

**HIT Policy Committee
Information Exchange Workgroup
Vendor Transitions of Care and
VDT Listening Session
Transcript
February 13, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good afternoon everyone; this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Information Exchange Workgroup. This is a listening session to hear about Stage 2 vendor – hear from vendors regarding Stage 2 transitions of care and view, download transmit. This is a public call and there will be time for public comment at the end of the call. As a reminder, this meeting is being transcribed and recorded, so please make sure that you state your name before speaking. I'll now take roll. Micky Tripathi?

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

Here.

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

Deven McGraw? Amy Zimmerman? Arien Malec? Chris Tashjian?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

I'm here.

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

Hey Arien. Chris Tashjian? Cris Ross? Dave Goetz?

Dave Goetz – Vice President for State Government Solutions – OPTUMInsight

Here.

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

Hi, Dave. Gayle Harrell? Jeff Donnell?

Jeff Donnell – President – No More Clipboards

Here –

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

Hi, Jeff. Jonah Frohlich?

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP

Present.

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

Hi, Jonah. Larry Garber?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Larry. Peter DeVault?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation
Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Steven Stack? Ted Kremer? Thomas Greig? And I'm going now see if there are any Meaningful Use Workgroup members on? I believe Marty Fattig is on.

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Marty. Charlene Underwood?

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Healthcare
Yes, I'm on.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
– Charlene. And Patty Sengstack?

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Hi, Patty. Are there any other Meaningful Use Workgroup members on? Okay and then Kory Mertz is on, who's the ONC staff lead, correct Kory?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology
I'm here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology
Any other ONC staff members on the line? Okay, so before I turn it over to Micky, I just want to go over a few logistical things. I first want to thank all of the panelists who have agreed to participate in today's call. As a reminder, during today's call, we ask that you please stick to the five minutes that we have allotted for your testimony. As I think we've shared, we do stick to that five minutes pretty closely. I will give you a 30-second reminder when it's four minutes and 30 seconds and then at five minutes, I will have to cut you off, so, I hate doing it, so please don't make me. And so also to the workgroup members who are on, who may not have already heard, when we open it up to questions, we are going to use the "raise the hand" feature, which is on the top panel of the webinar. So that will put you in the queue to ask questions and then we'll just go in order of who has asked questions. So, thank you all and with that, I will turn it back to you Micky.

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

Collaborative

Okay, great, thanks. Welcome everyone to this listening session of the Information Exchange Workgroup and –

M

Excuse me –

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

Collaborative

Hello? Hi, who was that? Oh, okay. So, just want to welcome everyone to this listening session and also want to welcome Charlene, Patty and Marty from the Meaningful Use Working Group as well. And today we're going to kick off what is two listening sessions, one – both of them focused on the Meaningful Use Stage 2 requirements related to information exchange and specifically related to the transition of care summary exchange and view, download, transmit requirements. And what we've is broken that up and sort of a vendor listening session and then a provider listening session. Today we

will be doing the vendor listening session and then a provider listening session and today were going to be doing the vendor listening session and a week from today we'll be doing the provider listening session.

The goal here is really to understand the state of market adoption of the Meaningful Use requirements and want to understand – we know that it's very early and most organizations and vendors are just starting to field their certified systems. And many of them are still in the certification process and not many providers have started their attestation. So we recognize that, but on the other hand, we want to take an early pulse to get a sense of what's going on in the market, to be able to get a good read of any early issues that may be out there. So we've asked the vendors – we've broken up the vendor panel today into two parts. The first will focus on transition of care and I will facilitate that. Once the speakers have each given their 5-minutes of remarks and then we will turn next to the view, download, transmit panel and Jonah Frohlich from the Working Group will facilitate that panel.

And what we've asked each of the panelists to think about, and they've responded to some questions so we'll have the formal part then we'll go into the questions. What we wanted to do is really have a wide-ranging discussion on issues related to certification, implementation and adoption, really all three. And we've asked the vendors to each give some perspective on the area – on the issues that they've found in each of those areas and we have that – for a conversation and a discussion so that we can have sort of a good process for understanding what issues might be out there. So with that, let me turn it over to Michelle.

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

Thanks Mickey. So I'm going to first introduce the first panel. So the transitions of care vendor panel will be first Peter DeVault from EPIC, Rick Reeves from CPSI, Catherine Britton from Siemens and Bruce Schreiber from MaxMD. So with that, I'm going to ask Peter to begin your testimony. Actually, one more comment about logistics before I do that, just a reminder to all of the panelists, your bios were shared with of the workgroup members and the need to take time in your precious 5 minutes, letting people know who you are and who you work for, because hopefully that is already in the bios. So now

I will turn it over to Peter and as a reminder, I will give you a 30-second warning when your five minutes is almost up. Peter, are you ready?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Yes I am, thank you. Thank you everyone for inviting me to speak on ours and our customer's early progress in the transitions to care workflows. For those of you who may not be familiar with our customer base, we have about 300 customers, most of which are in the United States. They're typically integrated delivery networks, although there are also some academic medical centers, Children's Hospitals, and other types of organizations in that mix. About 250 of those organizations that are our customers do plan at some point to achieve Meaningful Use Stage 2, for whom it's appropriate. Everyone in the US who is using our software has a certified version today that will allow them to achieve Meaningful Use Stage 2, and that includes the transitions of care and the view, download and transmit capabilities. I'll be confining most of my remarks to the transitions of care.

