can flow, either across town or across the country.

Second piece, everyone recognized that we do need to have information flowing, we do have to requi...have the exchange going, but it's a bit hard to push the exchange and that's what's been going on through Meaningful Use. Rather, people would love to have people, in the highway metaphor, want to get to that destination. So perhaps a pull, some suggested through the payment, the CMS kinds of programs where there's an incentive to share information in care coordination, for example. Another kind of pull would be accreditation standards. These are on the pull side rather than pushing from the technology.

One of the sentiments that was raised was to try to avoid the double jeopardy. So if an organization, like we heard from Tom, gets their staff and systems in place to be able to exchange, it's a shame for them to also have to go help everybody else receive this information, is sort of that's what he called a double jeopardy.

Another kind of public good is policy interoperability, so it's sort of the rules of the road. So we have to have a speed limit, a very consistent speed limit across...as the interstate crosses various state boundaries. You know that it varied between 55 and 70, but you have the right idea. So people were asking for more policy interoperability as they cross town, cross competitors and cross-states. That's an area where they felt government could make a contribution.

And thirdly, the essential HIT functionality, it's sort of the cars. You have to...headlights have to be visible at 300 feet in every car, not just a car of one manufacturer, so that's part of the basis for having a certification program, to have certain functionality that's needed that may not be there with market forces driving alone. You do want to require implementation, especially where you have care coordination and there are two parties that have to be involved. But they mainly wanted us to...or the program to leave the details flexible.

So one example, an exchange that's where this example arises, where you have two parties that have to work together. You need to...you'd like to encourage that that exchange happens, but maybe not insist on a certain percentage. And the reason is because there are so many specialties in so many different locations where one percentage may not fit all. So for example, vital signs, primary care providers could achieve an 80% threshold. On the other hand, a dermatologist or orthopedic surgeon may not reach 80%. So it's really hard to have the one-size-fits-all and so the suggestion was to have more of them a minimum number rather than a minimum threshold percentage.

Along the lines of certification, it really echoes what we heard from the certification hearing, focus on the "what" and not the "how." In the example that George raised in terms of Direct, some people had to actually take a step back from their semantic interoperability and go towards the Direct protocol because that was sort of a baseline that was required as part of functional...as part of certification. And people expressed the need for more information for them to make informed choices, whether it's the choice of which product or to influence how the market improves usability, patient safety, or innovation. So if we back off on the precise scripts, in terms of testing for certification, and just cover the ho...the what, what needs to be done, then one possibility is to make the results of that certification transparent. That makes it available to the market, that makes it available for people to distinguish from one product to another and also to learn from one product to another, that would encourage innovation, that would encourage said usability.

George talked about the CQMs, this is really is an alignment. People are...CQMs take a lot to both build in vendor products as well as to execute in providers side. And one of the downsides is that people are not getting as much value as they'd like from it. So they're suggesting if we're going to go through the effort of measuring and outputting and reporting CQMs, make it measures that are more meaningful both to patients and to providers. And we all know that we're working on that process of going from measures that we already have, based on largely administrative and claims data to measures that can be more meaningfully derived from clinical systems such as EHRs.

More comments about certification process, how if we could get this better coordinated, streamlined, and working end-to-end, that would allow for the market to produce better products. If we were less prescriptive, there would be more room for innovation. And then to echo George's comments, sometimes the burden of documenting your compliance, either as a vendor or as a provider, may actually outweigh the effort it took to put in that functionality.

Timeline is...the 18-month timeline figures come up again. Not only would they like it to be an 18 month lead time for Meaningful Use, but also to align the timing of the various programs, particularly in CMS, that gives people an ability to tackle a number of challenges all at once.

Speaking of information, we all know that the public health and population requirements may vary in different states because of the readiness of the public health agencies. Once the...a provider organization gets ready to transmit to public health agency, it's unclear whether there is an agency available and if so, which ones? So there was a suggestion made by more than one panelist that we have a national database you could turn to and find out, in my locale, who's ready to receive what.

Same thing for centralized information, people expressed a desire to go to one place and get authoritative answers to their questions. These questions come up in all the providers going through their Meaningful Use attestation and it's not clear what the right answer is. They get different advice from their own people or consultants and it would be nice to have an advice...a ruling from the federal government in some central database with rapid turnaround. So a lot of times, if they only knew the appropriate interpretation, they could avoid a lot of work and rework.

So that summarizes what we heard from the listening sessions. We actually have more details on each panel in the appendix and that's available to you, but we've tried to consolidate these past four slides. So, open up to any questions. Someone on the phone? Marc Probst? Was there someone on the phone? Okay, Marc.

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

Okay, well thank you and that was probably some pretty interesting sessions you had. So thanks for summarizing that. And I like the analogy of the highway and the cars and the rules of the road and I think it's a good analogy. Did you talk at all about...or was it brought up at all the sequence of that? Because it seems to me if the cars are going to work on the road, you've got to define the road ultimately so that we can get to those levels of standards.

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

Umm, I'll see if George remembers anything more specific, but I don't think the sequence was discussed. I think probably where that...the feedback comes is the pace of change. And so although there could be a logical sequence, if we had enough time, I think there's a lot coming at people all at once and that's something that they did feel. Chris?

Christoph U. Lehmann, MD, FACMI, FAAP – Director, Clinical Information Technology – Johns Hopkins Children's Medical and Surgical Center; AMIA

Paul, extending on your last point about the frequently asked questions and a standardized interpretation, I just want to point to the fact that people report on their Medicaid. Mainly pediatricians not only deal with that problem, but they also deal with different requirements based on their state and territory, which makes things even more complicated. And a central federal role helping states to streamline what they're asking would be very helpful to vendors. We get a lot of complaints from vendors and it would also be helpful to pediatricians.

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

Definitely. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

First, thank you Paul and George, for an excellent presentation and an excellent job in the listening sessions. I sat through the Meaningful Use listening sessions and also the certification listening sessions and in my mind, it's hard for me to distinguish between what was said in each of the sessions. And indeed in the...it's my observation that from the standpoint of most hospitals and providers, they do not make a distinction between certification and Meaningful Use or between ONC and CMS, to them it's just like one program is the sense I have.

So I was thinking about your presentation and I was thinking about a presentation that Larry Wolf did a couple of months ago and trying to think about where there might be differences. And one of the things that was in Larry Wolf's presentation from the Certification Workgroup was the idea that certification should not be used for new concepts, something that's totally a new concept. And indeed, in the last workgroup meeting you and I ended the phone call where you were discussing why it was so hard for some organizations to do these things, and you were saying, well things...we're doing some things that have never been done before. And that perhaps that is one of the explanations as to why there are some challenges with Direct protocol.

And so my comment or my question is, do you think that understanding that gee, rolling things out on a national basis, a new concept is also something that perhaps should not be done, that we do much better when we simply choose among existing standards and existing capabilities and standardize them.

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

I think as a general rule, it's certainly easier to standardize something that's already...a function that's already happen...an activity that's already happening. The comment about doing things that haven't been done before, I guess you have to start somewhere, so George, the transfer of care document...the , transition of care document, is one of those things where we actually didn't have a very reliable way of doing it on paper. So we didn't have a workflow, we didn't have a failsafe mechanism and we certainly didn't have an efficient way to get it to places that the information needs to go and be processed. So, yeah, it's trailblazing, but I think we all agree that we need to get there and I don't know what...I don't know that the timeline is a Meaningful Use or HITECH timeline, the timeline is the new models of care demand that. So, care coordination, practicing as a team, getting patients what they should've had all along, coordinated care is one of those things that we have to do and the overall context, healthcare delivery, is demanding that on a timeline and the HIT is trying to catch up and support that. And so yes, it's new, but I think the timing and sense of urgency comes from the actual care.

Paul Egerman – Businessman/Software Entrepreneur

And I'm not questioning the rationale for doing it or the need to do it; I'm just questioning whether or not the method of doing it through a national rollout is appropriate, whether or not maybe there needs to be an intermediate step. Again, you look at what happened with transition of care and the Direct protocol and it just seems like those are new concepts and people are to the extent they're meeting the requirement, they're meeting the letter of it, but not meeting it in a really valuable way to their institutions. And perhaps there should have been some intermediate step where this was piloted at the VA or some large institution, at Sutter, to have used it and to gain some experience about what worked and not worked prior to making it part of a national requirement for compensation.

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

Well, I think that point's...that's a fair point and we did hear that from both, as you pointed out, the certification hearing and this hearing and I'm sure that ONC is also considering what things can be done to improve the certification process.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Let me just...

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

Yeah.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

In any...so I agree with you, Paul, and any highly complex program like this, usually what works is not bottom up and not top down but some combination of both with a flexible mechanism to learn from its mistakes and go forward. So I don't think a pure bottom-up approach as we were doing until 2009 was working on it for three decades, I don't think we got that far that quickly. On the other hand, Paul's slide said it, which was trying to say, when you're unsure say more of what you want and not how you want it, and that was the comment about Direct. So I agree with you but I wouldn't want to have a backlash and back off totally because we may just remain stagnant again where we were before we started the program in 2009. I think the important thing is to be flexible and learn from your mistakes and I think that's the most important thing.

Paul Egerman – Businessman/Software Entrepreneur

And I agree about the need to be flexible and learn from mistakes, but to do that you do have to realize that there have been mistakes. And sometimes in sort of like the highly charged political environment...people find it...are reluctant to admit that there are any mistakes that were made in Stage 2. And I'm sort of saying, the Direct protocol and the transition of care is a mistake, it just didn't work right, it didn't work anywhere near the way it was intended to work. And then that gets very hard for people to deal with and to admit, but if we could come to that point then we could also come to a point and say, well, what should we have done differently and then you could learn to do something better.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University

Well in that example, so is the mistake that we tried to push forward on Direct or that we mandated Direct at the exclusion of other things and could've been at flexible and allowed more sophisticated things to occur? The answer is not...it sounds like I'm saying that the obvious, we should be more flexible, but sometimes, if you have this distribution and you set the bar somewhere, there is someone on the far end. When we do these hearings, we try to find people who are at the forefront and so they may be sometimes exceptions. So I don't know...I don't want to get...I don't know the exact right answer, but it may be possible to do Direct...like it doesn't mean Direct is necessarily a mistake, I guess, it may be just the degree to which we mandate Direct in certain circumstances.

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

Two points, we didn't do anything, this is an advisory committee. And we're about to hear from someone who very...

Paul Egerman – Businessman/Software Entrepreneur

...responsible for anything, this is a wonderful position.

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

We're about to hear from someone who has a lot of experience in public service and knows how hard it is to work with such a diverse community. And also just point out really there is no right answer. So there are answers that can work better and there are these program policies and we can make adjustments, but Gayle, inform us and let us know your questions and comments.

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

Thank you, yes, being in the public arena does...there are lots of other pressures that go on. I also share Paul's concern about Direct. And really my whole issue deals with, do we have...we have spent hundreds of millions of dollars on health information exchange and trying to get us to a state of interoperability. Have we even stepped back and measured where we are? How do you go forward if you don't know where you are? So, with the hundreds of millions of dollars...the State of Florida, for instance, got \$20 million to set up health information exchange, I see very little of it happening outside of basic vendor exchange or may be small communities exchanging. How effective has Direct been? How many Direct e-mails do we do in the State of Florida? I can't tell you. I mean, we celebrated when we got to 1000.

I have a great deal of fear using public resources in the amount of billions of dollars we're spending on this and not stepping back and looking at what's working, what's not working and measuring it so that we make appropriate recommendations. And this is a committee that recommends to ONC and CMS, but let's look at all these parameters, especially when you hear from people down in the trenches. And I have to say, I can't congratulate you all enough for holding these listening sessions, we need more listening sessions. We need to hear from the people down on the streets, what is happening out there.

As I frequently say, I am the bottom of the funnel; all the complaints come to me as a public official. And I hear them, but this committee, ONC needs to hear them and the most effective way to do it is through these listening sessions. So, thank you for doing this. I think we're starting to get that input, but we need to also measure this, we need to find out what's going on and why this is not working and then take this strategically forward to change it. Learn from your mistakes and then change them.

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

No, I think it's fair, Gayle. There's definitely an interest in doing evaluations, I think it's a matter of timing, time and numbers. So just as we, I think, did a little over-analysis of the small numbers we had from our current experience in Stage 2, the benefits of a lot of this technology and the information exchange is one of the benefits, takes time to measure. And then in comparison to what? So as we pointed out actually on paper, the old-fashioned way or the way it's going on now is very unreliable in terms of information getting to where it needs to. And we all experienced that either with our own care or those of our parents, for example. And that's something we're out to try to correct, but it's going to take time to figure out when enough exchange is going on that we can actually measure, either in a pre-post or randomized controlled trial or a case controlled trial to figure out what good is really being done with it. So you're absolutely right, I think that we need to take the time to measure this when we have enough time and timing available. And thank you for pointing out the value of these listening sessions. We always learn things and it's good to get this information from the frontline and I think it definitely shapes how this committee thinks, how the workgroups think and how policymakers think.

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

Thank you.

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

Any other questions or...yeah, Troy?

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

Troy Seagondollar. I appreciate Gayle's request to have more comments from the frontline and I'm as close as you can get to the frontline, I believe. It's interesting to look at the comments and see that Direct is really under fire for all of these things. And I remember looking back at the whole process of how Direct came in, it was a very collaborative effort, a lot of people were involved, there were frontline people in there helping to devise just exactly what would be the best way to do that. Then we came up with CCDAs and I believe the platforms for CCDAs, I mean, we were moving forward with innovation. But I'm curious when they say fix Direct, were there any comments about what to fix? I...it seem interesting to me that that was a comment but there was no elaboration on what needed to be fixed.

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

Well the comment came from, and George cited a couple, one...a couple of people mentioned that they were already in the process of transferring information and they were using something that kept the meaning going forward from one organization to another. And so they said they had to "take a step back in order to implement Direct because that was the only choice in order to meet the Meaningful Use requirements." So that's definitely a lesson learned and I don't know whether it's offering more than one option or as George suggested, but that's one of the lessons that was learned from that and I don't know whether I can say anymore. So, I know that's...

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

...more, huh?

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

Pardon me?

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

It's just interesting that they said fix it, but there was no suggestions as to...or elaboration on what the problems were and that's okay, I get it. I mean, obviously we'll need to have more discussion about that. It is a problem and I'm thinking about the previous comments from our guests and how the impact and what you do, the different workflows based on the policies that have been implemented and the requirements.

I have a manila envelope and I just wanted to share with you, I got a call the other day...

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

That's Direct of a different kind.

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

I got a call the other day from one of the nursing staff and they said, you know, we went ahead and printed out one of these CCDAs, these summaries of care, it's 160 pages. Wow. Now granted there are some functionality issues that we've identified, but looking at the impact of functionality, not having time to test and then being put into production. This is the result. So anyway, it's just a comment from the front lines. There are things out there that we really do need to test before we shove them out the door. I don't know the timeframes, I mean, 18 months, is that enough? It would be better than nothing I suppose, but it really is an impact.

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

I think that's actually a good physical evidence for an example where people are meeting the letter, but not the intent.

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

Right.

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

And I think it's a combination is what we heard from the hearing, it's a combination of the fast pace, so if you're trying to get so much out the door either on the vendor side or the provider side, you just do what your interpretation is of getting that done. And if the test scripts prescribe something very specific, then that also interferes with what you could do to make things better. We actually...I'm not going to digress, but we actually tried to address that very problem in our Meaningful Use Stage 3 recommendations. But that's the kind of thing where people are saying, hey look, help us get certain functionality in these systems, but concentrate less on the how and let people innovate. And then...for example, that's an example of if we were transparent with what that produces, it would be pretty clear that there's more work to be done on the part of the vendor side, for example.

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

Yeah, because I reflected on this, my first thought was, well, it's supposed the electronic, but I can't imagine any provider looking through 160 pages of even an electronic document and saying, oh, this is important, this is not. So just a little more refinement.

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

Yup, that came out in the hearing...

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

Thank you.

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

...the listening sessions. So, these are all good comments. We're really appreciative of the folks who participated in the listening session and I'm sure all of this is used, as we try to formulate and perhaps improve some of the policies that are brought forth. Anything more?

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Yes, Paul, this is Karen DeSalvo, for those on the phone. I want to thank you all also for the listening sessions. The feedback is very rich and poignant and I think gives us a lot to think about at ONC and CMS, so again, thank you for that. And I want to tell you that we do listen, it matters a lot to us what this feels like on the frontline and what we can do better going forward while still keeping the, as you said George, the foot on the gas, using the car analogy. So we're still pushing forward, but doing it very thoughtfully.

There are...there's been a lot we've learned about Direct from the community, including some ways that they're solving it on the ground. There are...do seem to be some appropriate use cases, especially for communicating with entities that don't have electronic health records, for example, some non-eligible providers, like long-term post-acute care. On the other hand, I think there's a lot to be learned about the how and seeing how some folks are innovating that, but also to make it meaningful usable. So we're all learning as we go, this is a continuously improving process.

And to the earlier point about evaluation, would...we have been thinking about this inside of ONC, how do we know what the state of interoperability is in the country? And you saw a couple of...maybe it was last meeting or two meetings ago, Jen presented some information about interoperability is one way to look at it. But we've continued to push on thinking about not just Direct but query response options and there's some literature available, but there are also some other potential ways that we could capture baseline data going forward. So, I've asked her, through the miracle of technology while you all were all talking, to present next month, if she could, on where we are with interoperability assessments and what we're thinking about to enrich that information. So we'll know where we are today and going forward, if that's okay with the committee. Thank you.

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

While Helen and Terry set up, I'm going to come around and grab your lunch...

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

Okay. We're next going to move into a discussion that does require...that does have recommendations that require approval, and this is from the Quality Measures Workgroup. They're going to be talking about their recommendations for Stage 3 and beyond quality measures.

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

Hi. So this will be our last presentation as the Quality Measures Workgroup and if you have the slide, you have a ton of background reference slides, which we have presented to you. You may need to reference them at some point, but we didn't want to represent information that we've already presented. So with that, we're going to go on.

We really want to thank our workgroup as we move forward to present this to you. I do want to, Paul, and I'm going to take the liberty of presenting up here and commenting on part of the last dialogue. I just want to share some statistics that we have from the VA. So My HealtheVet, I just pulled these up, they're our latest stat's, 2.5 million users. We have a million people using our Blue Button with 5.2 million file downloads. We've had over 300,000 downloads of our CCD. We have pretty successfully look at our view download transmit. I would comment that the 129 pages or whatever it was that people got when they did their download is what we see, so we have a lot of veteran's request downloads and in the middle of the download, seemingly stop the download, probably because it's so many gigabytes of data.

I would caution us to recall that happens to us as providers. I still work in the emergency room and sometimes I have 400 notes and I'm like, which note should I look at. So I don't...I think what we need to understand is that the continuum of frustration with overload of data and how to process it confronts all of us. So, I just wanted to take the liberty and now we'll go to the Quality Measures Workgroup.

So, we've previously made recommendations to you multiple times. We keep getting...I think what people want is the sharp end of the stick and so we've been working on getting a piercing mechanism going so that we can give you what we perceive you want, which is more detailed recommendations. And what you're going to see is hopefully that today, they may or may not be as detailed as some people would like. But we were asked to make recommendations about specific measures. And you will recall that at the same time the Quality Measures Workgroup was going, there was the Accountable Care Clinical Quality Measure subgroup going. We developed a framework within that group, and that was from the accountable care group as well as the quality measure group that really functioned on quality measurement.