The approach that we take within interoperability is, as is true for many vendors, not simply a technical approach. We try as hard as we can to bake the workflows into the everyday use of the electronic health record system, so that it's not, for example, just an in basket hanging off of the side of the system, rather it's deeply embedded within workflows such as discharges or referral processes. And for that reason, even though all of our customers do have the certified release in production today, not all of them have implemented the workflows necessary for achieving transitions of care nor have they necessarily made the technical connections to outside entities, such as HISPs, to which I'll be coming in just a few minutes.

We do have about 10 of those organizations who are currently live with transitions of care workflows today, and about 24 others who plan to be live or are currently implementing and plan to be live by the next reporting date.

What we're seeing is that generally speaking, it takes about 1-2 weeks for our customers to do the technical work necessary to start doing transitions of care workflows. And that technical work can take a couple of different forms. The certified release of our software allows organizations to be, if they wish, their own HISP. So EPIC does not itself, we do not have the HISP here in Wisconsin that our customers transactions go through, rather our customers can themselves be their own HISP and many organizations are large enough that that make sense for them. On the other hand, for most organizations they'll be working with a third party HISP to do their transitions of care workflows. And so again, it usually takes between one and two weeks to do the work on the EPIC side to either set up that HISP capability, or to connect to a third party HISP.

The important part is that it typically takes much longer to actually implement and train the workflows associated with the transitions of care requirements. Typically, what we're seeing is that 6 months is not unheard of, 2-3 months is typically pretty fast. So because these workflows are embedded deeply within the other work that goes on with the electronic health record, it's certainly not a trivial thing to turn on. There are several concerns that our customers have and that we expect to continue as more of them come on board. One is simply that their trading – their concern is that their trading partners on the assumption that we're talking about non-EPIC sites, will not be ready in time for them to start exchanging information with them. That's probably the most prevalent concern and that either might mean HISP readiness or simply other endpoints that would be connected to those HISPs not being ready.

There's also concern that for many of those organizations, especially the integrated delivery networks, that the 10 percent figure is going to be difficult to attain because most of the referrals are internal and therefore excluded –

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

Thirty seconds.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Thank you. To finish I would say even though there are concerns, we don't recommend slowing down Meaningful Use Stage 2, but we do have some recommendations for Stage 3, based on some learnings from Stage 2. And I'd be happy to address those during the Q&A session.

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

Thanks so much, Peter. Rick Reeves from CPSI, are you ready?

Rick Reeves – Director, Government Relations – CPSI

Yes. Good afternoon, my name is Rick Reeves. I am Director of Government Relations for CPSI. Since 1979, CPSI has been dedicated to being a leader in healthcare IT for Community and Critical Access Hospitals across the nation. We appreciate the opportunity to participate and share our observations today. We offer the CPSI system 2014 edition as a complete EHR, certified last July. The majority of our hospitals will rely totally on us as a single source, integrated solution. Many are in rural America and serve as the sole hospital in their communities. The typical IT Department is one to three people. CPSI also supports approximately 20 percent of Critical Access Hospitals nationwide.

Our 2014 edition implementation process includes HISP deployment. Currently 91 percent of our hospitals are in various stages of implementation. Many hospitals have expressed needing a minimum of six months for implementations, therefore only about 50 percent of our previous meaningful uses have committed to a reporting period in 2014. CPSI system uses the Direct protocol for secure health transport. We also certified optional SOAP with XDR. Delayed availability for the optional testing tools, testing tool performance issues and unexpected upgrades resulted in the optional transport requiring much more time than expected and delayed its implementation.

We partnered with Inpriva, a fully accredited ENHAC/DTAAP HISP in efforts to reduce the complexity associated with electronic transmission and to expand our interoperability capabilities. There are no transactional level fees; however, the HISP service is associated with ongoing support service agreements. We sought this solution because many disparate edge systems and HISP were not fully accredited and resulted in one-off connectivity being established between HISPs, as one or both parties were not included in the nationwide trust bundle. Our current ToC on-boarding and education process requires an average of 30 days. None of our current hospitals requested connectivity with eHealth Exchange. Hospitals using our system as described here are able to produce both numerators and denominators for the ToC Measure 1 and Measure 2 statistics.

Our hospitals have implemented the ToC Measure 1 very effectively. Measure 2 has presented significant challenge. For the majority of these hospitals, the primary recipients of care are long-term care facilities and rehabilitation services not eligible for incentives in the Meaningful Use Program. Our hospitals are usually the anchors in their community and often the only healthcare facilities capable of satisfying the electronic exchange requirements. Many have actively engaged with referral providers, in order to establish Direct messaging services. These efforts require cooperation and resources, both physically and financially from non-stakeholders in the MU Program.

Measure 3 has unfortunately created a roadblock for our early adopters engaged in first quarter reporting 2014. Measure 3 requires meeting either criteria "A" or "B" to exchange with another EHR. We realize that many of our rural hospitals were unable to satisfy Measure 3 using criteria "A" and communicated the urgent need for criteria B to CMS and ONC. Criteria "B" was not available during the first-quarter 2014, therefore the early adopters who successfully completed all other objectives were prevented from attesting. The EHR randomizer was launched January 16th. We believe the situation will improve, but we still anticipate many rural providers will continue to encounter difficulties with electronic exchange in their settings, relying upon criteria "A." I would note that today, our first hospital achieved successful test results with EHR randomizer.

We have seen significant progress in implementing the 2014 edition. As developers, we encountered many challenges in achieving certification, but implementation has proven to be a far greater challenge. ToC and VDT have both been the most troubling objectives for hospitals. We partnered with a fully accredited HISP to help simplify the ToC process for the majority of our hospitals. The rate-limiting step remains the availability of exchange partners with necessary technology utilizing fully accredited HISPs in rural locations. We appreciate the opportunity to provide input on behalf of CPSI and our hospital partners. Thank you.

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

Thank you, Rick. Catherine Britton, are you ready?

Catherine Britton – Product Manager – Siemens Medical

I am thank you. Hi, I'm Catherine Britton from Siemens and my testimony is going to sound very similar to the two prior panelists. Siemens has certified EHR technology for acute and ambulatory venues that among the other certified criteria, includes certifications for inbound and outbound transition of care criteria and for the view online, downloading and transmit criterion. Our EMR products create and transmit the care or referral summaries via automated and manual user process flows. Transmission protocols include Direct SMTT and SOAP Direct XDR/XDM. Our certified inpatient and ambulatory EMRs automatically receive and archive these documents and then make them available to users to view in total, view by section and/or to reconcile and consume the medications, allergies and problems into the patient record.

Customers have implemented or are implementing these functions in preparedness for 2014 attestation. Like the other vendors who have provided their testimony here, the challenges we are seeing are related to the implementation of not necessarily the technical features, but more the operational processes. Their priority is on outbound document processing as they already have medication reconciliation processes in place and are not yet focused on document receipt from other providers. We offer our EMR software in hosted – customer-hosted models as well as software as a service model. Our interoperability functionality related to the transition of care, including our HISP service, are both service offerings.

We are operating our own HISP as well as interoperating with other vendors HISPs. Siemens is a member of the Direct Trust Organization and is currently in the application process for Direct Trust accreditation of our HISP. Our HISP service is identified as additional software required for certification for our inpatient and ambulatory modular certifications. The software is optional though, for customer implementation as, per CMS, they can meet the measures without a HISP or by using a HISP offered by any other vendor. We do not certify various packages with other vendors HISPs, as CMS has clarified that the HISP functionality in and of itself does not need to be certified. Our certified EDGE protocol to interoperate with third party HISPs is Direct XDR/XDM. We've tested this functionality was selected third parties HISPs to ensure ease of implementation by our customers and we're supporting customers implementations and validations for other HISPs as they finish their implementation for 2014. For customers who want to use an eHealth Exchange for transition of care, we have implemented connections with our products via SOAP XDR/XDM.

We measure both automated measures and provide certified reports for both transition of care measures, the 50 percent and the 10 percent measure and we have embedded the processes to capture that data for patients that qualify for the denominator using – trying to use normal processes for discharge and encounter referrals. We therefore use things like the discharge disposition or a physician or provider order, or charted elements to capture those patients who have been referred. As the other vendors mentioned, the greatest challenges we see are actually with customer implementation, not specifically of features, but of process.

The first challenge is to ensure that they are compliant with the letter and intent of the regulation and then harmonizing that compliance with both other regulations, other existing processes. The effort to understand the regulation specifics, translate that understand to our software features and to their existing processes and then to define and roll out those updated processes may take a number of months. They have challenges with things like, who exactly qualifies as a referral per the CMS definitions, and then how to chart that. Operationally referrals and transitions occur in orders or may be captured in provider documentation and they are challenged to harmonize that in a way that we can count it. Many customers have done substantial process management and process improvement on their referral and discharge processes to accommodate patient-centered medical home and accountable care and many other initiatives and they are now challenged with harmonizing the content they provide with these referrals with the content of the C-CDA and addressing any duplication –

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

Thirty seconds.

Catherine Britton – Product Manager – Siemens Medical

– any duplication or gaps so that the patients and referral partners are not confused by the content they provide. They are also challenged with operationalizing the specification of an intended recipient so that their transitions and referrals match the ToC numerator. So as other folks have mentioned, the challenges are in implementation of a high-quality C-CDA – a high-quality C-CDA and referral process that matches the intent. The technical challenges have been focused on things like discoverable HISPs and healthcare provider directories so that it's not a clumsy process to address these C-CDAs. Most customers –

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

Thank you, Catherine. Hopefully we'll get to the remainder of your testimony during the discussion portion.

Catherine Britton – Product Manager – Siemens Medical

Right, thank you.

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

Sorry. Now we'll turn it over to Bruce.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

Hi.