We believe that that framework that we developed should inform the quality measures as we go forward and we'll represent that to you. And you also asked us to collate, clarify the recommendations, aggregate specific measures and that's what you're going to get today. I will also remind you that we did have then some additional charges. Every time we met, we had some additional charges, so we were asked to look at core measures, recommended required measures, comment on feedback that we got about the measures up until today. So we're going to present all of that to you today. And this is what you'll get from us today, including an attempt at an updated innovation pathway. If you'll recall, innovation has been presented multiple times over the last 1 to 2 years. Is there a way we can get to innovation through quality measures, giving a little more latitude and flexibility to the situation?

This is the measurement framework; it should look familiar to you. Before, as you may recall, we really tried to move to health, so not disease specific, not just public health, not just clinical care, but really a focus on the patient-centered value of health. And what you see in this is our desire to focus on that. I am not going to spend a lot of time on this, but I would caution or refer you to the intermediate outcomes across the bottom, which are expenditures, experience, and outcomes that may be familiar to you. If you look at or think about the Triple Aim, this may, and is, just an extension of that interpretation into these three domains.

This domain framework, once again, is where we want to go, the current state. And you will hear this when we ask people to give us feedback on the current measures, we got repeatedly, and I think Paul heard this during their Meaningful Use listening sessions, that we are functioning on process measures, people really want us to move to outcome measures. We all recognize that's a long, arduous process, which is why we're not there year. But we obviously within this framework have embraced that concept of looking at outcome measures with this desired future state, which is really focused on the concept of health.

So you see the word generic there, it's not meant to presuppose that we don't need to function on specific diseases, but it is this sense that we need health overarching throughout the community and the population. And then what you see across is the safety, clinical decision support, coordination of care, these things we've talked about previously. And you're going to see them embodied in the work we've done.

This next slide may be reminiscent to you of data that has been previously been presented to this committee with the goal of how do you parse out what you really need to do a measure. And you'll see this in specific improvement concept, the concept metrics, the numerator and the denominator, the data elements because we have had concerns that the data elements may either not be available and/or constrained into a standardized data set, the data source and finally the potential of HIT infrastructures to operationalize.

At the end of this, what you will see is some fairly specific things for us about infrastructure from a more conceptual capability model. We've talked about this repeatedly in the past few years about how do we move from hard coding a specific measure to getting at the capability that would allow, in our case what you'll see, an innovation pathway. That will require you to have the ability to do some reli...to have reliance on an infrastructure, but allow you to do more on the on the fly dynamic assessment of your patient population. So, we will go to that, but I would recommend, just because I'm into this HIT infrastructure stuff, too, that you pay attention to this from a capability perspective. And I know David Lansky feels this really strongly, too. And that's why that arrow points to that, is that why? I think that was me, I think that was me that said that was really important. So, okay, so now we're going to go to the package of recommendations.

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

Great, thanks Terry. And we will return to infrastructure the end, not surprising, given Terry's role and the importance of it, I think, to really achieve the next set of measures that we all so desire. So we're going to try to give you a fairly specific package today, as requested, since this is our last presentation, you can't actually give us more work, Paul, unless you put us on other committees going forward. So, there we go, thank you Lauren, wherever she is, for this incredible amount of work, yes.

So, a couple of guiding principles that we just want to share with you, first, we recognize that the quality measures have evolved over the stages of Meaningful Use. There have been new measures under development compared to prior versions and we think there is a bit of a stepwise progression, we hope, from process to more outcomes measures. As Terry already said, the ACQM framework really is something we think should be broadly applicable with that focus on health, that move towards more broader outcomes in the near future. And we want to really think about how we can promote more forward thinking options for Stage 3. And again, we'll come back to the HIT infrastructure, specifically, if you want to get outcomes, what's required to make that happen. And I'll come back to that, particularly for some of the interconnected elements around care coordination or other key domains that are critical, I think, to the future work of Meaningful Use.

So these are the two tracks we'll present on, the first track one is really thinking about more in the classic MU eQCM reporting pathway, which is more about in the shorter-term aligning measures to either federal programs, moving towards e-specified measures and ensuring adherence to standards. Track two is really the more innovative approach, which is at the same time promote innovative measurement and infrastructure building. And to do that, promoting a pathway to test, share, and implement new and innovative measures and build the HIT infrastructure we know we need for measures that go across sites of care and advanced models of care.

So track one, Terry already went through these, but again, these were the prioritized domains that the workgroup had talked about and in particular, on our initial calls, there was a strong preference for really making sure measures around functional status and efficiency are ones that get moved forward, but the rest as well, certainly.

So just to remind you, we had a set of measure criteria we've been working with that we recommended and evaluated each measure against. Part of the way we did that was looking at the measures under development currently, the ones that will be fully specified by fall of 2014 to potentially allow them for inclusion in programs going forward. Some of them are going through a feasibility and validity testing process, and certainly although not required for this program, there's potential for NQF approval. Either for our new trial use approach, which is that measures that are new and innovative and specified as eMeasures, that don't yet have EHRs with which to test them, can move through our process without reliability and validity testing to get moved to market more quickly or potentially even endorse them.

Just to remind you, these are the criteria that we have used for a while that have really come through lots of different iterations, but specifically wanting to make sure that the eQCMs leverage data from broad sense of HIT systems. The second one here is probably one of the most important, I would argue, in terms of long-term recommendations that we want measurement that allows to be patient-centered and particularly a patient-centered view of longitudinal care across sites and providers. We want to support both health risk assessment outcomes, and I'd probably add here, and improved outcomes based on the future...work, you'll see a preference for reporting once, which is the alignment piece I mentioned earlier, across programs. And we want to make sure that at the end of the day the measurement is, in fact, beneficial and meaningful. And I know you just heard a fair amount about how sometimes it may not be, to multiple stakeholders wanting to make sure there's an opportunity to promote shared responsibility, efficiency and being able to use those measures to move towards population level reporting as well.

So, we worked with the workgroup of the last month or so to in fact try to prioritize of those areas that are under development now, what are the highest priority areas, potentially for MU3. We did little but of lumping here, but you can see at the very top of this chart are measures currently under development that look at functional status assessment and patient goal setting. And there's a range of specific conditions for which they're being developed for, as well as similar measures around improvement in symptoms for example, children with ADHD, people...adults with rheumatoid arthritis. And then some of these more wellness assessment, management and reduction of health risk kinds of measures. And then we added in two additional measures that are in other domains, specifically around care coordination, recognizing the infrastructure is still pretty lacking there, but as an example here, the closing the referral loop measure. And then finally looking at how we might be able to look at some settings or conditions that might influence safety, for example, returning to the ICU.

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

Helen, I just want to make one comment on this because you know that sharp end of the stick that you wanted, so this is pretty sharp. It may not be sharp enough for some people but what we wanted to be cognizant of is some stuff that I would argue just came up at the listening sessions that Paul did, is that the measures aren't pertinent to me, they're not in my population, I don't know what to do with them, can you push them along. So what we tried to do, and I think Helen stated it correctly, is that we lumped some stuff, but we lumped them looking once again at capability and the overarching parts that mattered. With the belief that then those could be applied across the lifespan, across the provider specialty span, so that you could really get to this next stage, which is assessment and goal-setting and then you'll see on the next slide where that pushes you.

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

Great, thanks Terry. So...but recognizing that's where we are now, there was also very much forward-looking thinking about what we would recommend as the development of, as sort of the next stage there. So very much continuing on the path of measures that reflect patient-reported outcomes, functional status, and particularly moving beyond functional status assessment and goal-setting, but in fact, looking at goal achievement and potentially change over time or change with a particular intervention, for example. Measures that allow that evaluation of delta over time, improved hypertension, improved functioning after total knee or hip, for example. And then really being able to continue to think about more general functionality as opposed to everything tending to be still very condition specific at this time.

So, some key recommendations here, we do recommend there should be a subset of key measures identified in MU3 that address priority conditions. It was pretty clear that the workgroup had some concerns about wording, it wasn't clear exactly. The word "core" turned out to be a bit of a Rorschach test as to whether "core" meant required, should do it, some should do it and so we would just recommend that we not confuse people and just indicate whether they're in fact required or recommended. English helps. And then given the types of measures that are developed or in development today, there were really only a few measures currently that are really applicable to all providers. But if there is a subset of those required measures, they should be applicable to most or all providers. And we did have some minority opinion of folks who didn't think any should be required, only recommended.

Certification policy requirements, there was a fair amount of discussion about this as well and generally felt that vendors should be required to certify the measures applicable to those providers, to be able to report on as many measures as applicable. But there were some concerns about the costs and burden to vendors and EHR developers as well and recognized that there should be additional tools to help them create these measures more efficiently and avoid rework.

Path to the innovation pathway, I've already presented this slide, but again, how do we move beyond this kind of build on innovation that's already happening on the ground. So our recommendation here, revised from our last discussion with you is we do continue to believe there should be an optional innovation pathway whereby MU participants could waive one or more objectives by demonstrating they're collecting data for innovative and locally developed CQMs.

We had a couple of different approaches we looked at, one was a bit more tight in terms of who could do it, you had to be a certified development organization. But instead, we actually went with a more open process that any eligible professional or hospital certainly could come forward, but that if they develop these eCQMs, they have to be expressed in national data and standards, so that they could, in fact, be used by others. So that is our preference. And we would also ask and we would...I think additional work needs to be done here to think through what would be required in terms of the evidence that they would need to provide that those measures are, in fact, innovative and help to improve care in their organization.

Key measure dependencies, I'm going to turn back to Terry to wrap this up.

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

And this is stuff we've presented to you in the past and if you reference back to the material at the end of the deck that systems need to be interoperable. They need to ensure that there's data sharing across providers this is that interoperability theme that I think we've heard for the last year, at least. The tools that exist need to be used for population health as well as for patient encounters. If you look at the delta recommendation measures where you look at does your practice, however you define that, have improvement in hypertension control. What it means is that you look at each...obviously each individual patient as well as the ability to aggregate the data into a population health set.

That measures need to be built across multiple data sources. Once again, this is in the back of your deck, this is the work we did with the ACO QMs, really looking at how do we get cost data in here, how do we get utilization data, how do we get referral data, we have not figured that one out. All we know is this belief that the measures need to be able to accommodate using multiple data sources and in fact some of them should probably be dependent upon using multiple data sources.

The coordination of care measure, obviously, is dependent upon access to information from the person or the provider that is receiving the patient, to ensure that there is continuum of care. Measures and data accessible by all providers, this really goes back to the standards work once again, that the measures and the data accessible, I would say really it's probably more than accessibility, it's usability by all providers, which means we have to have some standards there. And once again, that goes to the latter part bullet there, consistently capturing variables required for stratification. You will recall, if you remember, one of our another charges was the behavior health and long-term care group. And what we heard repeatedly from those groups is standards, standards, standards; can you help us figure this out? So consistently capturing variables, I would argue, is a way for us to Trojan Horse...to you that once again, we need to really be looking at standards so that we can get the data in a simil...in that way.

So the key recommendations we shared with you, once again the key measure, concepts, that's that list that you saw. The next stages of measures, we did give you some specific grouping of those measures, once again recall that they are generic in some ways in that they may not be condition specific. But they are not generic in terms of what we believe needs to be assessed. For instance, the patient at the point of care when they enter into care, whether they're able to set a goal, if that goal that is set can be recognized by the health IT system. And then you'll recall that on that second slide Helen shared with you, our desire to really push to whether the goals were met. Once again, to do that for a patient, but also to be able to do that for a population as defined by that practice.

The measures EHR developers certify to, that's where we got away from core, the concept of core fell by the wayside. And then the updated innovation pathway, which we shared with you was this belief that EPs and hospitals should be able to use...develop and use their own measures to report, to get credit for, but to do it in a standardized way. Now the push for doing it in a standardized way obviously is so that we can extend how many people understand, in my opinion, measure development. But also can extend that to other providers. So if a subspecialty develops a measure that really makes sense and it's done in a standard fashion using standard data sets that are available, that we would be able to look at it. Obviously there needs to be additional work on that in terms of what gets "certified." Is a measure good enough? Are the standards good enough? Are the standards adequate and appropriate? We did not go into that amount of detail.

And finally this need for health IT infrastructure, I did tell you that I would close with that. It's really because I think that we continue to have this opportunity to ensure that we have transactional and analytic data available for providers at the point of care, as well as for organizations, that they can use that data both in a static and dynamic way. My personal belief and it's always good to be at the end of a workgroup because you can share your personal belief, is that if we continue to force ourselves into highly structured, highly coded measures, we're going to have a set of 20 highly coded, highly structured measures. And we're not going to have the larger capability in the health IT systems, which is really what we need to move to the next level. And I think that that is the end for us.

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

Literally.

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

Yeah, literally.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

There are no balloons, sorry.

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

The one thing I did want to share though is, because we didn't do a slide on it is what people commented, we did an e-mail poll on the comments on what do you like and not like. And so I just took some notes because we don't have a slide on it. People really...Paul, this is so reflective of what you just said, harmonize data sets, simplify, make sure definitions are clearer, make sure data sets are clearer, focus on outcome measures, ensure, ensure, ensure that patient generated data is somehow included in measures as we move forward. Functional status is really important, and actually we had captured that earlier. And leave something flexible, I love that one, leave it flexible. I don't know really what that means, but...and with that we'll take questions.

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

Well I want to thank both of you for not only leading this workgroup over the past whatever years and thank you for an excellent presentation. And I'll admit to being guilty as charged in terms of adding questions to consider as time went on, because this was your last work product. But also appreciate the complete package that you presented. I think we've had a series of recommendations and I don't know whether others have this problem, but keeping it all together is challenging and providing the context.

And I think this so...this quality measure, this measurement...performance measure is so important from the pull side, as we talked about in the Meaningful Use discussion. It's...we're turning over to the pull and the pull is going to depend on these measures and people are not happy with the current measures and people wanted better measures, both for patients and for providers. So I think what you've done is put together the whole context and it really does, I think, summarize well what you've been talking about throughout this whole time. The concepts that we're after, some actually specific examples of those concepts and where we need to go as well as a way, like the innovation pathway of getting to newer concepts. So thanks very much from my perspective at any rate. And I think David Bates and...

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Thanks, Paul. That was terrific, thank you. I wondered if you'd talked about who should support development in this area going forward. That has been kind of a big issue because it seems to me like where we are now and where we would like to be, there's still a big gap, especially from the getting to the outcomes perspective. The second question was I know you didn't want to have the highly specified measures but...Terry, but I wondered if you talked about a potential role for conformance testing in this area. Because it seems to me like that also could be something that might accelerate progress, for example, if an org...if a vendor could do some conformance testing and show that they can actually measure a specific set of measures.

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

I'll let you start.

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

Okay, I'll start on the first part. So we actually didn't spend a lot of time talking about the supporting of the development of measures and interestingly, a fair number of the measures we actually looked at and presented to you prioritized are funded by CMS and ONC that are under development. So that's more the de novo measurement pathway. I think part of our hope, and again I'll speak freely for myself right now as well is I think the hope of the innovation pathway as well is that you build on what's already happening on the ground. Places like the Brigham and others who have been building e-measures for years and in fact, think about ways to support the infrastructure to take what is a local, homegrown measure built on standards and create it as a national standard others can use. So I think there's an opportunity there to kind of really get into the...accelerate the measurement development and availability cycle more rapidly. But it's a really important question.

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

And on the other two, I think what we wanted to do is give specific attributes that needed to be included in measures, but not define the disease state, so if you look at the one slide, it gives you A+B and you get D, but you can put whatever you want for C in as the disease state. In terms of the testing, David, you know this is critical, and this conformance testing is critical and I think it's been important to the vendors in terms of the burden that comes with conformance testing. And who wants to be the first one out the gate doing that because you're going to deal with the burden of it.

I'm going to speak from the federal...from where I've stood at VA right now, there have been lots of arguments over the years that there should be a work bench that is...I don't know how it's funded, I don't know if it's public/private. But that there be a workbench where people can come with measures and propose them, that there's anonymized data sets that they can run those measures against and we can see what we get out of it. And those anonymous data sets are consistent with whatever the data standards are out there for certain domains like lab and pharmacy. I think that that's a really reasonable way to try to get at some of this and to release the burden.

I think because what we'd focus on is that the burden is the standards and mapping to the standards. I agree, I think that that's a burden, but then the next stage is when you really operationalize it and you're running it through 100,000 people data set, what happens and where are the issues there? So I think there is an opportunity to really focus on that. We did not talk about that so what I'm stating here is just based on my previous experience.

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

Devin, Gayle and then Christine. Devin?

Devin M. Mann, MD, MS – Assistant Professor; Attending Physician – Boston University School of Medicine; Boston Medical Center

Thanks as well for the report. And actually, when you mentioned your ER shift that you have coming up, it made me think of my clinic tomorrow and how I'm not looking forward to the documentation burden I'm going to endure. And I thought of some of the reports we heard from the CIOs earlier and one of them talked about how they've kind of forced their physicians to do all this work. And then the other one talked about how they all think of him as sort of a Devil victimizing them all and I guess I've been victimizing myself over the years.

But really it makes me think about quality reporting and I saw listed in your focus areas, one of them was efficiency, but I have a feeling we were thinking about that differently. And it really makes me think about what measures, what innovation is happening and our ability to measure the efficiency of delivering the documentation, the care. And, I was talking to Kevin last night, and often that gets wrapped up into physician burnout, which is sort of the end of the line. But much more proximal to that, I don't see yet, and maybe...I would be interested to hear what you guys talked about, what are the more proximal measures of the efficiency of documentation of delivering this kind of patient-centered care, which I'm in charge of. And I try to improve and deliver medical homes and all of that, but I don't see a lot of the quality measures in the technology focusing on that efficiency. Be interested to hear your thoughts.

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

I can start on that. We didn't deal much with documentation. What we know is it's a holy grail out there; however, if you look at what we stated in terms of patient goal setting. So right now, can you imagine patient goal setting, lots of free text, lots of really difficult queries? You could do a lot of...an LP on there and figure out if A is equal to B, it'll be really difficult. I think what it calls out for us at least is that there needs to be some standardized work to figure out how to do that in an efficient and effective manner. However the much larger issue about efficiency related, and I'm just going to project onto you, because I would project onto myself here, how do I really more efficiently look at all this data that's here and make sense of it? We didn't focus on that.

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

Yeah, and just one comment, one of the criteria specifically was that measurement is beneficial and meaningful to multiple stakeholders. I think our first iteration we brought this forward is measurement does not add burden and there was a sense that that was too negative. And I think the question is really we need to be able to assess and measure the true burden and understand what's the sort of bang for the buck. And I think that's a lot of what hasn't been done, but we certainly did talk about that in terms of feasibility.

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

First, I want to thank you all for your tremendous amount of work. I know how much developing this whole kind of concept is and how difficult it's been and your reports along the way have been terrific, but as you're coming to the end, thank you for everything you've done. And I want to thank you specifically for the flexibility in what you're saying here in moving away from core measures and moving more towards flexibility. I think for specialists especially, this is going to open new doors and really allow them to be better users of EHRs and it's going to give them new tools. I think you're on the right track in doing that.

My only fear and what I'd like you to comment on is, are we in the process and what do you foresee as the ability to continue the development of those specialty specific and using quality measures that are going to allow people to differentiate practicing modes? And what do you see happening in the future? The flexibility you're building in now, but where is this going to go? And we have different societies doing this. What...who is going to be in charge of that and what ultimately is going to make those decisions? What's your view on that?