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

Hi, if you're all set – please go ahead, sorry.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

I'm all set. My name is Bruce Schreiber, I am the CTO at MaxMD. MaxMD is a privately held ENHAC accredited HISP, RA and CA. Our company has been involved in the secure healthcare business for 8 years. We are active, contributing members of DirectTrust and participate in many workgroups that are shaping the standards and direction of the nation's healthcare, secure communications policy and technology. The list of workgroups we participate in is in my bio. As an accredited HISP, we operate a Security and Trust Agent according to the specifications of the applicability statement for secure health transport and Direct Project policies – and DirectTrust policies.

As an accredited CA and RA, we identity proof our customers, issue Direct Certificates and Direct Accounts. Our CA certificates are the DirectTrust Transitional Trust Anchor Bundle. This Trust Bundle enables interoperability by creating a central repository for DirectTrust accredited HISPs, Trust Anchors without the need for without negotiating one-off DURSAs and other agreements. Direct Certificates issued by participating HISPs will pass the trust requirements between accredited HISPs seamlessly.

What is our role in making the transition of care possible for Stage 2? The MaxMD HISP operates a SAAS solution enabling EHR technologies to achieve ONC certification. Our HISP facilitates the sending and receiving of transitions of care data through using the Direct Protocol. We help EHR vendors pass through the NIST transport testing tool during the certification test. Our EHR technology customers are provisioned with Direct accounts that can interoperate with any other Direct-enabled healthcare technology. MaxMD can extract data from legacy technologies, structure the data and then deliver transitions of care via the Direct Protocol through our HISP Security and Trust Agent.

Our Security and Trust Agent supports all the Direct Edge protocols, SMTP, XDR/XDM, SOAP plus XDR/XDM and we also have an SFTP endpoint protocol. MaxMD also addresses the Edge community issues by offering data translation capabilities that deliver structured and unstructured data via Direct to entities not using certified EHR technology. Generally adding just the MaxMD HISP directly to the EHR technology is a 1-2 week exercise. Our data translation offering can be added to legacy technologies to produce structured transition of care in a 2-4 month timeframe. This is largely dependent on the scope of the project, the time needed.

How are we addressing certification requirements? As mentioned earlier, MaxMD HISP is EHNAC accredited as a HISP, RA and CA under the DTAAP accreditation program, We've assisted many ambulatory vendors in ONC certification. We've connected our HISP to QDMR technologies as well and we offer message delivery notification, delivery status notification to assist our clients in calculating the numerators for MU2 reporting, our EHR partners calculate the denominator.

Interoperability questions, we – MaxMD participates in Connect-a-thons. We also actively work with other HISPs to test and solve interoperability issues. We have actually participated in an interoperability exercise through DirectTrust for the past week, determining the ability of all of the members of the DirectTrust Transitional Trust Bundle to communicate with each other. The MaxMD CA certificate is in the DirectTrust Transitional Trust Bundle.

Transitions of care issues. The initial – initially EHR vendors – vendor partners reported difficulty structuring data for certification. That issue has been largely solved with software enhancements and third-party add-ons. They continue to report staff training issues, which vary by EHR technology vendor. The concern we hear repeatedly are about workflow changes and EHR ergonomics.

What fees are we charging? MaxMD is an account subscription model. We feel this is scalable and sustainable. We do not charge transaction fees for Direct messages. If a customer proposed a different economic model, we would entertain it.

What issues with regard to exchange are we encountering? With regard to exchange of transitions of care of any form, it's too early to report issues or results. Most of our customers are in the beginning stages of implementing the technology and workflow changes. We support the DirectTrust EHNAC accreditation program. We believe that accreditation promotes scalable, trusted exchange among audited entities with known policies and procedures. We're concerned that vendors can achieve ONC certification without the assistance of an accredited HISP, that they can be the unaccredited HISP and have difficulty interoperating after they are certified.

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

Thirty seconds.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

We believe messaging around Meaningful Use incentive should focus on the vision of benefits of future interoperability. We want achieving Meaningful Use metrics to be a starting point and not a goal unto itself. Thank you for inviting me today.

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

Thank you, Bruce and thank you to all of our panelists for the transitions of care panel. We are now going to open it up to discussion from the IE and Meaningful Use Workgroup members. For any members that may have a question, if you could just use the "raise the hand" feature, it will put you in the queue. I don't see any questions at this time, but I will give the workgroup members a chance to find that feature and go ahead and raise your hand, and I see a couple. Arien Malec, please go ahead.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thank you. So I'm going to see if I can sum up what I've heard and see if I can get the panelists either to agree or disagree. What I've heard has been that the main struggles that people have experienced, number one is in understanding what a valid transition of care is for purposes of recording. Number two, for making sure that all of our counterparties are addressable and in particular, making sure that their counterparties who are not eligible for the Meaningful Use Program including LTPAC are addressable. And number three, outside of the complexities of transition of care specific to the Meaningful Use Program, that is figuring out what a valid transition of care is and isn't, this is also a new process and in particular it's a new process with regard to electronic receipt and incorporation of that electronic information into the acute-care practice. Have I summarized that right? And are there – am I missing some key pieces?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Arien, this is Peter, I'll take a stab at that. That's mostly correct. What act – one of the other things that some of our customers find difficult is that for some of them, this is not automating an existing process. So for example, there are organizations who do not – go through a formal, structured referral process because the payers in the community don't require it.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Right.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

So this is not simply automating something that was done by fax or phone or paper before, this is net new workflows.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Got it.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

And then the other area that you touched on that's been important is addressability. So there's certainly no guarantee today that the HISP-to-HISP interconnectivity exists, for example.

Catherine Britton – Product Manager – Siemens Medical

This is Catherine, I'd like to agree with that and then add that one of the simple operational challenges is that something that a panelist mentioned before is that the various referral partners to whom folks would be referring, are not incentivized either at the same time or maybe even at all. And because it requires resources of some sort – process resources or technical resources of some sort, it is a challenge to ensure that everyone is participating in the project in a way that will guarantee success for the person who's being measured for the Meaningful Use Program.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

Hi, this is Bruce Schreiber. The comment on addressability is an excellent comment. We have seen a number of our hospital vendors come back to us and ask if they could purchase individual Direct accounts for providers in the community, so that they could achieve Meaningful Use. And have someone – have an addressable counterparty to send the ToCs to, so that they're using some of their own resources to fund the counterparty interoperability and addressability.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

And Bruce, I'm going to follow up and say that we've seen exactly the same pattern of hospitals literally purchasing endpoints for transition of – for LTPAC facilities to serve as the receipt arms, so that they can meet their 10 percent.

Rick Reeves – Director, Government Relations – CPSI

This is Rick with CPSI. I would agree with everything that I've heard and just reiterate that point that especially in our rural locations, it's an issue and they are often pursuing those people to give them some sort of Direct access, so I agree with everything you guys have said.\

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thank you.

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

Thank you, it looks like Larry Garber has a question.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yes, now that I'm off mute, actually, I have three questions, but I'll start with one and they you can kind of feed them back to me as the queue opens up. So I wanted to just expand a little bit more on your ability to send messages to the destination that you desire and if you – in situations where you've actually successfully connected to the HISPs that you'll be connecting to for a destination. Those HISPs often have provider directories that you then need to integrate with as well and I'm wondering how successful you've been connecting to the HISP provider directories or state provider directories or community provider directories and integrating that into the clinician workflow.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

This is Peter, I'll take the first pass at that. So far, because there aren't necessarily agreed upon standards for provider directories, the progress has been slow and mostly manual. We do see on the horizon the ability to automate the incorporation of changes from HISP provider directories into the EMR system, but that's actually part of our recommendation for MU3, which is that we hope that rather than introducing new standards, for example. In MU3 we can focus on some of these things, like provider directories, HISP-to-HISP conductivity and the like that really are kind of on the edges of the transitions of care requirement.

Rick Reeves – Director, Government Relations – CPSI

This is Rick, I would agree with what Peter said, it's somewhat a manual process for customers to submit to provider. They have the capacity to load that information in a table for future reference, so that it doesn't have to be reentered again, but it's certainly dependent upon there being directories in the future.

Catherine Britton – Product Manager – Siemens Medical

This is Catherine, I agree. We have a manual process, we have an upload process, we have an HPD plus that will discover from other sources and are working with other vendors to support HPD plus to help that automated discovery. But it is quite a challenge and customers are indicating why is – if we can indicate NPI numbers for physicians, why is it we can't have a discoverable addressing scheme.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

Hi, this is Bruce Schreiber and I agree with what everyone has said. Directories are that nascent stage right now. There is work going on, on how to federate directories among HISPs. There are issues around privacy policy and shar – and ownership of the data that are being worked out.

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

Larry did you have more questions to ask?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Of course. Okay, now a lot of the focus is being very hospital-centric, but – and especially when you're talking about where you're sending the information to. And I just wanted to focus a little bit back on the ambulatory providers. Have your customers been having issues defining what is a specialty referral and then – both in terms of – well, mostly in terms of the pro – the workflow of actually sending something during a specialty referral and also then running the Meaningful Use Stage 3 reports to identify what was the specialty referral versus a non-specialty referral? Maybe I should clarify that to say, so, if you're sending someone to go get dental work, does that count as a specialty referral that ought to be in the denominator? If you're sending someone to a nutritionist, optometrist, which of those should be counted as in the denominator for these referrals?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

This is Peter, I'm not aware of particular problems around that, although I'm not closest to that side of things, so it could be that there are some.

Rick Reeves – Director, Government Relations – CPSI

This is Rick with the CPS. I mean, I would say that we don't perhaps address the definition of that, we allow our customers the capability to input that information in the discharge process. There's a way to capture the information, which pulls and generates the statistics, but we do not control what they consider valid or invalid.

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

So Rick –

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Michelle, do I have time for one –

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

Sorry, this is Micky. I just wanted to – sorry to step in, but I just wanted to ask a follow up question on that specific point to Rick. So Rick, does that mean that in the software that however you set that up in the workflow for the transition of care, by default every transition of care, every referral that goes through that, that that would be counted in the denominator?

Rick Reeves – Director, Government Relations – CPSI

No, there's a drop-down table that's loaded with specific reasons, and they have to select the reason that they're using for that transition.

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

I see. Thanks. Sorry, Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I was just asking Michelle if I have time for one last question.