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

That's a great question and we actually did talk a fair amount early...some point, midpoint, I think, through this workgroup about, for example, what's the relation of EHRs to clinical registries? And certainly I think that the move of the qualified clinical data registries as part of federal legislation and CMS, in terms of allowing providers to report on measures directly out of their registry, has implications for the logical path they'll likely go forward on will be through their clinical registries. I think one of the challenges for us going forward is thinking about how the data that's put into a clinical registry connects the data in their electronic health record so that information is more interoperable, is available, how the patient reports a functional status or changes after a procedure, in fact flow into the broader electronic health record system. So, I know those are happening in parallel but we've got to make sure those trains cross paths or we'll be looking at systems that are again completely siloed without any connectivity between them. Some specialty societies have already moved along that path and are starting to specify some of the data elements within their registries, but it is a pretty heavy lift and I think another piece of work that needs to go forward for the additional workgroups.

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

Yes, I'd like to comment on that also. I think that this committee perhaps needs to look at that. I don't know what entity in the federal government is charged with that kind of coordination that needs to again make the burden less on the physicians in this reporting mechanism and do more of that coordination so that we don't have silos developing. And you don't have CMS requiring something, ONC requiring something and other agencies requiring different things and different silos developing. This coordination is so key if you're really going to get the bang for your buck at the end of the day.

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

And I would comment Gayle that that...if we harken back once again to the behavioral health work we did, what we know is that there are not indications, there's reporting of lots of health data elements related to behavioral health that are not captured in EHRs right now so it's requiring double duty. It may be double duty electronically because you're passively doing an extraction, but then you're adding other data.

At the VA, we're quite familiar with this because we report with multiple specialties and I just did an analysis of it, we have thousands of data fields that are in registries that are not in our electronic health data metadata model. We haven't even modeled them in there because they've been developed by the specialties. They're probably very appropriate data fields, but my guess is any large integrated health institution is confronting this whole issue where there's subspecialty reporting that requires additional data and there's probably a human doing some of that data entry. So our recommendation would really be to have some alignment, obviously it's not going to be 100% aligned, there will always be some subspecialty data sets that are unique to that subspecialist or that subspecialty practice that will probably be maintained independent of your larger health IT system.

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

Christine?

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

Thanks Paul. Really good work you guys, I really like the two tracks a lot. I think it's very reflective of current reality but again trying to keep your foot on the gas pedal. And I really like the general functionality focus instead of disease specific because I think to Gayle's point, it does help to cover a broader array of provider types and of patient types, which is really, really nice. I really like the innovation pathway.

We started talking about this probably back in 2012. I just went and looked up the files and I know there's more thinking that needs to be done around the details of how does someone propose a measure? Do they have to get some kind of approval? What are the criteria? I can send you what we worked on if that's of interest to you. We vetted it with David Lansky. We vetted it actually with Kevin. We vetted I think with you Helen, before you were Co-Chair, so we had a lot of folks look at it and we tried to come up with a way that would provide some guideposts. But I think...I want to say, at this point from now that we've learned what we've learned in Meaningful Use in terms of program design, we have to make sure that it is really lightweight and flexible and easy. Otherwise people will be such a burdensome process to try to get out from under burdensome measures that it's like really...well. So, I just wanted to make those statements.

I have two questions. One is, I think the piece that's missing for me and I think there's probably a very good reason why, is patient experience measures. And I think it's a real challenge because it's not something that is necessarily linked to the EHR. You can do the survey electronically, but it doesn't have to...the data don't have to live in the EHR. And so I don't know if you guys are continuing to think about that at all or if there are opportunities there. I'm struggling to find it, I'll tell you that. It may be that it needs to live separately and we can think about the...I mean the portal will have a survey capability for Stage 3, we hope. Maybe that that's as far as we can take it, but I just want to flag that and ask if there's any thought on that?

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

I'll point out that the domain framework does specifically include patient experience...

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

Right.

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

...so it's on the table. I think it has been challenging to think about how that flows in, I mean, you certainly want to necessarily do it at the patient level and then the provider sees what you thought, so you'd have to think creatively about it.

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

Right.

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

It's still important that information should flow in so that you can, in fact, look at experience against outcome measures, against cost and get that full picture at a provider level, but I agree, there's more thinking to do that.

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

And I think we've tried to capture it also on the key measure dependencies from the previous recommendations was this multiple data sources, how do you align them? How do you bring them together with the belief that those multiple data sources will probably continue and that we're going to have to figure out how to interpose them?

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

Okay. So my last question is you guys have a recommendation about vendors being able to put these measures in their systems. And I think we've all been nervous about too much sort of hard coding of measures when specs could change or people may want to use different sets and so it becomes pretty large work effort for the vendor to cover the whole array of e-measures, etcetera. Has there been any work done to think about...we've talked before a little about the sort of plug and play concept. And I'm think about my iPhone, right, when there are updates to specifications just gets pushed out through the cloud or whatever. So is anybody thinking about that approach and trying to develop more of a lightweight way that vendors could easily update systems and updates can be pushed out? Because in think about the innovation pathway particular, that in the future we could end up with a really interesting suite of measures that are very, very cool but very numerous and so how do we get updates out to folks and give them the option to really leverage those measures but without requiring a gajillion hours of coding work?

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

I don't want to take that. So I think what's important to note is where are we right now with measures? The vast majority of measures are hardcoded into EHRs with proprietary logic and maybe they have some APIs that I can plug into but the odds are that I have no idea how people are getting their measures. And if you look at the certification process itself, nobody looks at the code, what they do is say here's the database, run your logic through this database and see if you get the appropriate results.

I will give ONC credit, over the years they've really focused on this pop health initiative, but really in a sense that's really measures and how do we look at measures from a population? And they work with an FFRDC and developed some open-source tooling. I think it's a great idea, I think the first step is really this publication of consistent measure logic with consistent data fields. But whoever does this is going to have to somehow interface it into their data structure, because they're going to have to pull the data over from their lab file, I don't know where their lab file is. But I think it's a really interesting concept to see if we could push on it. I really like the app idea, Christine, so I may not know where all your data lives, but I am going to have enough API...enough interfaces that I can just plug in and play. I think it's something that we should try to get to.

I do agree with you the potential burden of the innovation pathway is that there's going to be a zillion really cool measures out there and I'm not going to just be able to take it. And what I want is to just be able to take it...

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

Exactly.

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

...so I can on-the-fly figure out what's going on with my population. So we may be able to just do some design constraints around that work to get there.

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

And just one more thought there's often...we often hear from developers that there's a real chicken and egg phenomenon as well. You develop an innovative measure, but the vendor doesn't want to test it or help you actually make it real because it's not in a program or it's endorsed by NQF or it's not been picked up by CMS. So somewhere along that pathway, we've got to also create innovation space for them to work with the people who have measures on the ground to in fact think about how we standardize them and get them to something that is more plug-and-play. That can take a measure David's had at the Brigham for years and say, this is a really great measure, how do we bring it to something like a workbench, get it standardized and get it moved out in a way that allows more plug-and-play.

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

So Christine, to your first question about HIT support of patient experience, maybe that's something your workgroup can follow-up on.

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

Sure.

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

Okay, Troy and then David.

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

Thank you very much. I just kind of want to take it back. I always feel like when we're talking about quality measures and the CQM that I am chasing the horse that got out of the barn. You talk about data entry and that word to me just scares me in healthcare because we are not data entry clerks, I mean, we're clinicians. But I can tell you that a lot of the CQM stuff, especially in the early days, and I fight this tooth and nail on a daily basis is yes or no rows, where there's...the CQM request comes out, this is what we want to capture. It's put into some statement. And as clinicians, especially nurses, we have to check the box and it just scares me.

Early on, I mean, I've been dealing with EHRs since 2000 and really got deeply involved in it back in 2003. We took this overarching premise that documentation would be done as a result of care that we rendered to a patient and we really, really pushed hard back against the yes/no rows because the quality was in the care that we gave, not in the documentation that we checked the box yes or no. So I'm hoping as we go forward we can keep looking at that. Yeah, I understand, I mean we need to be able to measure it and yes/no is a real good static way of doing it.

But somehow we need to educate the researchers, the QI and the QA members of our health staff to look and extract. Maybe the APIs are a way to do that, maybe robust systems...the expert systems that we're hoping to achieve in the coming future. When we get away from all of these competing priorities of Meaningful Use and CQM and things like that, we can really begin to develop those expert systems. That will go in and extract the data that we need, maybe it's out of a...maybe it's out of some kind of documentation in structured data fields that are set up in a specific way that aren't just yes/no rows. So just kind of a hope...what I'm hoping to achieve as we go forward and something to keep in mind that when you say data entry, it really leaves a bitter taste in a lot of clinicians mouths, we're not data entry clerks, we're caregivers.

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

I totally agree when you look at registries there is a lot of data entry going on in registries, it's just important to recognize that. I think we will get there. I think the push to expanding what are the standards? The move to things like SNOMED CT, which gives us, more granular mapping that is...that should be, in a good system, invisible to me as a provider. I'm just saying diabetes with nephropathy and somebody is helping me figure out what's the appropriate code either through some natural language processing or some querying or perhaps a coder. And then all of a sudden I have more discrete data that enables me to not only care for the patient better, but really go, I think, to the next stage.

So I think the focus we've had on standards and terminology needs to continue. Is there a quantum leap here with natural language processing, with query tools, with search engines that will enable us to do more Boolean logic on-the-fly queries? I think there's tremendous opportunity as the computer science part of health IT moves forward. But right now I think there's a reason why there were check boxes up until now. Did we do hemoglobin A1c? I think it's important to go back where we were to really have a sense of how far we've come. That question of did everybody get a hemoglobin A1c who should get a hemoglobin A1c, remember, that data was terrible and now we've really moved ahead. Are people getting Pneumovax, yes, and has health IT played a role in that, obviously. And was that checkboxes, was probably for most people checkboxes. But I agree with you, as we move forward, especially as we look at patient experience, when we look at that next set of outcome measures, outcomes are not checking a box.

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

And I was going to say to similar to what Terry said at the end there, the more we move away from process measures that inherently are if "A" and then "B," you move away from those kind of boxes. And if we move towards this program and others just having outcomes as the thing you're really tracking primarily, then you potentially will have less of that. There still is, I still see patients a half day a week as well, there is still an amazing amount of documentation of just doing the work of taking care patients these days. And I think we can't...we still the to be cognizant of the fact that it's still pretty burdensome even to just use the EHR to write your note, as I watch my residents type notes every Monday. I mean, so it goes beyond even a quality measurement piece of it, but just broadly the EHRs themselves are still not very friendly to clinicians and others who want to use them.

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

Well...and this is Troy again, that's evolving. I mean, we're getting better at it. I think in the very beginning, yeah, I mean we needed to get people attuned to capturing the demographics of patients. I think as systems evolve, we'll get better at it. You pointed out a number of very good projects that are out there, things that are evolving; natural language processing is one of them. The problem I have is once those...it's kind of like a law, once it gets put in there, it never goes away. And so people just continuously capture this data.

Let me give you a perfect example. I mean, I was at a conference a number of years ago and a representative from JCAHO said we don't understand why we're asking you if patients take aspirin before they arrive to the hospital anymore. We haven't done anything with that data for years, we don't know why it's still there, but yet we continue to ask patients every day when they come in, did you take an aspirin before you got here? And there are just some things that are embedded and I'm hoping that we can retire some of those and there will be a recommendation that comes out of the quality measures groups that say, you know what, we don't need this anymore. You can stop capturing that data. So remove the yes /no rows or the way that you're actually capturing it.

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

Right and just to...and that's a really good point. And just one more point is I think there's a really important connection between the work of ONC and the work of CMS. So they are now increasingly, if you look at the federal programs, in fact we're moving some of those topped out measures that are just...no longer need to be there. I think we need to stay in sync to make sure that we're also not still having systems out there electronically still requesting that those data be hand done, even though the measures clearly 100% performance, it's been built into systems, thank you, let's put our energies elsewhere. Really good point.

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

I appreciate that, thank you.

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

Yup.

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

David Lansky?

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Bu

Thanks, Paul. I really want to thank you both for leading this work for so long and getting so much...making so much progress and getting so much well represented now for the next phase. So my couple of comments are really about where we go next with this kind of work and I think just...some of the places you already mentioned. The slide that has the prioritized six domains, the two that aren't carried over to your slide that has the functional pathways are shared decision-making and efficiency. And so I just think we all should stay very conscious of the fact that those are two important areas, especially for the movement to alternative payment models and patient engagement that the next round of work has to bring back in. Especially for Stage 3 I would hope we'll find a way to create a functional row of the work plan that keeps that in...under our attention.

Second thing I wanted to mention, I think it's been highlighted all day in all the testimony we've heard, we have to really keep working on the link between the infrastructure...the tight link between the infrastructure piece that you alluded to Helen and this quality measurement strategy and the things Christine said about patient experienced data. That's to me partly an infrastructure answer, how do all of these pieces, as you said Helen, come together?

Data interoperability and the emerging measures are kind of connected to each other. Part of the problem we've had is the process measures fit into one tidy EHR silo and everybody is content to check the boxes, as Troy said, within a work setting. And that's been a relatively manageable problem. Now that we want to look at outcomes, which are inherently over time, across settings, that require connectivity between the nodes of the network and we don't really have infrastructure play for that, that supports quality measures, except maybe registries and that's complicated. So I think we have a big body of work, we're almost stuck at the top of the hill or the first hill we've climbed and to get to the next hill we've got to deal with the infrastructure or else the measures are going to be stuck at places no one today seems to like. Thanks.

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

David, first, we would be remiss if we didn't thank you for all the work you had done on the quality measures, we're coming in on the tails of the work you and the previous members of the committee did. So thank you so much for giving us an opportunity to wrap it up. I think what you just said is really important and it hasn't been a discussion we've had a lot is that what does interoperability give us right now? So that C-32, that CCDA I'm downloading with 120 pages, it does not give me outcome measures. It gives me process measures. It does not give me the ability to even translate into outcome until I figure out how to consume all of that data. So it is a point, I'm so glad you brought it up that the next...so we think of the next stages of quality measures, we need to think, even though I know we're struggling with interoperability, now we need to think of the next stage of interoperability, which is interoperability to support outcome. And I think what we believe is that interoperability because it supports an experience of care, may give us that. So it does give us that for an episode of care, but the issue is how do we really focus and design interoperability to do these longitudinal long-term outcomes? And it's just important and on the table.

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

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

So thank you and as everyone has said, it's a terrific job, Terry and Helen, that you've done. I just sort of wanted to second the comments that I heard Troy and Devin make about data entry and documentation. It would seem to me it would be great if all future quality measures had a simple rule, which was to have to use the data that exists. I mean, there's a lot of data that exists in the systems. Christine wants some vision where you can download like any quality measure you want. Well there's almost an assumption to that vision, which is, you already have the data to produce the quality measure. And so if people would just write these things and simply use of the data that exists, that would make a huge difference.

I also sort of wanted to second Troy's comment about these...there are a lot of these reports and things that are there and that are old. I mean, I Chair a patient safety and quality group at local safety net hospital and once I asked how many quality reports do we produce because we have to? And I got an answer that was over 500 reports and an argument whether or not that really counted all of the reports that we produced because we have to. And those reports really aren't quality reports, they're penalty reports; you produce them because if you don't produce them or based on what is in the report, you'll get penalized. So these are penalty reports and they have a huge impact on data entry.

And so I also think if we're going to do an expansion of quality metrics, I wish that there was some vehicle to get rid of some of these old quality reports. I mean...so I know this was suggested in another environment but maybe CMS could come up with a quality report death panel and we could get rid of some of these things that we have to produce because they don't really improve quality. And the quantity of quality reports and the quantity of quality measures is not going to improve quality. We don't need all of this stuff to improve quality, we need to try to understand what it is we're trying to accomplish with all of this process.

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

Just two quick comments on that, you're absolutely right. And unfortunately there actually is, in fact, an HSS-wide workgroup now that is focused on measure alignment. So there is very much a goal to say, use a measure, use it once across programs and not to have slightly different measures across different programs. There's actually now an effort as well with the private health plans to begin to do that alignment work as well. So you're absolutely right, cacophony without value is something that just needs to stop and I think that's important roles around alignment, but I think are things we can continue to work on. I've never thought of calling them death panels, but it's very attractive.

Just to your first point about using data that exists. We actually did some work with...for ONC and CMS specifically on this idea of coming up with a metric around e-measure feasibility. So now as new measures come forward to us that are specified for EHRs, they have to, in fact, demonstrate that the data they're putting in this measure is available in an EHR, in a specified way. So to exactly your point, we have to be able to start moving down that path and in fact the measures that move forward, at least at NQF, have to have demonstrated that e-measure feasibility. Now that's complex because it may not get you to the measures you want, the sort of visionary measures of what you want, because oftentimes those data elements won't be there. But as at least a way, I think, to temporize, to say for the ones that you are putting into place now, the feasibility exists. Really good point.

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

Yeah though the caveat to that, Helen, which I think is what you are alluding to is, if we only rely on the data measures that have that have data standards, we will never get to health. Because we have so many factors that aren't standardized and are not in the electronic health record. So at the same time, for measures for reporting Paul, that...I am right there, but I think there needs to be a concurrent sidebar going on, which we see in the standards groups, saying let's push into these other areas. I harken back to behavioral health and long-term care, they need some standards, because right now that data is free text and it might be findable, but it might not be findable.

Paul Egerman – Businessman/Software Entrepreneur

And I don't have any trouble with standardization of the data, I think that's a valuable function that ONC has performed and is performing. And it's useful for quality measures; it's also very useful for what people are calling interoperability. So when a healthcare organization can see, based on how a laboratory test is coded or a medication is coded, just what that item is, they have some vehicle to do that, they all use the same codes. So I don't have any problems with that, but it should not be an additional burden on the individual healthcare provider to gather the data for the quality measure, that's my belief. A lot of these things come from the old view of how these things work where people used to do chart abstracting and they would read the chart and come to a conclusion. And we're not doing that anymore, but we need to change our view, I think, of how the quality measures work.

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

Yes.

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

Tom?

Thomas W. Greig, MD, MPH – Chief Medical Information Officer – Department of Defense

Yeah. Terry, Helen hey, nice work and I concur with the comments to date. But on the question of standardization, have you guys looked at standardizing the methodologies, particularly you mentioned earlier different systems and different vendors use different me...sometimes proprietary methodologies on their calculations. Have you looked at how to go about and evaluate and standardizing the methodologies?

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

We have not looked at that, it's a really good point. The assumption is during conf...if we want to say that certification testing is really conformance testing, which in some ways that...it is, we assume at that point that there is some consistency in the way, for instance, a query has been coded and the way it's retrieving the data. But I don't have...we did not look at that.

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

Okay. David Bates, final question.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Sure. So I just wanted to note that in the UK, they now have about 170 measures that are routinely extracted. These occur as basically as a by-product of practicing, so that there’s nearly no marginal effort along the lines of what Paul was suggesting. If you can get to that point, then you don’t really need to retire measures so much, because they just occur as part of doing business. There are occ...there are, often times though, when you need to ask a specific question like how bad is the person’s asthma or, how are they feeling? And that may not...they may not be in there and somebody does have to put those pieces of information in. So I don’t think we’ll get to Paul’s vision of no marginal effort for the providers, but we could get an awful lot closer than we are today. And I think we need a lot of metrics going forward.