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

Yeah, go ahead Larry.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay. And the answer may be that you don't know yet, but as we start cranking these up and sending more documents and transfer summaries during the transitions, I was wondering if you're getting an early experience what it's like on the receiver's side, to be receiving these documents. In terms of first, medical record matching because there's no necessarily a medical record number, I mean as a receiver, routing it to the right person, whether that has to go through medical records or you can automate the routing or everything goes to the PCP. And then – and whether this involves whether you're seeing more staffing requirements in organizations as they receive things.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

I'll take a pass at that Larry this is Peter again. So we did develop tools within the EPIC EHR to allow a work queue of unsolicited messages that are coming in to have somebody work that queue and either match those messages up to an existing patient or create a new patient record in the event that the message is for a patient that hasn't been seen at the receiving side yet. That is one of the workflows that is typically new. Typically, our customers who have implemented that to date have made that an HIM function, as opposed to a clinical function. It's a little early yet to know whether it's a problematic flow or not, I don't believe anybody has had to hire net new staff at this point though.

Rick Reeves – Director, Government Relations – CPSI

This is Rick from CPSI. I would say that we probably have a similar approach, although I can't say that we've generated a lot of experience with it so far. I would say certainly in the hospital clients, they're very excited about receiving that information from ambulatory providers, especially to help them with their med reconciliation process and others. So there's quite a bit of excitement about it, but we don't have enough experience yet with it to tell how long it's going to take them and how successful it will be.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you.

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

Thanks, Larry. Deven?

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

Thanks a lot Michelle can you hear me?

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

We can.

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

Okay, great. So my question is a quick one and it goes back to the point that was made a bit earlier about hospitals purchasing Direct addresses for the physicians who commonly refer patients to them or to long-term care facilities. I'm wondering whether anybody has mentioned whether there are any obstacles to doing that in terms of sort of the fraud and abuse laws and the exceptions for that, whether they're broad enough to permit that to occur. Because it sounds, in my mind, like a good idea, I', just making sure that the policy rules are – to allow that to happen.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

This is Bruce Schreiber. I am not aware of any rules, but I'm not an expert there. I can tell you from field experience that it is happening.

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

Okay. Okay, yeah, no, that's good to know. We can certainly dig in on that on our end, but I'm just curious as to whether you all have heard anything, in your experience. All right, great. Thank you.

Rick Reeves – Director, Government Relations – CPSI

Deven, this is Rick. I would add to what you just said is, in terms of what we're seeing more of is that these hospital providers are contacting these referral facilities and helping them to understand what they're trying to accomplish to meet Measured 2. And trying to provide some education there in hopes of it also benefiting those referral facilities to have those documents. So, it's a multipronged approach, I think, that I've seen to help the hospital and to encourage those referrals to realize some value from that adoption.

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

Yup. Thank you.

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

Thanks, Deven. Micky?

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

Yeah, sure. So I have two questions, one is about DirectTrust and organizations like that that are trying to facilitate federated trust and just wanted to get all of your views on where that is today. I think, I think Bruce, I think you talked a lot about your participation with DirectTrust, but would love to – and I don't want to focus necessarily on DirectTrust itself, but there are a couple of federated trust kinds of efforts out there and we'd love to get your perspective on that. And then the second is related to, since Peter DeVault you had raised it, I know it seems like it's – like we're still in Meaningful Use Stage 2 and still very early to talk about Meaningful Use Stage 3. And I don't want to go into a deep dive on Meaningful Use Stage 3, but would love to get any early perspectives you have on some – any lessons learned that you might offer as we start thinking about Meaningful Use Stage 3. Because we know – Meaningful Use Workgroup here and they're in the middle of starting to think about the Stage 3 requirements.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

Okay. This is Bruce, since you directed the first half at me, I will be happy to field it. Yes, I'm very active in DirectTrust.org. DirectTrust.org is an outgrowth of the rules of the road committee from the early days of the Direct Project. In fact, Arien Malec who's on one of the panels here ran that group. DirectTrust –

(Indiscernible)

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

Pardon me.

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

Go ahead, I think it's just background noise. Sorry, go ahead.

Bruce Schreiber, MS – Chief Technology Officer – MaxMD

That's all right. And I guess I should give a shout out to him for all the good work he did to get this thing started. The DirectTrust.org has an objective setting policy and procedures for keeping the bar consistent. The Direct Protocol involves a trusted, secure, interoperable network and in order to achieve that there needs to be policy and procedures in place to give relying parties assurance that a HISP or other organization that is participating in this network is who they say they are and is operating according to standards that are widely known and agreed upon. And that DirectTrust is doing an excellent job of accomplishing that through a series of very dedicated volunteers.

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

Other panelists, any thought on sort of the federated trust efforts that are out there?

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Micky, I'll address your second question. This is Peter. I think there are some things to learn from our early progress in Stage 2 for Stage 3. I think anybody who's done any actual implementation work with Direct understands that it is a new standard and relatively immature. And that we're finding out a lot of things about how the whole ecosystem of EHRs and HISPs and other actors need to be coordinated to really make transitions of care work well. And as I mentioned earlier, I think one of the takeaways that we can apply to Stage 3 is rather than introducing new standards or significantly new workflows around transitions of care, as an example, we should really try to shore up some of the gaps and some of the boundaries with the transitions of care as they've been specified for Meaningful Use 2. So work to ensure discoverability, HISP-to-HISP interconnectivity, error reporting from HISPs, provider directories and a lot of things that people are kind of doing on their own in various ways, but which haven't been widely coordinated to date.