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

Thank you. So the workgroup has presented a set of recommendations and we do need to get your approval for those. Is there a motion to approve their recommendations? And second? Any further discussion? All in favor?

Multiple speakers

Aye.

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

Any of opposed or abstain? Good. Thank you and thanks again for your valiant efforts.

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

Thanks.

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

And thanks to Lauren Wu in particular and Kevin for just invaluable support. Lauren has been spectacular, so, we couldn’t have done it without here.

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

Yeah, at the last minute, in the middle of the night, she’s tolerated us, so we’re appreciative.

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

Thank you, Lauren. All right, so we’re going to move to the final report of another workgroup, the Accountable Care Workgroup. They had presented some draft recommendations one or two months ago and now they are coming back with their finals.

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

Great. Good morning everyone and thanks for the opportunity to present our final recommendations from the ACO subcommittee of the HIT Policy Committee. This has been a very interesting group to Co-Chair. And I’ll tell you a little bit of a...a short vignette as to why.

After I finished my residency, I went to business school and my economics professor told a story as to why economics was more important than health care. And the story he told was of the British in the 18th century sent large numbers of prisoners to Australia to prison camps. And the unfortunate thing was many of them were showing up dead at the end of a long journey. And the Church got a hold of this and appealed to the moral obligations of the ship captains, and you can imagine how that went. The government got involved and tried to regulate the number of prisoners and the length of the journey. That didn't make anything any better. And then the economics discipline was consulted and they said, pay the ship captain per live head delivered and the problem was immediately and completely solved.

And I tell that story because work in the HIT Policy Committee, we've really not had the power of economics working for us. The fee-for-service environment really doesn't encourage data sharing. When you think of our challenges with the HIEs of today, one of the biggest challenges has been the lack of a business model. Accountable care organizations really are one of the unique players in the industry because they solve many of those problems, when you take accountability for a population of patients as a delivery system, all of a sudden data sharing moves from a nice to have to a must-have. Discrete data becomes something you absolutely need because you have very little chance of managing the health and wellness of a population without being able to look at the data that represents their health, their wellness, their disease state and being able to analyze it.

And so this subcommittee, I thought, was a particularly interesting group to participate in because we did have the economics working for us. And if you want to talk about some robust listening sessions, you can imagine putting some vendors and providers in a room and the providers now on top of wanting data sharing have financial risk. So, it was a very interesting and rewarding experience.

In terms of what we did, our members are listed above here. And the approach we took to come up with the recommendations that we developed was to not use Meaningful Use as a constraint. Because when you look at what's going on in the industry right now with accountable care, there are a lot of activities that are required for success in accountable care that differ from Meaningful Use. And so we took a perspective of looking at the providers, trying to understand their needs as best we could and then looking at what would the technical and operational requirements be for success rather than kind of arbitrarily limiting ourselves to Meaningful Use. And we then tried to bring the recommendations back as close as we could to Meaningful Use.

The workgroup heard from a variety of stakeholders. We had a listening session from providers of care who are participating in ACOs, vendors and other members associated with ACO delivery of care. And we came up with a series of recommendations that we're going to bring forth to you now. I will kind of echo some of the comments Paul made about excessive numbers of quality reports. We heard those same types of things but what's interesting in accountable care is, wouldn't the quality report that you would want to continue and focus on be the ones that actually caused the change in the health and wellness of the population you are accountable for? In other with ACOs and the economic interest almost create an alignment of what quality measures you want to focus on, because you've now linked the economic interests to the overall program. With that, I'll turn it over to Grace and we'll start walking you through the recommendations.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

So really there are only three things we have to do to fix healthcare in this country and that is, we have to change the way we actually practice through care model redesign, we actually have to change the way we're paid and we have to clinically and informationally integrate all that at the same time that we're doing it. So it's really pretty easy, but it's not. But probably the place, the sharp edge to use the metaphor that was used earlier today, that we were actually working to do that may be accountable care organizations. Because it really, for the first time in a long time, is really looking at information integration with care model transformation and redesign of the payment system simultaneously in these new little laboratories called ACOs.

So, within that context a lot of what we heard both from vendors and others was really essentially from folks that were on the front lines and really had a lot to say about the problems as it relates to it. We basically decided to divide our thoughts from the committee into four areas, exchanging information across the health care community, the data portability, clinical use of the data, and leveraging existing sources of information.

Something that was also talked about a lot, but that we did not actually put in our final recommendations, I was hearing things of all morning long is...from the other presenters. And it had to do with really focusing on how we can do this with less administrative burden and how we can do this in a financially sustainable model. Because it's not altogether clear to us who are on the sharp end of things right now, what ACOs will be able to produce from a financially sustainable standpoint as we're moving from a fee-for-service world to another one?

So as we got into that, we basically had sort of two approaches to it. One was our strategy statements within the four categories and these were basically the overarching themes that we heard throughout our committee time. And then we have some very specific, actionable recommendations for you that has to do with what we consider ought to be the highest priority from a policy focus standpoint. Some of it we thought was quite immediate in terms of where we may get benefit and the rest of it may be more intermediate or long term. But nonetheless, we felt like it was something that needed to be focused upon. So I'm going to give some detail behind the first of the four and the third and Charles will do the second and the fourth, and where you can then sort of hear some of our thoughts on that and then get into some questions for us.

Within the exchanging data across the community, there were several broad themes that we heard throughout the workgroup from many providers and that was that the data is still very siloed in their communities and that major hospitals and health systems are not widely sharing it, either intentionally or because of lack of capability. And a lot of the focus was on how that needed to be approached. There was a real serious concern raised about patient safety and the ability to succeed in accountable care if there was not a better, more integrated approach to information, with less siloed approaches to it.

We also heard many concerns about the challenges to integrate with all providers across the continuum of care such as long-term care facilities, behavioral health providers and others that are not traditionally yet part of the ACO, either the federal programs that are called ACOs or some of the private/commercial ones that are out there. So within that context, the strategy statements that we felt were important was to really focus upon a strong set of expectations for providers, particularly health systems that they were to share. And we've been doing a lot of discussions about, can we interoperably integrate providers? But we felt that there needed to be more of a focus, from a policy standpoint, from a governmental signal standpoint, that providers should exchange information, not just that we can as we're creating that.

Within the providers that were ineligible for EHR Incentive Programs now included LTPACs and behavioral health and home health, we felt that there needed to be a closure of the investment gap for crucial providers that are basically lagging in deploying certain IT infrastructure now. Basically because we feel like is we're going to get better with across the continuum of care. It's going to take more than just the ones that are now participating in ACOs as they're currently structured. And within the exchange of behavioral health information, we really feel like SAMHSA has signaled that there may be some regulatory changes that can address current barriers. They held a listening session last month that specifically called out issues for ACOs and we had a lot of discussion on the importance of that and are looking forward to seeing progress being made there.

So within the context of our actionable items, when it came under information exchange across the community, we felt that CMS should really leverage innovative service delivery models to encourage the use of ADT feeds, which we felt was a high impact, relatively low-cost way for organizations to share information outside of their walls. And that innovative services and payment delivery models that are being scaled now, as well as forthcoming models, should encourage participating hospitals to make their ADT feeds available to support communitywide care coordination.

We felt that as the ONC works with CMS to update hospital survey and certification standards, that really it's probably time for CMS to also look at more robust levers for encouraging data sharing, such as the conditions for participating in Medicare for those that were not doing that. And in the future rule-making, CMS could also add to the current survey and certification guidance by requiring hospitals to demonstrate that they have a process in place for determining the patient's primary care provider and the capability to transmit electronic discharge summary to that provider.

Within the recommendation to increase public transparency around performance on measures related to health information exchange, we think that public transparency could be an important tool for encouraging institutions to share data. And could look at something such as requiring reporting on exchanges through the Hospital Compare website, for instance using Meaningful Use Stage 3 transitions of care so that consumers could see how hospitals are doing on exchanging patient data.

In terms of providing additional shared savings to those that are not currently eligible for them within the shared savings...rather ACO programs. Those of us that are in ACOs believe that there is strong interest around investing in entities that currently are not eligible, such as LTPACs and existing ACO or future models could add program features under which ACOs could qualify for additional shared savings for partnering with providers and then using these funds for additional investments in HIT adoption by these providers.

And then finally, under the recommendation for issuing additional guidance around sharing of information protection under 42 CFR Part 2 across participants. There was a discussion at our public hearing that ACOs have reported erroneous interpretations of privacy policies for protected information that's continuing the hindering of shared protected information, even when sharing is permitted in accordance with privacy protections. And we believe that SAMHSA could build on valuable past guidance to further reduce confusion that's out there right now in the ACO world. Some examples of where this could help would be how ACO entities could include substance abuse facilities, which might establish QSOAs across participants with an administrative relationship to permit sharing of clinically relevant information or conditions under which primary care providers conducting SBIRT services would be considered Part 2 providers. So that is a lot of detail about part 1 and I'll see if I can get Charles to give you a lot of detail about part 2.

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

Data portability, so when we began our discussions around data portability, the first question we asked ourselves is, there are lots of activities in the Policy Committee around information exchange and a wide variety of efforts that the Standards Committee to focus on data portability. So what is it that the ACO adds to the data portability discussion? And in our view, there are really two things, the element of time and the element of financial risk.

When you begin to participate in an MSSP or other program and you take financial risk for a population of patients, in general the way those programs have been operating, and commercial programs as well, is that you don't have a lot of lead time to begin to manage that risk. And so time to value...or time to deployment of a system that enables interoperable data exchange and more importantly time to value the ability to use that mobilized data to manage that population suddenly becomes incredibly important to these delivery systems. And many of them express some levels of frustration associated with their ability to get their vendor or whoever they were dependent on to provide that interoperability in a timely fashion.

The other element of time that is important is the timeliness of the information itself. And what we mean by that is many of the organizations that came to our listening session talked about the way they had done quality measurement is almost like a check, a retrospective check process. In other words, to draw an analogy, if I were to drive from Washington, DC to Los Angeles, upon completing that journey, I might do a quality check to see if I stopped at all of the signals and made optimal use of the freeways. But when you're in an accountable care type of arrangement, what you're really looking for is more of a navigation system. A system so that as you manage the patients and as new events come up for the patient, that you can anticipate complications, anticipate disease progression and so again, to draw an analogy with the highway system. You'd want a navigation system that could show you where accidents might be, where traffic congestion might be, so that you could optimize your management of that patient through their clinical care pathway. And so the notion of the time of the information, the time of the analytics is uniquely underscored in an accountable care relationship.

And then finally the notion of financial risk. Although certainly every delivery system wants to get good performance from their vendor, putting hundreds of thousands, if not millions and in some cases tens of millions of dollars at risk, associated with your management of a particular population, creates a new level of pressure, a new level of focus that really goes across much of the delivery system itself and creates a greater effort to get interoperability and portability to be a greater part of that organization's focus.

Also what we found was that the information tools that are being used for ACOs are very much in their infancy, many are being adapted from claims-based environment, others started their life as disease registries. And so we found the tool sets...our delivery systems who testified at our listening session, found many of the tool sets to be in a nascent form. And so the notion of being able to execute a best-of-breed strategy to be able to have the tool they feel does the best job for them in managing their population, again underscored the importance of data portability.

And lastly, the EHR really has a different role in an accountable care type of arrangement. Yes it does all the things it normally does, but it also becomes a critical data repository, source of data for these population health management tools to be able to then make population-based assessments from. And so the notion of the HIT vendor or the EMR vendor again making their data portable becomes even more critically important to delivery systems participating in an ACO.

And so to walk through our recommendation, again, we acknowledge all of the great work that really everyone has done in trying to move the data portability challenge forward. We would simply make a few recommendations, one, that there be an emphasis on publishing and we're using the term APIs here with intent. What we mean by that is not some kind of bulk data download that happens after the fact or at some future point in time, but something that's real-time that allows the data in the EHR to be made available to other tools required for accountable care, such as these new population health management tools. This API is going to need to focus on making the data useful in terms of discrete data and timely.

Two, that we will continue to need to focus on a greater level of specificity for the interoperability standards, specifically in the area of semantic interoperability. We heard some feedback from our listening sessions about the importance of maintaining the meaning of the data as it moves from let's say an EHR to a population health management tool.

And then our last recommendation talks about strengthening data portability elements in the certification criteria so that EHR systems that are able to send out a CCD also demonstrate that they can receive and process data so that it can actually be used most effectively in the workflow of treating the patient. You can use these population health management tools to generate a report that says here are all of my high-cost patients, here are the folks that you should be reporting on or focusing on. But when it gets down to in the office and having a physician and a patient, the recommendations, the ability to leverage the data is still quite challenging. And so strengthening our certification criteria in that area is another one of our recommendations.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

You mentioned the need for data to really get better and how currently where we are with population health is just in the infancy of it. So it looks like there are several stages of development of health information technology. The first one is the mature technology that we call our revenue cycle management systems and billing and collecting and scheduling, which has been mature for about 30 years and was based on the fee-for-service world. And the second one is where we are spending most of our time now in, which is clinical decision support in electronic health records. And that's not mature either, as some of the discussion this morning was about.

But when we actually start talking about population health management and information technology, particularly as it relates to ACOs, we really, really, really are with very immature technology. And it has not done yet what it needs to do, which is actually make care better as it relates to the experience of using the information to improve care. And doing it at the level of clinicians that are really focused on how to do this with both synchronous and asynchronous information both at the bedside and at the analytic level.

So within that context, we've got several strategy concepts that we want you to consider, such as the dynamic shared care planning that needs to occur now, really has to be interdisciplinary and virtual and across the continuum of care. And it's going to be very critical in team-based care to understand and learn how to do this. And we don't think that any of us know how to do this yet, particularly as it relates to accountability across the continuum. Certainly care planning is something that has been part of inpatient care in certain settings for a while, but across the continuum is a whole other ballgame and we do not have information technology yet that is the least bit capable yet of making that something that's part of our culture.

There's a wide range of healthcare stakeholders beyond those who have just traditionally conducted care planning that are going to need to understand how to do this and to develop workable models there can be some consensus around. And clinical decision support tools that are going to be a strategy for ACOs are going to need to adhere to evidence-based guidelines, even in the midst of the need to be focusing across the spectrum of care with different professionals. And there's going to be really a lot of work that needs to be done, even at the research level, to understand whether what we're going to do is even going to be effective. We simply don't know. There's a lot of talk about changing everything, but very little evidence yet of what's going to be effective.

Providers within ACOs need access to actionable measures that address both the quality and the cost, in order to make decisions for a value-based care environment and currently those two things are bifurcated and very, very difficult, at the clinical level, to put together. So within that context, we had several actionable items.

In terms of learning what we don't know, we believe it might be important for there to be the establishment of pilots to understand how clinicians actually use electronic shared care planning tools to develop effective team-based care across settings. Because we don't think at this point that there's adequate real world experience with care planning models to make su...to put anything in a much more mandated way. We think that HHS could fund pilots using shared care planning tools, including HIE-based services, EHR-based modules and care management software, so that we can learn how to do this more effectively.

We recommend convening a group to accelerate clinical consensus around standards-based electronic shared care planning across the continuum of care and to develop strategies to promote wider adoption of these tools. Better standards for care plans are not enough. The clinical community beyond those clinicians who have traditionally done care planning need to come to consensus about what workable models would look like for conducting care planning across the continuum of care. And how do you update things? What does it mean within the hyper dynamic spectrum of an individual whose care is going to change from setting to setting and time to time?

So we think that groups such as the AMA, the American Nursing Association and other relevant organizations might opt to be part of this discussion. Such a group could also think about adoption by looking at all of the places where government programs require care planning and moving these programs towards uniform practice and use of standards-based tools.

We recommend there be pursuance of research with federal partners such as AHRQ around the effectiveness for clinical decision support to improve the impact of these tools, which are not yet mature within the context of point of care. Workgroup members expressed a substantial amount of concern that high variability in the current effectiveness of clinical support tools is hampering their ability to support ACOs. Better research on what tools would be useful to clinicians could help inform future certification as it relates to Meaningful Use.

And we recommend that there be an increase in sensitivity and specificity of the clinical decision support algorithm tools by implementing standards that will support the incorporation of external data from multiple sources. This circles back to our first recommendation about de-siloing the information into the various health delivery system silos that are out there right now. A key use case for ACOs around clinical decision support is the ability of external data to be integrated with data in the EHR so that it can trigger a specific and sensitive algorithmic driven CDS alert. More work is needed around how to get to this level of functionality.

So we believe that the overall industry as we want it to be has a long way to go. That research needs to be done and that what we've got to do at this point is to really start focusing on that, not only at the committee level but also at the policy level as it relates to funding and research.

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

Okay, our last area is a leveraging existing sources of information and a lot of what we are talking about here is administrative data. And administrative data really has not been a focus of the HIT Policy Committee with good reason, administrative data is not timely, it can be 30, 60, 90 days out of date. It's not accurate, in other words there may be many clinical conditions that a patient might have that you will not find in the claim data stream. And it's not granular enough, you may get ICD and CPT information, but certainly the richness of a clinical interaction is generally not represented in the claim data stream.

That said, on a population basis, which is the key objective of an ACO, claim data and administrative data sets can be quite valuable. They help you understand costs and cost benefits. Claim data can help identify opportunities for efficiency and effectiveness and also claim data can support operations. One of the most important things in an ACO is managing a term I think in the industry we use is leakage, patient leakage or patient keepage. If you're going to be accountable for a patient population and you're going to get your revenue off of that, if those patients begin to seek meaningful amounts of their care outside their system, that's a problem for you from a patient management perspective and it's also a problem for you from a financial perspective. Claim data may in fact be the only way you're able to know if those patients are getting care outside of your system. And so claim data...administrative data sets overall, actually play a very important role in making an ACO successful.

That said there are huge challenges in integrating clinical and claim data. Do you trust it? Should you act upon it? Does the clinical data by itself...does the clinical data support what the claim data says or is it in conflict? And so there are really tremendous challenges in figuring out how to optimally make use of claim data in an ACO setting. But again, we do see value and to give you one more example, one of the ACOs we work with, we used claim data to identify something we call unnecessary ED visits. They are claims where the ICD code is for something that could have been managed in a non-emergent setting.

And we saw one ACO where a clinic had the highest number of avoidable ED visits we had ever seen and upon further examination, what we found was that the clinic was overrun and the front office staff had put the phones on forward to the answering service without telling anyone. And you know what happens when a patient calls the answering service? If you need care, go to the ER. They were preferentially referring to the emergency room. Now those kinds of insights may not be directly improving the quality of care from a clinical perspective, but certainly it improves the quality of the patient experience, may even improve the quality of patient care and certainly is critically important from a financial perspective for the ACOs overall success. So we believe clinical...claim data has a contribution to make in the overall ACO operations.

And so we have a series of recommendations around leveraging existing resources. First, we didn't come up with a specific solution to this. But we believe that the use of claim data, its role with health information exchanges, its use in clinical settings is important enough that CMS, ONC, and HHS should work together to articulate a strategy as to how the government can advance this kind of a federated infrastructure to meet the needs...the data needs we've described to you, as well as the analytic needs of providers in accountable care organizations.

Secondly that although claim data can be available from commercial payers, it's not universally so. And if you're trying to create an ACO and you are trying to use the data to reengineer what you do, to reengineer how you take care of patients, you really need that data to be available not just for a slice of your commercial business or a slice of your Medicare business but really quite broadly. And so our second recommendation is to support the development of all payer claim databases and to support accountable care arrangements, such as what Medicare is doing with the Pioneer and MSSP Programs.