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

Thank you. Charlene Underwood has a question.

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

Hello, can you hear Michelle?

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

Yup, I can hear you.

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

Thank you. And I appreciate all of your effort and time to put the testimony in. So Peter, since you were talking about Stage 3, one of the focuses certainly all of the Meaningful Use Program has been on interoperability, and again, there's a lot of demand to do more faster, as you well know. So as you're making recommendations, certainly addressing some of the gaps and issues like the provider directory I think is going to be critical component. Sometimes it's a challenge to figure out where to put that in Meaningful Use and actually make it a requirement, so that's kind of a struggle. But if you've got other advice, because again in the Care Coordination Workgroup, we did a lot of work trying to create a future framework for more collaborative care and the piece we're talking about is really important to being able to accomplish that, the ability to share different kinds of data and get it more patient-centered. So your advice in terms of in addition to certainly shoring up what's in place, is there anything else you would advise for Stage 3? There are a few additional requirements, as you know, on the table such as notifications, as well as enhancing the type of exchange that's done with – under care coordination.

Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation

Yeah, I would just repeat a bit, of what I said a moment ago that rather than introduce – I think it's probably fine to introduce additional content to the exchange. So other kinds of encounter summaries or specialty specific summaries for oncology or transplants or something like that, that aren't really creating net new standards requirements or net new workflows. But I would be very cautious about recommending items that would, in fact, require new standards while we're still trying to make the current ones work.

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

Any other comments?

Catherine Britton – Product Manager – Siemens Medical

Yes, I echo what Peter said. And overall, if Stage 3 focuses on the outcomes desired and then understands the process and technical challenges and focuses on making truly meaningful and useful, as far as outcomes are concerned, the existing functionality that is required I think that will go a long way. It will move folks from a check the box or a scrambling to get it done into a truly useful process that will achieve the outcomes. And not just technologically, like we've been talking about, but also as harmonized across other regulations and market programs. There are a lot of things within the Meaningful Use Incentive Program that should be harmonized and one of the things we're seeing is customers getting very confused about how they relate or don't relate to other things, and privacy and security, patient matching and patient safety. I think we need to think about what we want to achieve with transition of care, look at the gaps and shore up the gaps in the existing infrastructure, and focus on that to get it really useful all around instead of investing in new things that will take us off in a new direction.

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

Thank you.

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

Well thank you everyone, that was perfect timing, we've actually stuck exactly to our agenda. I don't think that ever happens, so I appreciate it. So I think we'll now transition to Panel 2. Jonah, did you want to make any introductory remarks before we introduce the speakers?

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP

Thank you Michelle. I think just to make it clear that this, like the first, is focused on Stage 2 Meaningful Use, the information requirements – information exchange requirements specifically around view, download and transmit. So other than making that statement, we might veer into Stage 3 as well, as we've heard in this panel because there are some considerations about that. We've asked, like in the first one, the vendors to weigh in on specific aspects of Stage 2 requirements around this topic, looking at such aspects as certification, implementation and adoption. And so we're looking forward to hearing their statements and then, like this, having an interactive discussion with the panel members. So I think with that, Michelle, if you could please introduce the panelists, we can get under way.

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

Thanks, Jonah. So on Panel 2 we have Doug Wager and Greg Meyer from Cerner, Bob Barker or Robert Barker from NextGen, Sean Nolan from HealthVault and Jitin Asnaani, and I'm sure I butchered a few of your names, so I apologize, from athenahealth. Just a reminder to our panelists, you each have 5 minutes, I'll give you a 30 second warning when your time is almost up. And Doug, if you are ready, we'll get started with you.

Doug Wager, MS – Director of Personal Health Innovation – Cerner Corporation

Sounds good, sure, I'm ready to go. So, my name is Doug Wager, I'm the Director of Personal Health Strategy at Cerner and Greg Meyer is with me, the Distinguished Engineer at Cerner. Thanks for inviting us to participate. As background, Cerner is the leader in health information solutions, was founded on a person-centric model of health and care, so we're very supportive of the incentives to accelerate giving people access to their health information. Cerner released our certified portal in 2013 to meet the view, download, transmit and activity log capabilities, to date we have over 170 acute, 450 ambulatory sites who have implemented the portal. They haven't all implemented the transmit portion yet, but all are planning to do so who plan to attest. We do not charge specifically for the transactions, that was one of the questions.

Diving into some of the details, we meet the view requirement by giving the person access to both discrete information and then summarized health information. So discrete for example would be specific labs, medications, problems, allergies, things that are stored literally that way in the EMR. And then the summaries, of course, would be care documents and C-CDA, that format. For download, we enable the person to select the documents they want to download, they can choose to save them as a PDF or XML and then they will be able to save those to wherever they want to save them. For transmit, we are using Direct message sent by the organization on behalf of the patient at the patient's request in the portal.