And then lastly, one of the things we heard in our listening sessions was the importance of chronic disease management. For many populations, chronic disease is going to drive \$.70 or more on the dollar of total healthcare spend. And as ACOs begin to look at the underlying drivers of chronic disease, one of the things that jumps out is the social determinants of health care. And we don't have a lot of data currently on the social determinants of health data elements within our clinical systems and within our clinical environments. And so we recommend that another area of advancement be progress on standardization and capture of the social determinants of health data elements.

So, that kind of wraps up our presentation and I think wraps up our workgroup. We acknowledge that our recommendations are a bit broader than Meaningful Use. But again, because the underlying intent of an ACO is a bit broader than Meaningful Use, we felt to make a meaningful contribution, we really need to take that broader perspective. Thanks.

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

Great. Thank you very much. And actually, you aren't limited to Meaningful Use, HIT would be a nice scope, but, no, very comprehensive series of recommendations. David Bates?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Thank you. That was great. I just want to underscore what Grace said about the importance of team-based care tools and better tools around care coordination. And I really do think we’re at the stage where we need some research about how to figure out how to do this. We did a study for NQF in which we called 25 of the best organizations all around the country and even the ones that were doing a really good job with this were largely doing it with Excel spreadsheets, which was...I was a little surprised about. I thought we would find some sort of examples of people who had really figured it out, but we did not. And yet I think it’s one of...that’s one of the things that will be most highly leveraged as we move forward with accountable care.

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

David Lansky?

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

Thanks. Charles and Grace, I think this committee’s been really great, I’m glad that you didn’t just stick to the EHR portfolio and I’m glad you broadened our scope a lot. I have two comments and a question. In general, I think there’s still an opportunity to drive progress in this area through a stronger emphasis on outcomes measured over the...across continuum and there are a couple of places where the recommendations, I think, pull back from that, and maybe that’s pragmatic.

But I think some of the pla...in section 1, you suggest tracking the exchange of patient data as sort of a process measure and you talk about counting the partners of ACOs in the behavioral health, long-term care partnerships. I think both of those are actually better done by measuring whether the outcomes are achieved as a result of that coordination and transfer of information rather than counting the partners in the chain. So I’d like to see that strengthened as we go forward.

The second one is, I think to David’s point, I think there is a lot of value in strengthening the research base around the care planning functions and tools for CDS, but it makes me a little nervous some of the language in here sounds like the federal government will convene a panel to decide how to do it. And I think that we should be careful not to suggest that there’s going to be at this early stage of development in the field, any federal consensus committee is going to somehow define the way to make this work successfully. And it’s another case where the market will probably innovate if the outcome measures are strong enough to reward successful care planning and coordination.

And the third one is just a question for you. I agreed very much, Charles, with your emphasis on opportunity to leverage claims data as a piece of this infrastructure. There was a recommendation from this West Health Transparency Report a few weeks ago about using Meaningful Use 3 to require the display of cost data at the point of clinical decision-making and referral and tying that link really tightly so that the EHR becomes a vehicle to stimulate the provider patient discussion about cost. Did your committee discuss that at all?

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

No. We didn't discuss it within that context. Most of the committee work on that was in much more broader terms and one of the concerns was too much information at the point of care actually is not helpful either and a lot of discussion was on hitting the right information there. I don't think we talked very much about the cost data per se, but it certainly is a point that's well taken. Some of that's already starting to be in the EMR, if you will, just when it comes to things such as the cost of various prescriptions and what they may be. Doing it at an entirely different level is something that is not out there yet, certainly in my own practice, it would often be useful.

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

Yeah, I think one of the physicians from Baylor talked a little bit about the value of that in our listening session. But again, we didn't get into, well gee, would you actually represent the cost data or would you kind of maybe have a list of drugs that might be sorted by cost and the physician just knows that? We didn't get into that level of granularity; the feedback that we were getting was much more basic. The Medicare data is dirty; I'm really challenged in using it in a productive and timely way. So I think absolutely where we need to go, but I think we have so many more fundamental basic kind of blocking and tackling issues that we didn't really get to that point of innovation.

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

Thanks.

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

Christine?

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

So thanks, you guys it's a really comprehensive set of recommendations and I wanted to follow-up on the care planning piece. And actually, David Bates, you just were talking....the interviews that you did that you mentioned, were they around care plans? I couldn't catch what they were on.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

They were on using IT to improve the coordination of care and...yeah. And there was a big focus on care plans because if you're going to improve coordination...yeah.

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

Okay. So, we did some work probably...we started the work probably three years ago at the National Partnership to try to understand more about care plans. And we did that thinking that we could go and find a template that would actually help us in our work on Meaningful Use. And we figured out, of course, there is no such thing and we talked to people literally all over the world about the different approaches that they've taken. And so that work helped inform some of the data set in the transition of care summary that's now in Meaningful Use, but without a really standardized template it was very difficult to do.

So our approach instead was actually to engage a very diverse and large set of consumer organizations to try to understand what it was that patients and families wanted from a care planning process. And I was surprised at how broad and diverse their viewpoints were when I compared them with what is in many care plans that I've seen from the clinical community. So I just wanted to suggest...we developed a set of principles that I'd be happy to share with you around consumer views on care planning and what the process should be, what the content should be, how the relationship unfolds, etcetera. And I'm happy to share those. It was on the list for the Consumer Empowerment Workgroup to also take on.

But I note that you have a recommendation around accelerating clinical consensus. I think there's an opportunity there for us to work from both sides, both the clinical side and the consumer viewpoint. And so I wanted to suggest that if you're amenable that that recommendation be broadened a little bit to not just be clinically focused, but really include consumer viewpoints as well, who bring a clinical focus themselves. And then maybe we can think about it in the new workgroup structure, how the Consumer Empowerment Workgroup can collaborate with whoever it is that takes on the next step in these workgroups and to think more deeply about care planning and how to accelerate it.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

Thank you, it's a great idea. As you were talking, I was thinking about something in my own organization that we've been working on and how difficult what you're talking about, what any of this is. And it relates to a partnership we have with several poly-chronic clinics with a retail pharmacy where they're doing health coaching and where we're trying to share care plans across the spectrum. So you really are getting to the consumer level there. There are 1000 complications related to it. The nurse navigators guide it, they were used to it, they understood it on both sides of the equation, if you will. The patients were enjoying the engagement on the retail pharmacy side. The docs didn't get it at all. And so it's a work in progress, it's a cultural work in progress, which is really what you are getting at.

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

Yeah.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

And even the very early stuff that we've done, it took us a lot just to get a little benefit from it. So, again, I think it focuses on our research and to broaden that to consider the consumers aspect of it is absolutely spot on.

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

Thank you.

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

We have a number of cards to try to be brief, please. Chris?

Christoph U. Lehmann, MD, FACMI, FAAP – Director, Clinical Information Technology – Johns Hopkins Children's Medical and Surgical Center; AMIA

Just a quick comment about your recommendation to study these tools, the federal government is actually a little bit ahead. CMS just gave a large, \$18 million, grant to Vanderbilt University to study, MyHealth Team, which is an IT product developed there, to actually do care coordination for hypertension, diabetes and heart failure. So...

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Great.

Christoph U. Lehmann, MD, FACMI, FAAP – Director, Clinical Information Technology – Johns Hopkins Children’s Medical and Surgical Center; AMIA

...I think we’re on the right path there.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Thank you.

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

Thank you. Marc Probst?

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

Yeah, two quick comments, one is on the first one, information exchange and talk about the increased public transparency of who’s doing information exchange. And it’s a little bit implied in “e,” but I think it’s important that we also have transparency on where all these patient’s data now resides. Because one of the real challenges is, it goes one place and it ends up in 100. And I’m not sure our patients are comfortable with that or even understand that. So anyway, that was just a comment.

The other one was, just because I have the microphone and it’s my favorite topic, I don’t know how many times the word standard has been used today, but this whole concept of ACO takes standards to a whole new level. Where we’re just looking at transitions of care and some of the specific standards we’ve been talking about relative to Meaningful Use and I just think it really puts an onus on us to figure out how we’re going to do that. Because we’re talking about it, but all these things are dependent upon it, I mean, almost every category your team went through require a very detailed level of standards for us to be successful, and we need to do it pretty quickly.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Thank you.

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

Paul, I mean Neal.

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

I’ll try to be brief; I’ve got two comments and one question. So I think you’re touching the Holy Grail around basically a care plan...a health plan care plan that persists across the continuum of care, that’s going to require, as Marc pointed out, basically the content of that plan. I believe that needs to be an open architecture, it needs to be consumable by a number of EHRs, both at the content as well as the application level. I applaud you touching the payer and bringing that. I do not believe that payers are very willing to share claims data they contractually protect that. And if we’re going to have really population health, we’re going to need PBM payer data and at the end, probably employer based data at enrollment time, too.

So, and then my question is interoperability is a theme of the entire morning, most every panel has touched it but very...nobody has really dealt with the identification. It implies, because the prerequisite to moving data across, this is basically my data sharing it among providers, is that you know who I am. And we're the...we are a country that lacks really a national ID...identification system. And we seem to skip over that in these discussions and we assume it.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Yeah.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
And I quite frankly don't know how we could ever assume that. So maybe that's not a question, maybe that was a comment and in the interest of getting to lunch, I will make it a comment.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
Just real quickly, if you look at the KLAS report on health plans, there are some health plans that are sharing claim data very openly and you can see that report. And some do, absolutely you're right, some don't. And then in terms of a national identifier, we...there have been other committees who have focused on that, we kind of punted on that. We recognize it's a serious issue and whether you can get there is through EMPI algorithms or not was something we left to another subcommittee, standards or whoever.

Neal Patterson, MBA – Chairman of the Board and Chief Executive Officer – Cerner Corporation
I think a lot of people have punted on that one.

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

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA
Well one very nice thing being part of the Medicare Sharing Savings Program, to your point, is actually getting global data from one payer across the spectrum. We are now, in our organization getting claims data from several of the payers and the others we like to publicly shame, but I won't do it today. But it's...that's been an absolute gift to be part of the Medicare Shared Savings Program for all the complexity related to it, because it's the one database where we can look at it across the spectrum, both internally and externally.

Paul Tang, MD, MS – Vice President, Chief Innovation and Technology Officer – Palo Alto Medical Foundation
Thank you. Kim?

Kim J. Schofield – Advocacy Chair – Lupus Foundation of America
In the interest of lunch, I just wanted to underscore Charles' recommendation to capture the social determinants, especially in standardizing the health elements for chronic disease management and the coordination of care. I think we do have a unique opportunity on it...and are at a critical juncture right here because, if we're going to see the effectiveness of APOs, then we're going to have to move that a little bit up the food chain.

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

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Thank you. Thank you again Charles and Grace for an important presentation and I agree with Neal's comment. I'm glad you did include administrative and claims as materials in your presentation. I also agree with Marc's comment on the transparency about where the data is stored. If we're going to do transparency on information exchange, that's very important.

I have a couple of comments and a question on your slide 13 where you say, you're talking about these APIs. And then you explained that what you really meant by that, Charles, is you said you wanted real-time access to the data. And my first comment is sort of like; we just had a presentation from the Meaningful Use Workgroup about being overly prescriptive. It would be, in my mind, just much better rather than talking about APIs, if you simply said you need real-time data access and left it out, what is the vehicle for getting there. So that's a suggestion.

Also, I didn't understand why you needed real-time access to that data for population reports, though. So, I'm wondering if you could explain that.

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

We wouldn't be using the data specifically and only for population reports, some of the analytic tool sets will give you recommendations like gaps in the care. And the way they operate today is there's a tremendous time lag between when the data...when the patient is seen, the data is shipped over to the analytic tools set, the analytics are run, and then the gap in care is produced. And so what we were trying to say is, in an ACO construct, you don't want to, hey, I saw the patient this week and then they come back and then you have to call them back and incur the extra expense of an extra visit to fix the gaps in care that were identified through that process. You'd really want to have that happen more at the point of care.

Paul Egerman – Businessman/Software Entrepreneur

Okay, and that's helpful. And then I have a similar comment about being prescriptive in the, I think it's the last slide where you talk about a federated infrastructure, in your letter "A." I think you'd be much better off rather than saying that it has to be federated by simply saying what your need is instead of being that prescriptive. But anyway, thank you, I appreciate those comments.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

Thank you.

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

Fair enough.

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

Troy?

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

Thank you, appreciate it. I'm really pleased with the direction that you are looking at, especially around the...plan of care. But there is one thing I think we need to kind of clear the air, I mean, care planning, we have a couple of different definitions floating around out there about care planning. One is for advanced care directives, right? And then the other, one of course is for the actual plan of care, the sharing of the patient's care across the continuum. Just hopefully we can get that...we keep talking about the standards, hopefully we can get that vocabulary in that definition kind of level set.

But I wanted to make a comment about that the...it's really kind of concerning that Christine, you explored a number of different avenues to see if you could find a care plan. Again, I mean, I've said this a number of times but the nursing community has established care plans since as long as I can remember and we do have a lot of very useful tools. They're interdisciplinary, they're patient centered, they use medical diagnosis as a foundation and then we expand from there into the social determinants and any other situations that may actually impact the patient's ability to reach their optimal level of health.

I would like to make the suggestion again to the Policy Committee, either through a listening session or through a presentation from the ANA or other nursing communities, professional groups, to come in and show you some of the tools that we utilize in order to coordinate care within the hospital setting. And also share that we're working on a process now where we can share that into the case manager aspect of it, which is a registered nurse who actually works side-by-side with physician to manage CHF, diabetes, any of these high-risk illnesses and diagnoses. So I offer that up. I would like to know, from your point of view, in petitioning the ANA and petitioning the other professional groups, what would you hope to achieve out of that? Is it to find one standard that everybody can use or just get a lot of different examples of how it's actually happening in the community?

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

I think the recommendation came after we actually reflected on your comments from the previous committee meeting where we presented. And back at the discussion level of the committee afterwards, there seemed to be, I don't know whether you would call it a consensus, but there was certainly a feeling that there was much learning and work that needed to be done across the spectrum of professional providers. And it may be that one a profession had skills and sort of cultural knowledge and ownership if you were to cross that, but it was not the case across the spectrum of the sort of provider world.

So I think our recommendation more or less came out of listening to you, but realizing that once we got back to the...to our committee level, that there was not a consensus or even a clear understanding. And to the way you started your point about the difference between the care across the continuum versus what may be a much more traditional and well developed understanding of care plans say for example, in the acute care hospital setting. So I don't...that was where it came from was actually trying to sort of wrestle with that.

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

I appreciate that.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

Yeah.

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

If I could...add on, what we found were a number of examples of care plans. What we didn't find was any agreement about any kind of a core data set or some sort of common approach to it. And I think the eye-opener for me was looking not necessarily in healthcare, but in the disabilities community at the person-centered planning process that they use, which is not a healthcare plan but includes healthcare dimensions and is much closer to what consumers really want. So I think there are definitely examples and they're clinically driven. But I think what consumers are looking for is probably a little bit different but incorporates much of that. And there was no way to sort of come to an agreement around either a set of principles or some kind of more common understanding and approach that would apply to a broad range, as Grace was saying, of different provider types and different patient types. So that's what we struggled with.

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

I would like to offer up, I mean if you have specific criterion that you're seeking, certainly send it to me, let me do some exploration, see if I can actually bridge some of those gaps. I think there are a number of models out there; there are a number of tools, electronic as well as paper-based that may surprise you. I will actually concede that yes indeed there is a lack of understanding from other professional groups as to what the value is with any, I'll use the term nursing care plan, at this point. And physicians generally they look for value in it, but it is a little bit more obscure that they're used to looking at because they're very, very treatment plan oriented, which means to say there's an acute process, they're rendering prescriptions to get the patient through that particular acute phase of care. That's why we have the case managers, the care managers in the ambulatory settings to follow these patients for their chronic care needs. So that's what we look at. I don't want to take up any more time.

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

Thank you. Terry?

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

So Paul, I do have a question, are we voting on these recommendations?

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

(Indiscernible)

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

Okay, so I kind of have a list of some concerns, but...sorry, sorry to do this at the end. One of it is, I'm just going to going to go down, 1-D, I don't know that we usually comment on additional shared savings incentives, maybe we do, I just don't know if it's in our purview. "E," issue additional guidance, I guess...my only comment is, I think this needs to be a little clearer, it kind of goes back to what Marc was saying, I don't know, is it just the sharing of the information, is it a comment on 42 CFR? I'm worried it could be misinterpreted.

Data portability for accountable care, “C,” I don’t know what strengthen data portability elements in certification criteria mean. You guys talked to this, I just wonder if you need a little more definition. I don’t disagree with it, I just think it’s pretty open and I don’t know how people will interpret it. Three, Paul, I wondered if we had had previous recommendations on CDS and I...if we had, I don’t think they would be in conflict with this, but I just wanted to be attentive to the fact that we may have had some previous CDS recommendation's. I also don’t know what you mean by sensitivity, 3-D, increased sensitivity of specificity by implementing standards. Is that messaging standards? It that CDS tool standards? Is it data standards? So I’m not averse to this, I just think that clarity of it may help us and so I’m not saying anything to stop us voting on the recommendations.

Four-A, I would like to propose, and I realize this is about ACOs, but there are other federal partners beyond just HHS, i.e. the VA, that might be interested in working on this, so I wonder if we could change HHS to federal or we could just inveigle our way in later, that would be okay. And then finally, 4-C, I actually think this is very, very important and you have heard that over. My concern is that you’ve said “critical to accountable care delivery models.” I actually think this is critical to all of us and I wonder if you want to just take the opportunity to...I mean it could stay as accountable care delivery models as long as there was somewhat of an implicit understanding that there are lots of other people that need this same work.

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

Do you want...?

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

Sorry, I kind of just dumped on you.

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

Just on the last one, these are ACO recommendations but absolutely acknowledge there’s value well beyond ACOs. I totally agree. I don’t know how...

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

...accountable care delivery and other...accountable care and other delivery models? Or do you want to take out the word delivery models and be more...even more broad and pull it out healthcare and talk about health? How far did you want to go?

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

I would like to see us say it’s about health, I don’t know what the exact wording would be. But I don’t want to constrain it because I think we’ve hear...we heard it from us, we heard it from other people today how important that is, so...and they’re all with a grain of salt, I wouldn’t know if you...

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

Well there are a couple of minor tweaks, one was...I mean you could explain her last one, 4-C; you could explain that you’re making recommendations, but it has a broader applicability. You can include the VA, by federal partners, that was another easy one. I think it gets harder as we go backwards.

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

I mean in total, should we vote on this? I mean we've heard a fair number of requests for edits and additions. I...and Gayle has more.

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

Let's see, this one's not on the timeline, except for the group going away, but they can vote, yes.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

...can just fold it in to...

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

That's right, that's right. So we could...

W

They're all addressable.

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

...they're addressable. I think they are fairly addressable; in fact, it may be so addressable that you can get back an e-mail for re-endorsement. Is that acceptable to the...to the gentlewoman on my right? Gayle?

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

Thank you, Paul. I just want to make a comment, more of a comment, not a question. But I'm concerned that, when we look at section 3 on improving care, that there's no real discussion here on what the value is. The value is really the quality of care over the cost of care and there's too much emphasis perhaps on cost of care and the reason we're doing this is really to not so much improving outcomes. Perhaps we need a little bit more on outcome measures or involving or speaking to outcome measures and clinical quality measures in that whole discussion. So that when you're doing your analytics, when you're really looking at, what do we need? We need that interoperability in order to make sure that we are improving outcomes.

And in the whole discussion, I really think it's been more about how we reduce cost versus quality of care. And the interoperability and portability of data, needs to be something in there talking about outcomes and outcome measures. Outcome measures are a significant part of why we need that portability and interoperability of the data.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

It was certainly a part of the broader discussion that we had, if it didn't end up in this, but part of what happened to us early on this group is that we carved out the quality ACO work and put it back in the other workgroup. And so it was always a part of the conversation, but I don't think it quite ended up being part of the final recommendations here because it kind of got...it was such a broad aspect of what we were doing that a lot of those specific recommendations around quality and therefore outcomes sort of got pushed over into the other. I mean Paul, I don't know if you think that had any impact or not, but that sort of happened.

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

And the good news is we're going to bring it all back together in...workgroup. So it's going to be motivated by the new models, both the quality and the efficiency side.

Okay, we do need to vote on this and one proposal would be, we've had some editorial comments, I don't think there have been serious disagreements, but maybe what we could do is vote on the spirit of these recommendations, subject to the editorial edits that would follow. And then we can even redistribute the redline version for people to approve by e-mail, if that's okay with people. But I don't want to put words in a proposer's mouth in terms of making a motion. So, looking for a motion to approve the recommendations, you could state it so that it's subject to the editorial edits that follow based on the discussion that we just had.

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

I'll move to approve the recommendations pending the edits that we just talked about.

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

Okay. And second?

(Indiscernible)

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

...are we going to get those edits back before we then send an e-mail vote affirming the edits?

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

Well, what we'd do is we'd redistribute the redline version for your e-mail vote of approval or not.

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

Perfect.

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

Good. Any other discussion?

M

Who's going to write...?

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

Presumably the Co-Chairs.

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

Paul, can we submit our own suggestion/comments as part of this loop, based on today's discussion?

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

Is that a submit your wording change proposal? Or not...as long as it's no new subjects, otherwise we'll end up...

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

No, no, comments that we made here today to formalize some of this.

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

Yes, absolutely.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Guys okay with that?

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

Okay?

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

Sure.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

I'll be in Italy accepting...

(Indiscernible, multiple speakers)

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

I just got back from Italy.

Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA

I know I'm leaving Thursday.

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

All right. Okay, so we'll take a boat. All in favor?

Multiple speakers

Aye.

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

Okay. Opposed or abstain? Okay, so the Co-Chairs will reedit and you can submit your comments that you made in this...in public to them to help them with that and then we'll redistribute a redline and solicit your e-mail final approval.

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

Paul, can I just ask that the comments come to me and then we'll aggregate everything?

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

That's fine.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you.

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

Perfect. One proc...and now we're open for public comment.

Public Comment

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

If there's anyone in the room that would like to make a comment, please come up to the table. As a reminder, there are 3 minutes for public comment. And while you get ready, we'll open it up for the operator.

Alan Merritt – Web Specialist, Digital Communications Services – Altarum Institute

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

Koryn Rubin, MHSA – Assistant Director, Federal Affairs – American Medical Association

Thank you for the opportunity to comment. I'm Koryn Rubin from the American Medical Association. As you are aware, the AMA has been deeply engaged and involved in quality measure development and educating physicians on reporting. Therefore we are concerned with the lack of transparency and engagement from ONC and CMS around on the development of clinical quality measures for Stage 3 Meaningful Use and reaching out to stakeholders to learn where the pain points are. We echo concerns with resolving underlying challenges with reporting quality measures before recommending more advanced measures and ONC focusing its energy on innovation pathway.

Keep in mind; many of the proposed new measures assume interoperability and the advanced stages of Meaningful Use are seamlessly in place. Therefore it is incumbent that before any of these measures go forward, that there is real world testing in multiple types of physician practice settings and sizes to ensure the EHR can capture and calculate the measures without putting an undue burden on physicians and the standards are put in place. The AMA has currently completed a pilot project to learn where the issues are with care coordination and closing the referral loop. With this project, we have learned that the current vendor systems do not have any functionality to facilitate sharing of patient information, only the ability to request a referral. This is leading to extensive customization and cost within each vendor system for a function that should be considered a standard operating practice, since it occurs thousands of times a day. Thank you. And we'd welcome the opportunity discuss the referral issues more.

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

Does anyone else in the room have a comment? And it looks like there is no one on the line.

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

Okay. We are really pretty much on time, if I could beg your indulgence for 60 seconds, just wanted to do a process check. Putting together the agenda and the time is an art and....that Michelle manages and I wanted to get your sense for the substantive...for the substance of the content of the presentation and the time allotted for the discussion. Good? This is appropriate?

M

It's good.

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

Okay, good. Congratulations, Michelle. Thank you. Okay, so now we will break for lunch and we'll resume at 1:30 PM. Thank you.

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

If everyone could take their seats, we're going to get started. Welcome back everyone; I think we're ready to get started again. Ready, Paul?

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

Yup. Welcome back and we're going to start out...we have two more workgroup reports to go through, both of which are seeking approval of their recommendations. The first is the FDASIA report review. As you know, the tri-agencies put out a report rece...and we're providing feedback from the HIT Policy Committee. And David Bates is chairing that group and David has a report.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Thanks very much. It’s my pleasure to report on behalf of the Safety Task Force. These are the Task Force members. I served as Chair of this group; we had a really diverse group and a lot of useful discussion. We had six meetings, in the first one we basically went through introductions and got our charge. In the next meeting we decided who we would want to hear from, we then had a number of presentations from outside organizations, including the National Transportation Safety Board, from AHRQ about their PSO program and common formats for safety reporting.

We heard from Jeanie Scott, who runs the VA HIT Safety Center, which analyzes a safety-related events within the VA. We heard from Ronni Solomon from ECRI who...and ECRI has established what they call The Partnership for HIT Patient Safety, which is a PSO that’s focused on patient safety. And in the next meeting we heard from EHRA and then from ASIAs, which is another aviation safety agency, which uses data to identify risks and issues before accidents occur and then we came up with our recommendations.

So, our charge was to respond to the FDASIA Health IT Report and to provide recommendations specifically about the HIT Safety Center, we were asked to focus in that area. And asked to consider in particular what governance structure the Safety Center might have and what functions it might have for it to serve as a central point for a learning environment to complement existing systems to facilitate reporting. And then to promote transparent sharing of things that go wrong, adverse events, near misses, errors, and then also to share lessons learned and best practices. We were asked to consider the 3Es, which are engagement, bringing stakeholders to the table, evidence and then education, moving data to information to knowledge that fosters improvement.

The testimony was really helpful. The NTSB has a governance structure, which may provide some lessons for the Safety Center going forward. It seems likely that the AHRQ PSO program and in particular the common formats may be something, which will be very helpful to the Safety Center. At AHRQ they already have a...basically a network of PSOs so data can come in from multiple organizations. So far though, there are not much data coming in, hopefully that will change. But as of now, the data that are there are limited. The report from ECRI illustrated how PSO can target this specific areas, most PSOs target safety issues really broadly.

The group found the ASIAs model relevant. I think many of us knew NTSB better than ASIAs, but what ASIAs does is they nationally aggregate the safety data from individual airlines. They look at multiple data streams and bring the data together. They are very much data-driven; there are multiple institutions, which have voluntarily shared. The approach is non-punitive and its used for safety purposes only and they are viewed by the industry as a trusted third partner and they have deep technical expertise.

From the governance perspective, we thought that there were a number of things that might be helpful around thinking about setting up the Safety Center, in particular, they elected to start small with interested organizations and providers, but gradually, essentially everyone came in. They now include 98% of the industry, even though they started with basically people who were willing to work out some of the kinks. They picked a few manageable problems. One example of a health IT issue is the wrong patient in computer order entry. Every hospital, in particular, ends up with this problem. Sometimes you think you're writing the order on one person and it ends up being on somebody else. But no one has really completely solved that. It was clear that there's some conflict between being inclusive and then actually getting things done, which is true for any organization like this. They have a large board, which is very inclusive. It includes all the 50 major players in the airline industry plus a number of other stakeholders from other niches. But they also have an executive to actually make decisions.

So, our charge was to really to address these four key issues. We were asked to think about the value proposition for the Safety Center, the governance issues around the center, issues with what the center should focus on and then what its functions should be. So from the value proposition perspective, we thought that there were sort of four main themes, that the Safety Center will be a place to analyze data from different sources and then to disseminate best practices. It also pretty clearly has to provide value and improve safety at a national scale. It will have to have some defined products and it ought to offer services that foster stakeholders in the health care system to feel a vested interest in HIT safety.

From a governance perspective, we believe the Safety Center should be a public/private partnership. It should be outside of government but resourced, at least in part by ONC, although having some private funding would also be desirable. It will need a clearly defined mission with related priorities. We felt that it should avoid duplication of existing activities and try and complement safety activities in the public and private sectors. We did look to other industries for examples of successes and their governance models. And as I mentioned before, ASIAs and the NTSB programs are example of current aviation safety programs and investigative systems, which have some parallels to what's being imagined here.

We think that starting with the small group of vendors and providers and then building from there would be an attractive approach. With respect to the board, you could have a large board, which is very inclusive, which is probably what you want to do eventually. But you would also need an executive board, which would have 10-12 members, which would do the decision-making. We believe there should be both institutional and individual members. We think it's important that there be patient representation, probably from a consumer organization.

A number of stakeholders felt it was also important to have representation from key leaders, like those we heard from earlier today, who are dealing with this on a regular basis, like CIOs, CMIOs, CNIOs. There was a strong sentiment in the group that this should be...the agenda should be driven by frontline provider concerns, which are really the burning platform in this area and multiple disciplines are involved here. Nurses have some different issues; physicians and pharmacists and so on. We suggested that the goal be to grow the organization and then redesign the governance structure, 18 to 24 months in. You could thus just start with a smaller board and then work from there.

Issues that came up are that consumers, both healthcare providers and patients, expect systems that they used to be safe but as we know, there have been issues that have emerged. We felt like some of the safety partnership activities do provide some valuable lessons. An example would be the partnership for promoting health IT safety, which facilitates providers, PSOs, medical societies and vendors to come together to address safety issues using existing safety data.

From the challenge perspective, one issue is that we'd like to have incentives for reporting events. And another challenge is to be able to identify HIT related events. Sometimes even the person who's reporting isn't sure whether the event that they're reporting occurred because of an HIT related issue or not.

With respect to focus, there was very strong sentiment that the center should address all types of HIT and not just electronic health records. In today's world, all sorts of HIT is coming together. The focus should be learning and not enforcement. We spent a lot of time discussing the fact you have to consider sociotechnical issues, as well as technical. In fact, if you look at most of the problems that occur, they're not technical, they're much more sociotechnical.

Again, there was strong sentiment that the center needs to incorporate a variety of data streams and not just at adverse event reports. We'd have to include, for example, near misses, hazard reports and a variety of different inputs. It should rely on evidence when possible although evidence in this area is often limited. Again, should include multiple disciplines and it should cover both broad trends and that should be the main focus. But less often, there can also be learnings from serious individual events.

With respect to the key functions, we felt that there were four broad areas. The first is engagement of the key stakeholders and they are stakeholders from...really from across the industry. Analysis is the second one, so this aggregation of data streams of multiple types. And I'll say some more about PSOs later, there was some sentiment within the group that we spent too much time talking about PSOs and other sources of data will be much more important than PSO data.

There's clearly a convening function, which would involve identification of best practices. And then there are...there's a very big education and dissemination role. And that would include education and dissemination to vendors, to providers and health systems, to frontline reporters. For example, helping them decide what to report by putting forward some best practices and by getting them used to using some definitions and tools to standardize reporting like the common formats.

There were a number of things, which the center might be involved in, but it might also not. So for example, the usability role, if any, would have to be defined, we discussed that usability could become part of a certification. User centered design is already part of certification. There was strong sentiment that there should be two-way learning between the Safety Center and the certification program because there are issues that come up in certification that would be of value of the safety center and vice versa.

The roll in post-implementation testing, if any, would need to be defined. There is pretty strong evidence that there's a lot of customization that goes on at individual organizations. And it's not just which vendor product you pick, but really it's very important how you actually implement it. One potential function of the center could be as a clearinghouse for safety-related rules, there was some support for that. And clearly, the center should promote the use of guidelines and best practices. There are a number of these but one good example is the SAFER guidelines, which are a set of guidelines that were commissioned by ONC, which help organizations try and implement HIT more safely.

From the data sources perspective, again we talked a lot about how useful are the data from PSOs versus everything else. PSOs do have this major advantage that they have legal protections, but they represent a very small proportion of the global universe, so there are both pros and cons. And vendors have large amounts of data, which could be very useful to the Safety Center if they're willing to share it. Just this week there was an interesting report from...I think it's from General Motors about their OnStar data. And they have a very large supply of data, which they were not really effectively using to improve safety, but they might. Providers also have large amounts of data about safety-related issues, so people are reporting about problems that they encounter with systems all the time that includes hospitals, clinicians of all types and the networks. And patients could also be a data source and there are certainly others.

With respect to dissemination function, we believe that the center should regularly report to involve stakeholders. This might involve a monthly report or a quarterly report basically updating people about what the key safety issues appeared to be. Again the main area of focus would be broad trends and not so much individual events, unless there was some very specific learning from an individual event. The key target groups obviously would vary, depending on the specific issue that was involved. But the notion is that we would...that the center would be very transparent about what's going on and what its findings are and recommendations.

Another area that we talked about at some length is whether or not the center should perform independent investigations of specific events itself. ONC does not have a legal mandate to do investigations and the Safety Center would be outside of ONC. But it could...even if it did not do investigations, it could partner with others for example, PSOs that do do investigations. We noted that Safety Centers in other industries do do many investigations. So for example, NTSB essentially exclusively does, that's really their primary role. If the Safety Center were to engage in this, it would have to be on a voluntary basis and it might not do any at all.

There was consensus that the Safety Center should not be regulatory. It should not make policy; it should not develop standards itself. It might identify a domain where there is a need for additional standards, however. Again, the Safety Center might not have the legal protection of PSOs and yet would need to maintain a transparency.

Some things to avoid would be interrupting the strong relationships, which already exists between clients, and vendors in which a lot of safety information is coming in that helps vendors improve the safety of their systems. Also important to avoid duplication with existing efforts and also to avoid assuming that reporters can necessarily define themselves, whether an incident is HIT related or not, it's often very hard to tell.

In conclusion, we believe that the Safety Center has the potential to deliver substantial value to the country. It will need adequate resources. It should be supported longitudinally, as the problem with safety issues around HIT are not going to go away anytime soon. It will be critical for the center to engage the key stakeholders effectively and everybody has to feel like they are getting something from it. So the vendors, for example, have to feel that there's value added to them to participate in the center. And again, the key functions will be engagement analysis, as we've discussed, convening and then education and dissemination. And I will stop there and take questions.

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

Great. Thank you, David. Questions from committee members? Tom?

Thomas W. Greig, MD, MPH – Chief Medical Information Officer – Department of Defense

Yes, really nice. I can tell you the DoD and particularly the Army runs a safety function very analogous to the NTSB and it's been very effective in addressing safety issues Army-wide. And so my point is just that I think your track and you're spot on, I think that this would be a very fruitful way to disseminate and look at issues in a way that's non-punitive.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Thank you.

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

Gayle?

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

Thank you, Paul. I have several questions. We have tried to establish similar kinds of safety in a general medical arena dealing with liability issues and things of that sort in Florida and truly have not been terribly successful in doing it. My first question deals with funding, how do you envision this being funded?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Well, as I described, we think it would be des...it would be best for the center to have some federal support, there's actually already some money in the budget to support the center at a level, which I think would likely be adequate. But we said...we noted that it would be desirable for it to have some private funding, which would come from industry.

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

And secondly, how do you address liability issues? Especially if you're going to start talking about, and really get down to the nitty-gritty of what's happening and where things are going wrong and how you make improvements. How do you deal with the tremendous liability issues from vendors, from providers, from a variety of people?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Right. So most of what is presented would be broad trends and not issues which are individually discoverable, so there would have to be sufficient blinding so that it's not obvious which individual cases you are dealing with. And actually, most of the issues that come up are issues across multiple vendors. It's not that, for example, one vendor has a major issue with some specific problem; there are things that everyone has struggled with. And we did spend some time talking about this, especially the...so the PSO discussion that I alluded to is relevant here.

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

And a follow-up on that, if I may. Do you think you can really get down to root cause analysis and find out what is truly happening from a broad trend perspective without some kind of either confidentiality or immunity or...that would allow people to speak very openly and frankly about truly what is happening out there?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Yes, I think we’d largely would be using root cause analyses that are done by others. And there are...around the country, there’s a huge array of work around that that’s being done.

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

So you really envision this as an aggregation then of other groups that are doing investigations and pulling together that kind of information? I still don’t have a total perspective on exactly what this group would be doing, are you going to pull from other groups around or...I’m still not totally understanding what...where the information is going to come from and how you’re going to do this.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Right. So there’s a huge amount of information already in a variety of places. The PSOs already have a great deal of information. Vendors already get very large numbers of reports of safety related issues, providers get reports, and the notion would be to work with all those groups and to bring in data from...really from multiple perspectives. So...but a large part of the hard work would be synthesizing that and trying to convert it into some sort of meaningful picture. Now, in other industries, that’s worked effectively, so that’s the sort of thing that ASIAs does today.

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

And then your goal would be to make recommendations to ONC, to CMS or what’s the ultimate goal?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

So the recommendations actually would not be so much to CMS or ONC, it would really be to be key stakeholders who are the actual users, that’s largely the vendor and provider and patient communities.

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

Thank you.

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

Christine?

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

Thanks David, this is really a thoughtful piece of work. So, I had a question and then a comment. You mentioned that the Safety Center should work with all kinds of health IT, not just EHRs. And I’m wondering if you think...or if you could give some examples and if you think that includes like say for example, a health app that a consumer might use the VDT function to upload data into or...what’s the kind of spectrum of IT that it would cover?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

So that’s exactly the kind of thing that we were thinking about. I think increasing it will be a diabetes monitor from which you’re uploading data or data that are coming in through a health information exchange and you’re trying to make sense of those. They’re will clearly be new safety-related issues that come up as we do more of that or an IV pump or any of the things like that.

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

I just want to reinforce and say thank you for including consumers as a data source as well, in being able to report problems because they see them often very quickly. So my comment is, and I can give you more off-line if you’d like, but it’s around governance and consumer engagement in governance. We’ve spent some time studying what works, best practices in the field, and there are a couple of key things that I would just mention to you.

One is that you have more than one consumer representative, whether it’s an organization or an individual, because often times, especially in the technical field right, we’re going to be sitting in a room full of clinicians or technical experts. So, having more than one consumer is really actually important also because you need a diversity of consumer viewpoints themselves. And to have them involved early. So I would just ask that you maybe think about...I understand that it makes sense to focus on vendors and providers in the early governance structure, but I’m not sure there’s a reason not to have consumer representatives at that stage because it will be more helpful for them to shape the process early on in collaboration, I think, with you.

And then just the last thing that I would say is, I completely understand why you say likely from a consumer organization, because it’s a very technical field and you need someone who has the bandwidth, i.e. has a day job, and can sit at those tables. But I think...I don’t think you need to worry about describing the type in a constrained way at this point. It’s a best practice that you actually have consumer organization representatives, as well as individual patients and families, where you can because they bring two different things to the table, so the more the merrier, I think. But those two different types are important and I think there actually are a number of individual consumer representatives in the IT space who would and could be helpful here based on their experiences. So, thank you, again.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Thank you.

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

Neal?

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

Thank you. First, just a reflection, so, it was November 1999, the IOM published that to err is human, 15 years later we’re talking about the errors that computers make can hurt humans, so it’s kind of interesting bookends. A quick question, so was there a question whether to create a center or not or did that...was that the Task Force was? Or was the Task Force to say, there will be a center and here are the functions and the value proposition?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

It was really the latter, so the...but there was strong consensus that such a center would be valuable to the industry and to consumers and to the country at large.

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

Was there discussion, I mean, we have the FDA and they have a very defined role for safety in a broad set of our society, across food and much of healthcare. So our organization voluntarily reports errors to the FDA, there’s already...I mean, there’s a current, in place process, but I think we’re the only ones that do. I don’t know why we aren’t more asking of transparency. I mean because safety...this is as important of a subject as you can get, it kind of launched this whole thing. It was around the hum...the errors that the humans made so we...so I don’t know, I’m for much more transparency here with current mechanisms, as far as reporting these errors. Healthcare providers do it routinely around medical devices, I mean there’s...so...and there’s a lot of sensitivity in my industry of being called medical device, because of a whole bunch of other things. But in this space, I think we should be all reporting near misses.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

I agree with you...

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

I don’t know why we’re not...

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

...about the need for transparency. As you’ve noted, the industry has not been terribly forthcoming.

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

Not all the industry, but the mechanism is there.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Right.

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

We could change this quickly.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

And I don’t, Paul, if you would like to make any more comments about how the...

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

...ONC...both David and I served on the IOM EHR Safety Committee and I think we...so I think we agree with you totally on the need for transparency. And I think what we were faced with is despite the mechanism that exists, it's not happening and so we tried to figure out...the IOM committee put forth some recommendations to try to address that problem. There was, I will say this about that, I mean there was sensitivity about the FDA, some based on past regulatory efforts...in blood banking software and just whether this was a new area for the FDA, the HIT safety. So I'm just...well, I'm not giving any personal opinion, I'm just saying those are some of the discussions as the IOM presented its recommendations.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

And there...

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

We're an industry that's been funded by our...the taxpayers of this country, \$24 billion invested. We already have current structures and processes in place. The fact that our industry is...and I'm saying we voluntarily report every incident. Every instance that hits the thresholds we internally report all of them and they already exist. So why would we go create another...I mean, there may be a need for a center that really focuses on IT, but why wouldn't we be saying to our...my industry, report misses and near misses?

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

If I can jump in for second, so, I think, I mean I think it's a valid point and I think that that is something we could talk with the FDA about. We were looking at...so we had worked with the FDA and the Federal Communications Commission to develop a proposed framework for risk-based regulatory framework for protecting safety and promoting innovation for health IT. The Safety Center was something that was put forward in that draft report. We did see comment for 90 days, but the comment period just closed yesterday, I believe. And so we had asked the Policy Committee to give us some feedback specifically on the Safety Center.

Now the point of the Safety Center, when we did propose it, was to be able to, and I think David has represented this, to be able to pull in data from various sources. So I think the point of encouraging more reporting of adverse events or near misses, I think is really critical for the Safety Center to be able to have good information. There are a variety of different places where information is being reported and to be able to see trends and to see where there may be issues, not just with the software itself, but also the implementation and use of the software. The thought was to have a place where the various stakeholders can come together to work through some of those issues and come up with some best practices.

And that's what this workgroup...this Task Force was looking at. That said, encouraging...there are also providers that are not necessarily working with a PSO and trying to encourage more reporting of events or near misses across the board I think is critical so we do have good data.

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

It's an important subject, there are current mechanisms, there may be a need for a center. If we think it's an important subject, we should basically send strong messages to the HIT industry that they should be voluntarily re...they should be reporting to MedWatch, which is...and get over the fear of somebody's going to call it a medical device.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

I think there was strong consensus in this group that the best place for the Safety Center was really not in the FDA, which is primarily a regulatory organization. And that there would be a substantial benefit to the public again from having an entity that is separate.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

And if I may say one other thing, we do have an MOU now with FDA to share bet...information with them about safety events in health IT as well as some policy issues that still leaves open the points about not having...

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

We're the only company reporting in there...

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

Yeah, maybe I'll just add one more...just be...so part of the IOM recommendations, the NTSB was seen, as David reviewed in his workgroup, had a good function of being funded, is federally funded, yet being independent of any regulatory...so they...any regulatory agency. So they can only do investigations and formulate conclusions and recommendations, but don't have any enforcement powers. That turned out to be a big asset in terms of how it promoted people reporting and getting benefit from that. That's one of the...that's part of the thought process that went into the recommendations, just to give you a little context to that.

Let's see, I think Gayle?

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

Yes, I'm going to have to have another little follow-up because I'm still not...I certainly value and understand the need for transparency and safety in this whole discussion on safety. If we're putting public dollars into something, and that's why I asked specifically on the funding, if you see this as a funding from the federal government, then you have to have oversight of those dollars. Who is going to...who is...are we establishing basically another bureaucracy that is going to be out there spending federal dollars? And we...who are they going to report to? Are they going to be ONC? Are they going to be under FDA? What is...what are we as the public going to get out of those dollars we're putting into it? And who has oversight to make sure that we're getting that benefit from it?

Certainly convening and bringing stakeholders together and things of that sort in a nonprofit kind of arena is very, very valuable, but when you put funding into it...federal funding into it, then you're raising things to another level where public dollars are being expended and we want to know who has oversight? Who is going to see that we are getting the bang for our buck out of that?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Right, so I think this would be analogous to the situation for the NTSB or ASIAs, which are...have...which are both public/private partnerships. Most of their support comes from the federal government, but they sit outside of the federal government and they have an oversight function.

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

Would they be under the purview of ONC?

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

So that’s what was put forward in the draft report that ONC would be the ones who would sponsor the Safety Center in collaboration with the private sector. So...and we would work with other federal partners, we’d work with AHRQ, we’d work with FDA...

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

So the ultimate buck stops here then at ONC?

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Correct.

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

...according to the report.

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

...that the FAA manages the ASIAs program that David was talking about. So the FAA funds a lot of the ASIAs program and yet it’s run autonomously with that governance board that has other stakeholders involved. So that the FAA is where the buck stops, to your point, and yet this organization isn’t constrained by the federal processes, has much more autonomy, has the governance and the engagement of the industry that we think is a model that needs to be recognized.

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

I mean certainly I’d say this is a public good, right, the protection of public safety?

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

Oh, public safety is extremely important and especially in a new arena where we’ve really not had the collaboration and discussion on it in the HIT arena. So I think it’s very valid from that perspective, but I think if you lay something out and start a new endeavor that’s going to receive public funds, you want to make sure that you have...you know exactly where the responsibilities are. Who does the appointments, how the thing is established and the ultimate public good that we’re going to get from it is worth what we’re going to spend on it.

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

...Troy?

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

Thank you. David, do you know if there was any an exploration into the Joint Commission Sentinel Even process...reporting process?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

We did talk about the Joint Commission process relatively briefly, but that did come up.

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

Because it seems a viable option to me, I mean, they are collecting the data, they do have a database, a Sentinel Event database. They’re nonprofit, they are actively looking at the certification of hospitals...

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

So that would be another source of input, but the things that are reported to that database are really a tiny fraction of what this group really would be interested in.

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

Right, right, but I’m just saying, I mean they have a structure in place, they’re already an entity that providers are reporting to in the event of a sentinel event or even a near miss, I mean, for that matter. So I’m just curious as to why we’re re-creating the wheel when there’s already an entity out there that notoriously causes a lot of heartache in the facilities already, I mean it could just be part of the...an additional layer to what they do.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Well, with respect, I think that their function is somewhat different than what we’re talking about having the Safety Center do.

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

In regards to sentinel event reporting or in regards to certification?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

So the things that are considered sentinel events are deaths related to medications, they are cutting off the wrong appendage, they’re things that are really mostly the never events and those are a very, very tiny fractions of all of the harm that occurs in this country. And so, they do not get the vast majority of the issues that this center would be interested in.

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

Hmm, okay.

Jodi Daniel, JD, MPH – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

I was going to make one point. We do...currently ONC has a contract with the Joint Commission right now where we are having them look at their database of these serious adverse events and to help us to understand where there might be a health IT related...where health IT may be related to those events and to give us some feedback on what they found based on the data they have. Again I agree with David, it is a limited set of information, it's certain types of events and it's mostly from the...it's the impatient data, so it's not getting in the ambulatory side either.

There are many different organizations out there that are doing similar kinds of work and I think that there's an opportunity to build on what some of these organizations are doing. I don't think we're looking to create something that would be separate from what's already existing. There are lots of PSOs that are taking initiative in this space. There are some patient safety organizations, groups like nonprofit patient safety groups, there's the Joint Commission, there are lots of different players in this space. And the hope would be to kind of be a place to convene and to bring together that...those different varied data sources. So that we can see trends across different products, across different types of providers, across different parts of the country, to be able to start getting a handle on where there might be opportunities to mitigate risk and to improve on safety.

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

Another one that comes to mind as well is the IHI, I think Don Berwick would just love to be petitioned for his input on how the IHI could actually look into this...

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

I was just asking Paul if the workgroup and I'll ask David. If the workgroup had this discussion about whether...so given that you think the work is important, the housing of the work whether it's a new tax ID entity or if it's folded into some existing efforts that are underway or is that further to be discussed or decided?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

Yeah, we thought it would probably make sense to embed it with some existing not-for-profit and that it would make sense to use one of the mechanisms to put this out for bid and to set it up that way.

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

Also just to comment on JCA...Joint Commission. I mean the non-punitive nature was a really high priority and so both the FDA and the Joint have enforcement powers that...so we're trying to encourage as much reporting as possible. Again, that's just the thinking behind some of the recommendations. I think I had Chris and then Terry.

Christoph U. Lehmann, MD, FACMI, FAAP – Director, Clinical Information Technology – Johns Hopkins Children’s Medical and Surgical Center; AMIA

David, an excellent report, very thought-provoking. There are a couple of minor things that I would like to tease out, one of the things is that what makes patients vulnerable in the system is also often times what makes them vulnerable to HIT errors. So I would...was wondering if this is going to be one of the areas that this institute would focus on?

The other question that I have is, have you thought about the necessary power...manpower for an analytics arm of this because I think this seems to be the main function of this institute. And then lastly, gathering knowledge is only as good as turning it over and closing the loop and bringing this back into the action. How do you...an institute like this, assure that if there was a specific harm that was found related to design feature or a user interface problem, that this would be closed with the vendors and the hospitals that have the systems implemented and turn knowledge actually into safety?

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

So, good questions. On the vulnerability point, that would certainly be one of the roles of the center and it’s clear, for example, that if patients have English as a second language or other issues that they’re more vulnerable, we did not. In terms of manpower for the analytics, we did not do a formal analysis, we did do some benchmarking with, for example, the number of people that are in some of the other areas in the industry and...but did not, elected not to include a formal estimate in our recommendations. On the closing of loops front, this entity would largely have a dissemination and it would not have a regulatory function. So it would not be able to, for example, ensure that loops were closed, I think that would have to be handled by someone else, if there were...if specific issues were identified that, for example, represented a major safety issue, someone with regulatory authority like the FDA.

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

Terry?

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

I want to support this conceptually, the details of it...the devils in the details. But I really want to comment on the belief that other people are doing this because from the VA position, I don’t think that that’s true. So we’re actively involved with Joint Commission, we’re actively involved with IHI, we actually have a National Patient Safety Center, David’s very familiar with this. And we, despite having all that, we have a group that just does health informatics patient safety and what we’ve seen, and I’m sure David is aware of this, is two fairly sentinel articles that were published from that group, one specifically on mobile applications and the need for what you need to look at. The other one looking at all our misses and what we did to correct them and we’ve always been pretty transparent about patient safety.

I don’t believe that if we hadn’t had that group stood up, we would have identified those and we would not have identified that they were substantial and due to problems in the health IT system. Many of which are due to business process change, as we know, so it’s not necessarily health IT, it’s what happens when it gets implemented. So I do believe this area is ripe to have people inform it. We know from anecdotal reports that a lot of the vendors aren’t appropriately sharing this information and/or they’re saying, you’re under gag order so you can’t share it. And we really need to get ahead of it, especially as we move into other spaces.

The one area, David, that I'm unclear about the overlap is the biomedical devices because we know biomedical devices are biomed as well as health IT, especially if they're informing the health IT system. So that seems to me a vagary area, who's going to do what there and we want to make sure that especially in terms of certification, we clarify that. But, I think this is a huge need and I am grateful that you did this work.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

No, thanks. The VA center was certainly a model and Jeanie Scott served on our group. And from the devices perspective, I think it...that is one of the instances in which things do get blurry. Increasingly these devices will be integrated with our broader IT systems and that, I think, would be where the Safety Center would have a role. The FDA would continue to have its role in terms of regulation of devices in general.

But it's just...it's becoming increasingly confusing to say exactly where the boundaries are when you have dozens of devices all integrated with your network, which are supplying information. And we expect that some of the safety problems in the future will happen when some of those devices send things in and you get conflicting information and something gets changed and when that happens, it's hard to sort out exactly where the issue was. And the FDA itself has struggled with figuring out how it should manage issues like that.

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

Troy, your card from the earlier question or...

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

Yeah.

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

Is it...okay. Any other comments, Judy?

Judy Murphy, RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

Yeah, Judy Murphy. If we've got time, as long as we do. We've been talking a fair amount about the way we would classify or group the different kinds of activities or errors or potential errors or adverse events. I don't think you referenced any discussion that the Safety Center would put together a classification or a coding schema, so I was just kind of curious if you had conversation about that.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women's Hospital & Partners

No, we did talk about that some and to the extent possible, we would hope that the Safety Center would reference some of the existing classification approaches. But some of those need to be improved and modified and fleshed out and so I think it would definitely have a role there. Clearly...

Judy Murphy, RN, FACMI, FHIMSS, FAAN - Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology

...multiples again.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Yeah, exactly. And having a good classification approach is very valuable in terms of thinking about how common things are and what you should do.

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

Okay, any more questions? So this is in need of a vote. So there’s a series of recommendations on governance and functions that have been laid out and are looking for a vote of approval of the recommendations from the Task Force. Any motion to that effect?

(Indiscernible)

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

One? Okay, and second? Any further discussion? And all in favor?

Multiple speakers

Aye.

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

Any opposed or abstained? Let’s...okay, motion passes. Thanks very much, David.

David Bates, MD, MSc, FACMI – Senior Vice President for Quality and Safety, Chief Quality Officer – Brigham & Women’s Hospital & Partners

Thank you.

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

Our final workgroup report out is from the Certification and Adoption Workgroup and we’re talking about workforce and classification of such.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So this should be a fun wrap-up for today because workforce is at the core of everything we do and I don’t think it’s going to be too controversial what we’re recommending.

W

Don’t say that...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Never say that, I’m inviting...I guess I’m inviting the storm gods. So, before it get too far into this, let me see if Norma could make it on, I think she’s having violent weather.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

I'm here, Larry. Thank you. Out of the storm shelter.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Oh, that's great. So, hopefully we won't channel that energy into this room. I should begin with a word of thanks to my Co-Chair, who's been really instrumental in pulling this work together, particularly on a lot of that training program stuff that we'll go over. And also to Chitra Mohla, who's been the ONC support person with this workgroup, who's just been tireless in keeping us on track. And you'll see, as we get into some of the folks we've heard from, it's quite a long list of folks that she had to corral for us. So, it's really been a great discussion we've had going on over really a couple of years now with some things that we've focused on. So this is the final update to the committee and a couple of final recommendations.

Okay, so we were here about a year ago and gave you a status update on several ONC programs, so this is a final report out. So the little color bar at the top of the screen is sort of telling you where we wound up. We recommended that many of the workforce development programs should be summarized so that people would know what happened and that did happen. And we give you some links to some of the write ups on that activity. Generally, very, very positive things happened, people got trained, they acquired skills that they said was helpful in the workplace and we have been seeing some continued work with that material.

ONC also funded programs around core competencies and these were developed and also publicized and we give you some links to those. I should point out that one of the issues with these is they were built in the era of Meaningful Use 1 and so some of the programs were very focused on MU1 requirements and we've moved on. So, it would be useful to continue updating these as we move ahead and to look at possible funding sources that keep these current.

Where are we going? So we were recommending that new programs address new needs and we heard from a bunch of folks. So there's a long list of the different groups that we heard from, ranging from people who do direct care as well as unpaid caregivers, families, and friends who sort of make it all happen for people. Different dynamics in rural or long-term-care settings, we heard from physician groups and their experience with EHRs and their need for sort of hands-on support. We heard a lot about some of the work Department of Labor is doing, as well as what many of the associations are doing and some other aspects of the federal government.

So some highlights of what we heard. That we have an opportunity to really create a comprehensive framework, career framework. That there's been some work on this in the UK, so supportive of ONC's international efforts to learn from what others are doing around the globe, so good work happening in the UK, often some lovely use of language. So it stretches our understanding of the English language by working with them as well. We continue to look at things like curriculum development, assessment models, competencies, veterans related activities.

One of the things that came up that we'll be making further comment on apprenticeship programs. We have a lot of anecdotal experience, those of us who are in the healthcare space of a lot happens on the job. We bring in a new system, we do training for folks, somebody surfaces as seemingly a great adopter of the technology and they get identified as the super-user and suddenly they have all kinds of new roles and responsibilities. So there's value in actually formalizing that around apprenticeship program, as a way to bring people in. It was one of the learnings from the training programs, both the community college and the college-based programs that are really helping able get on-the-job experience is a really powerful thing. We also wanted to support the CMS innovation activities as another place in which workforce development can be supported.

And finally come back to a theme that the workgroup named earlier about that the family and other caregivers really constitute the largest workforce and we don't usually think of them as workforce. But a lot of the training needs that the workforce has around use of health IT is health literacy, would apply to these folks as well. And so it makes sense to think about, as organizations develop staff training programs and start to do work on patient and family engagement, that some of those training programs actually might work very well for patients and other caregivers.

Some new things that have sort of finally happened that there was a release in the Federal Register back in May with a deadline in a couple of weeks from now from the Department of Labor looking for an update to Standard Occupational Codes. So we had recommended that ONC take this on and convene some activity, which has in fact happened. So here's sort of the update on that activity, complete with a new recommendation.

The simple cut to the chase piece is that there are a lot of occupational codes that are healthcare focused and a lot that are computer and math focused. So all the healthcare ones are the things that typically happen among healthcare providers and all of the direct support staff for that and the computer and math ones, the ones that happen on the computer and IT side. But there really wasn't a good home for informatics and that seemed to us to be one of those highly leveraged skill sets, training areas that really should get more attention. And so we were looking to that, to the update to the Standard Occupational Codes to specifically address a wide range of health informatics and then asking this committee to support that as a recommendation. Recommend up to ONC and then recommend onto the Department of Labor that we have a new classification created.

So on the left-hand side of the screen, we have the framework that is required to do a formal proposal. And we're not asking this committee to do that. We do have a spinoff of the workgroup that has been doing that and a variety of associations that will be submitting a formal recommendation through the SOC process. But we felt that maybe some interagency coordination would be helpful here. So we have a draft working definition that came out of the workgroup looking at health informatics as a healthcare occupation.

So, we're thinking about this as healthcare, even though the closest neighbor to this really is the existing HIM classification and that was put in math and computer applications, which to us seemed a little bit odd. But we're close to this and maybe there were reasons it this was put there. So we see it as a healthcare occupation where workers are the applying the science of use of data, information and knowledge in support of safe and effective delivery of healthcare to improve health and wellness. So we further look at interdisciplinary knowledge, skills and tools to enable this, the use of the information, its management and sharing it to support delivery and health.

So here are some examples of what we're looking at that would wind up in the formal material that's going to be going separately to the SOC process. So we're looking broadly at things that go under the heading of clinical health IT or informatics, the nursing informatics, medical informatics, dental informatics, pharmacy informatics and lab informatics, so sort of that whole, broad, informatics heading. The areas of health informatics, health...and information management, health IT systems support, so not on the tech side of system support, but really on the healthcare side of, what do you need to do to make these systems work? Some of the public health aspects, biomedical, analytics and consumer health, so pretty broad range of specialty areas and a pretty wide range of job titles. I think that's the last of these slides...yeah. So, we'll come back at the end to get your thoughts about this, but looking for a recommendation out of this committee to go ahead and say, yeah, there really should be something in that gap.

And finally some new recommendations and so this is really about the continuing importance of workforce development. And I'll go flash on a current bestseller, so we have a 10-year plan put forward from ONC about where we are going and there are many references in that to the needs of workforce and workforce development. And also sort of the latest, hopping on the current news, the JASON Report, which many of us are looking at also is looking to have skilled workers to be able to move forward in this area.

So our first recommendation on this is that in the new workgroup structure that ONC is setting up, that there is a home for this particular sub-workgroup in some form. And that it probably becomes a part of health IT implementation, because in order to implement something, you need the workforce to do it with. We further look to ONC to continue to work with other federal agencies, because this is a continuing need and isn't going to end just when this workgroup ends or gets reformed. And finally that ONC continue its work and possibly expand its work in a few key areas, the development of a career framework. That the resources to be used for workforce development continue to be curated and updated and maintained in some places. And the earlier links give examples of where that's being done today. That the competency model continue to be updated as we learn more and as the environment moves along. And that we look at new training models and that we look to further extend training opportunities to family and caregivers. I think that's it.

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

So thanks, Larry. I wonder if you could clarify, some of the slides you marked as current status and then some you have marked as new recommend...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

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

Can you clarify what recommendations you would like considered by the committee?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure.

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

And to whom is it going to and where would the funding come from?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sorry, we did not bring a bag of cash to the table. So, I'll start with beginning. So these three recommendations are new and the other one is a hybrid. So one of the old things was we recommended that ONC participate in this SOC process and then this describes what we did and has a request that this committee pass on a recommendation to ONC in support of an SOC framework...update to SOC to include health informatics.

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

That the committee ask ONC to participate in this SOC...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

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

...update process. Are you already doing this?

W

Yes.

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

So...okay, and then the last...

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay. And...the last three are...

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

The first one you're saying continue this work and you recommend the Implementation Workgroup...the new Implementation Workgroup, that ONC work with its federal partners to make sure we have this workforce. They don't have any more money to do that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

But in their role of coordination.

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

In the role of coordination.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And there also...potentially there's funding in other areas. So the Department of Labor does a lot of training and supports a lot of programs and so it may be that the funding is through Department of Labor, for like their apprenticeship partnership program that is currently funding apprenticeships and development of apprenticeship programs. So there could be funding opportunities in other parts of the government.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Larry, thank you guys for all of this and, it's, as some folks know, workforce is near and dear to my heart because it's a part of the economic opportunity, which is a part of better health. But it's also a necessary component to optimization and execution on the technology. And to Paul's point, there is a financial limitation on what we can do, some funding realities, but there is a lot of opportunity for coordination. And as I know you're keenly aware, our team has been very engaged with the Department of Labor, with HRSA, with CMS, just to name a few, IHS, on seeing that we are leaning very far forward for a better definition. So we can monitor and track the field so that we can help support the advancement of the curricula that we have developed and so we're talking with federal, but also private sector partners about the best way to keep this not just alive but let it thrive.

So I guess as the National Coordinator, I'll share with you that this is an ongoing commitment. The extent to which we can be involved as the lead or the owner or as supporter I think always varies when you're in a coordinator function, whether you're in government or outside. So there's nothing particular in here that would give us pause, I think maybe just a little language to your point that you just made, Larry, about in our coordinator role to lean forward and do what we are able. Being thoughtful about the continue expand language might imply that we had some of funding or significant resources as had historically to apply in the space, if you're open to that.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm happy with that edit. Sure.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Thank you.

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

Brian?

Brian Lee – Deputy Director, Informatics Innovation Unit – Centers for Disease Control and Prevention

Thanks Norma and Larry, this is obviously very important work. I saw in the specialty areas you have public health and analytics, so it's really good to see those and you talked about an example of titles and roles and levels and the others category. I just wanted to point out in a lot of the...you have the clinical informatics, you have public health informatics and other non-clinical informatics, they're also titles that are going to arise and be very fully implemented throughout the health system, if you're looking for other titles.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you. So Karen touched on this and you're touching on it as well, one of the things that we had as a challenge when we first put this workgroup together was we said, what are the statistics? And it was tough, right? There were a bunch of reports coming out of the various people in the industry talking about workforce and the needs of the workforce. But when you push into it, there are limited surveys, they're interpolating, we take the IT categories and we intersect them with healthcare as a place of work and look at those numbers. Look at hiring patterns and reports coming out of vendors, we look at job boards. But we couldn't sort of turn to Department of Labor and say, what do you know, because they said, we don't have a classification that matches what you're asking about. So in some ways, that was a simplistic driver for the SOC recommendations.

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

Any other questions or discussion? Can I characterize these three recommendations, Larry? The first one is sort of an internal of, it's sort of we can accept that. The second, Karen just talked about and maybe the third is the meat of what you'd like, the kinds of activities you'd like for this Policy Committee to recommend to ONC? Is that a charact...

Larry Wolf – Health IT Strategist – Kindred Healthcare

So these things really surfaced as sort of the main pieces of the work that had been done that seemed like it had real value and we wanted to see it continue. So you're right, so it's mostly process that we're coming back with...

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

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

...that we'd like to see this continue and then these specific things had surfaced as elements of our discussions that felt like they were specifically worth highlighting.

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

I guess I'm just struggling with whether this is just accepting your recommendations versus needing a formal vote to send a transmittal letter to Karen.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Do we have a formal transmittal letter about the SOC with the Department of Labor with this occupational code?

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'd be happy to write one.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

I would welcome a letter with the recommendations, honestly. It would be fine generally.

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

Okay. Why don't we do that and then incorporate some language for your recommendation 3 on the screen. I think that would reflect, I think, what the workgroup felt was important to continue, it seems to me.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great. Thank you.

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

Okay, so let me ask...go ahead.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

All of them would be fine.

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

Okay.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

If I'm understanding correctly, Larry, the workgroup essentially is saying this is important, it needs to continue, keep it at the forefront, use your resources, your relationships, your bully pulpit to continue to advance, but also do better...have an opportunity with Department of Labor to better monitor and measure our success.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sounds great, I'll take the transcript and add it to my letter. Thank you.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

I like that, okay.

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

Okay, so let me ask for a vote. Does someone want to make a motion that we accept those recommendations as stated by the National Coordinator to herself?

M

I do.

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

Okay. Second?

W

Second.

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

And any further discussion? So, Lar...so all in favor?

Multiple speakers

Aye.

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

And any opposed or abstained? Okay, we have a transmittal letter to reinforce the importance of workforce.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Thank you.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Thank you.

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

Thank you, Larry and thank you, Norma. Okay, we are beautifully on time. Okay, we're going to conclude with some words from the National Coordinator, right.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

So we're just...wanted...the main thing I wanted to talk about at the end was the workgroups and starting our transition and leadership therein, some elements still in the works. But we didn't want to wait to begin to get folks...so is there a slide with the...thank one, perfect, thank you. Paul could actually do this, too or Michelle, but I'll take the reins.

So as you all know, we decided a couple of months ago to make some adjustments to our workgroup structure so that we could focus our work and have an opportunity to sunset some of the workgroups and Tiger Teams who are completing their efforts and then bundle together some efforts. This is partially to help all of us in our daily work so we're not in multiple meetings, but also for staff work burden to be certain that as we are moving into our next chapter of ONC, that we're as efficient and effective as possible.

So these are the groups, hopefully look familiar to you. It includes an HIT Strategy and Innovation Team that is going to be chaired by David Lansky and be the group responsible for many efforts. But including helping us look up and beyond the tree and even the forest into what's coming, into the future. And very important work this fall as we're working on our Federal HIT Strategic Plan. And then moving into the winter, our national set of HIT Priorities that will have resulted from a series of listening sessions around the country that we'll want to bring back to the FACA to get some feedback on. All of that along the way, just an example of what will keep you all busy, but there's plenty more you will invent, I'm sure.

The second is Advanced Health Models and Meaningful Use. Paul Tang will continue to Chair that group with Joe Kimura as Co-Chair. This is also a large body of work that involves care model development, including ACOs but really beyond especially including the thinking forward about social determinants, for example and community level health and population health. And then the meaningful use of IT to support that kind of work, not just in the care delivery environment but beyond into thinking about health.

The third group HIT Implementation, Usability and Safety, David Bates is going to Chair that with Larry Wolf as his Co-Chair. This group thinking about the actual use of health IT in the clinical environment initially, but we're hoping also beyond, in the coming years thinking about health and that feedback loop of whether it's actually working on the front lines and if it's safe.

The fourth group is Interoperability and Health Information Exchange. Micky Tripathi is chairing that effort for us and Chris, a new member to the Policy Committee, we're putting him right to work as Co-Chair of that effort. Now this group is already partially working on the JASON assessment, they're...Micky's co-chairing the effort with David from standards to look at that JASON Report, which is a deeper dive into the standards of technology and privacy security components of that interoperability and IT report that came out last spring. They're going to pick up some work very shortly looking at governance and the business model and sustainability. And be also quite busy because we are at ONC, as many of you I think know from...we put out in our vision paperwork and on a road map as a strawman to get out to you all and to the broader community around getting interoperability advanced quickly so we can put it to use in all the ways that you all are thinking about today.

The fifth group around Privacy and Security, Deven McGraw will Chair that effort. We are still working on a Co-Chair. The last, but not least group, is Consumer Perspective and Engagement will be chaired by Christine Bechtel and we're still working on a Co-Chair for that as well going forward. And I think you all...those are groups that we had previously. I'm not going to say more about the details of the work except to go back, I want to talk about privacy and security again. Remind those of you who were not here earlier, who weren't tracking on it that we lose Joy Pritts on Friday, so we'll be working on all of the things that have already been initiated, none of that drops in important or otherwise, but her team is going to be able to continue to carry the ball. Kathryn's going to do a great job in an acting role. And then Christine was already not only doing great work but raising some new issues for herself today around care transitions so I am excited to see what's going to come out of that effort.

There is...there may be associated with this slide that shows transition...is that the next slide...the timeline, yes, thank you. This, as I mentioned, is going to be an iterative process as we close out work and pick up the new work. I do want to just point out that the Interoperability and HIE Workgroup is really already started and is going to be picking up some work, so it won't be until October that it's really formed. It's kind of in formation, but it's in a joint effort right now with standards, so slowly over time we're going to formalize that for the Policy Committee.

Anything Michelle I...you want me to mention I have yet to? And then very shortly thereafter we'll have a list of workgroup members. We appreciate people putting folks forward and/or self-nominating to participate in these efforts. And we're working to see that we've got a balanced perspective and people from as many parts of our nation and walks of life and background as possible so that we're being as inclusive and thoughtful about this really important work. Anything else, Paul?

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

No, just in terms of meetings, August is going to be virtual, September a face-to-face. We're working on dates for a joint meeting with HIT Standards Committee and for a real big kick-off in Interoperability, which is the main theme for this year. We don't have a date yet, probably October or early November. So I just want to give you a heads up that that's obviously going to be face-to-face and it's a little unclear Whether...what November and December are, face-to-face versus virtual. So we'll just try to keep you posted as soon as we know better, but just for your travel plans, just to let you know there's some discussion.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Thank you and that joint meeting will also be an opportunity for us to get feedback on the Federal HIT Strategic Plan draft, which we'll have out. So there will be a lot of content, a lot of pre-work to make sure that we're ready...you all are ready to give us some feedback on the broad plan and then this really deeper stream around interoperability.

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

Any questions on the schedule or any other feedback on the meeting? And if not, we'll look...

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

I just want to note that we'll start to work with the Chairs that we've identified to have planning calls and walk through the process and get everyone up to speed before we start to execute. But, those are coming soon.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services

Great.

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

Thanks, Michelle.

Karen DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology

Thanks and thanks to all of the Chairs and Co-Chairs who have agreed to either continue or to step up. We really appreciate that. I know it's a lot of work.

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

It's a hard-working, fast-paced group. Okay. We can open to public comment then, please.

Public Comment

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

If there's anyone in the room that would like to make a public comment, please come up to the table. As a reminder, your comments are limited to 3 minutes and while we wait for you to get ready, we'll open up to operator.

Alan Merritt – Web Specialist, Digital Communications Services – Altarum Institute

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

Darryl W. Roberts, RN, MS, PhD – Senior Social Scientist – Econometrica; Independent Consultant

Hello, I'm Dr. Darryl Roberts. I'm sitting here in a different role than I had been previously. In previous times that I have commented, I have commented on behalf of the American Nurses Association. I now work for a policy research company, Econometrica, Inc. and my comments reflect my opinions and to some extent, those of my company but not nurses at large. Although I will say that I'm a member of the ANA and still speak for me as a nurse.

A couple of the things that I heard today have been just, it's been a lot of great work that's being closed out here, but there are some issues that I think, particularly working in the implementation and policy evaluation space now, I think are worthy of mention. That we are looking at interoperability still through too tight of a lens, we're looking at it through a magnifying glass when I think we need to be looking at it through a fisheye lens. We're looking at whether we can get vendor A to communicate directly with vendor B on behalf of provider 1. I think from a public health perspective, we need to actually start looking at interoperability through the lens of the patient who might be seeing a provider A, might be subject to vendor A and B, but might not really care if the two vendors can speak together. But whether the providers can do something with the information that's being brought about on their behalf and share that information.

We need to reconsider the way that we evaluate public health from a perspective of quality and look at denominators that are at the person level. And be able to aggregate those up so that we can look at the provider providing care for that person, instead of the person for wh...instead of the provider for whom the person is getting care. It is very important that we look at provider quality, doubtlessly, but we need to look at it through the lens of the patient. We have to be very careful about making sure that the patient's needs are represented there and we have to look also at not just the person as a patient, but the person as a well individual who's avoiding the system. And then an individual who is in the system and back to wellness again and be able to track that trajectory in a reasonable and usable way.

Another issue is that when we are developing quality measures, I believe that it should be the onus of the developers to also look at a workflow delta analysis. To see to what extent does this new quality measure influence the workflow of the providers, whether that be a nurse clinician like myself, a physician, a social worker...

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

Thirty seconds.

Darryl W. Roberts, RN, MS, PhD – Senior Social Scientist – Econometrica; Independent Consultant

...anyone else responsible. Thank you.

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

You have 30 seconds.

Darryl W. Roberts, RN, MS, PhD – Senior Social Scientist – Econometrica; Independent Consultant

Oh, I thought you were telling me I was done. All right. Because I knew...I do tend to talk long, but anyway. That's really it. I just see that the work that's been completed has been excellent and is driving toward that way. I believe that the new workgroups that are being put together ought to be considering the public health model and the individual patient...individual person model, not patient model. Thank you very much for your time.

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

Is there anyone else in the room? And there is nobody else on the phone.

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

Very good. All right, well thank you very much for a very productive discussion today and we will talk to you, but not see you, in August. Thank you.

Public Comment Received

1. I agree with some of the questions...who is going to enter all this data, who is going to pay for all this? As a 4 person ortho group, we are convinced that all of you are in an echo chamber of puffery and backslapping. There is lots of work going on, but it's COMPLETELY in the way of care. I hope you start to actually hear those of us on the ground, in the trenches, that have completely given up on all these programs. Please listen to real working providers.
2. A report from a current EHR? It's time to stop and listen. You have lost us.
3. You even lost Google..." health is just so heavily regulated. It's just a painful business to be in," "I think the regulatory burden in the US is so high that think it would dissuade a lot of entrepreneurs." You need to completely redo what you are doing now. You have created a monster. If you are trying to make all of us quit or just take cash, then fine, I get it then. But you cannot be serious, if you actually listen to all of this complexity.
4. With the recommendation of the using administrative data, will it be expected that CPT II codes be part of the payor data set that is supplied from the EHR?

5. Safety Committee, as a front line provider, I see IT and EHR safety issues nearly daily. Twice in the past week someone was given a diagnosis of a history of a stroke but the EHR fired off as if it was an acute stroke, and prompted providers to do a slew of CQMs that were dangerous to their actual admission. Who do I report that to? I think our Cerner contract does NOT allow us to report. I can tell my IT or QA people at the hospital but they blame Cerner, Cerner blames the providers. There are real VERY large safety issues, and we need the ability and have the RIGHT to report issues, and we need a formal mechanism to get safety issues solved. We have no mechanism now.

6. I'd like to modify my comment. I hope everyone in this room understands that those of us on the ground, in the trenches, have given up on this deluge of complex programs. MU, PQRS, ACO, ICD-10, ACA, CQM, HIPAA, etc, we are literally overwhelmed. If you don't hear us, please listen now, we are saying "uncle"! We quit, we're out, we give up. It appears to many of us that all of you that do tremendous volumes of work to regulate and prescribe how and when and what we do in practice, you really do no listen, except in you echo chamber of puffery and backslapping. Did any of you really ever try to use DIRECT? ever see a CCDA 100 page document, or even read 18. Missy Willoughby: Were there new appointments to the HITPC workgroups or where the existing WG members placed on these new workgroups and no new contributors named? Thank you.

Meeting Attendance								
Name	07/08/14	06/10/14	05/08/14	05/07/14	05/06/14	04/09/14	03/11/14	02/04/14
Alicia Staley	X				X	X		
Aury Nagy								X
Charles Kennedy	X				X	X		X
Chesley Richards					X			
Christine Bechtel	X	X			X	X	X	X
Christoph U. Lehmann		X						
David Kotz		X			X	X	X	X
David Lansky	X	X			X	X	X	X
David W Bates	X	X			X			
Deven McGraw		X			X	X	X	
Devin Mann	X				X		X	X
Gayle B. Harrell	X	X			X		X	X
Joshua M. Sharfstein					X	X	X	X
Karen Desalvo	X	X			X	X	X	X
Kim Schofield	X	X						
Madhulika Agarwal					X	X	X	X
Marc Probst	X	X		X	X	X	X	X
Neal Patterson	X	X						
Patrick Conway								
Paul Egerman	X	X	X	X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Robert Tagalicod					X	X	X	X
Scott Gottlieb	X	X				X	X	X
Thomas W. Greig	X	X			X	X		

Troy Seagondollar	X				X	X	X	X
Total Attendees	16	15	2	3	19	17	18	19

7.