So the workflow is that only the user would select a summary that they want to send, they would enter a Direct address or they could pick one from an address list they've used previously. We let them write a brief note to the recipient for context if they want to. When they click send, the EMR sends the PDF and a C-CDA to the requested Direct address on behalf of the patient. As is the case with most technology solutions introduced in a population, while there's some IT work required, and that can be significant, really the bigger issue is investment required in processing culture change. And we're finding an organization sometimes struggle to establish their desired business goals for a patient portal, defining their related processes, training staff, marketing to patients and then measuring progress to make sure that they're actually achieving the things that they wanted to achieve.

So that goes beyond VDT, but VDT is effective there. If the organization staff don't understand the value or believe in the solution, they're not likely to champion it in a way that will enable it to be successful.

Another concern we here is really the widespread lack of understanding of what Direct is and how a consumer would find the provider's Direct address if they wanted to transmit their information. So we really see this as the largest barrier to people using the transmit capabilities and our client's greatest concern was rolling it out. One of the frequent asks that I receive is for a directory that patients can use to find addresses of the providers and there's also concern about how a patient knows whether a given provider's address will be in a given HISP. So the patient doesn't want to have to worry, or shouldn't have to worry about whether the address that they have is trusted or not in a given place they're trying to transmit from.

So to close out, and I'll let Greg comment more on some of the transmit or Direct capabilities. But, we've offered a patient portal solution with access to health records since 2004. Client uptake was really limited to most progressive organizations that were able to prioritize it in their other important investments. So we're really pleased to see the Meaningful Use incentives causing this rapid uptake of technology – they provide more access, transparency and portability of a person's health information, so we're very in support of that. Greg did you want to comment on – we have done testing with consumer directed recipients.

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

Yeah, okay. I was looking for my cue Doug. Yes, so thanks for inviting me to participate as well. Just quickly, a little bit on our Direct implementations. Cerner has chosen to open our system for transmission to PHR and other patient-centric systems by utilizing the scalable trust solution offered by the Blue Button Patient Trust Bundle. This allows us to seamlessly expand the size of our network without any additional operational effort, as new patient systems are added to the Patient Trust Bundle. And as Doug has mentioned, we have successfully tested interoperability with multiple PHR and patient applications. This does include HealthVault, Humetrix Blue Button, that's just to mention a couple. And we openly welcome engagements with new solutions as they come to market. Thanks.

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

Thank you both Greg and Doug. We'll now turn it over to the Bob Barker, do you prefer Bob or Robert Barker from NextGen.

Robert Barker - Vice President, Community Connectivity Solutions - NextGen Healthcare Information Systems

Bob is fine, thanks.

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

Okay, thank you.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

So, my name is Bob Barker, I'm the Vice President for Community Connectivity Solutions at NextGen Healthcare and thank you for inviting me to come on and talk. Obviously, we're all looking at these transfer of cares and VDT in a similar thread, obviously patient-focused versus provider-focused. The VDT, no actually, I'll go through my script first here if you don't mind. So NextGen Healthcare Information Systems provides an EHR system, financial, health information exchange for hospitals, health systems, physician practices and other organizations. Our company offers ambulatory products that integrates patient care with the clinical and administrative workflow applications; the financial and clinical management solutions; the community conductivity, HIE and patient portals, as well as our dental records. So we're pretty across an awful lot of spectrums for our product suite.

Holistically integrated with our EHR and our product management, I'm sorry, practice management solutions, the patient portal is instrumental in improving a practice's administrative efficiency by reducing phone calls and paperwork while cutting costs. Currently approximately 70 percent of the NextGen client base is using the patient portal in some capacity. Concurrent with meeting and surpassing patient engagement objectives, functionality included in the patient portal is now a requirement for successfully attesting for MU2 VDT. However, we are finding that when we get into these discussions with our clients that they want to go beyond just meeting the Meaningful Use requirement, they want a holistic, single-patient experience across the continuum of care, which is a different story in and of itself.

In my experience with the NextGen clients and in general discussions with other people in the field, some common issues surrounding the VDT objective, and I think we'll see a couple of these will be repeats of the ToC issues. So the transmit piece – the view and download piece are certainly easier from a NextGen perspective that we already had capabilities built into our portal. The transmit piece added certainly a twist to that, so it's been challenging to an extent due to the need to comply with the required Direct transport and the need for HISPs. So when a patient wants to send their C-CDA not to a PHR, but if they want the ability to send it to a primary care, to another physician, the need for a HISP gets – becomes prevalent and the need for a workflow of that receiving entity need to be taken into account. Because receiving a clinical document from a patient versus a clinical document from another healthcare – a trusted healthcare organization require two different workflows from the recipient.

So we combined this piece with the lack of production-ready provider directories for the patient to be able to search for their intended recipient as well as the need to know a Direct address at the user interface. That gives us a road bump on the transmit. The certification was not an issue for NextGen, only the production, implementation for the transmit and with the fact that a patient can review the C-CDA to meet the numerator, we don't believe the issue at HPD will affect any providers from meeting the measure for VDT. So although it's an issue, it's a backend issue that we expect to address as the HPD directories become configurable and more available.

One of the market requirements is a need to have an automated solution for delivery, so changing workflows in a practice to accommodate this would be heavy lifting, as well as labor-intensive. So the automated availability of the C-CDA was a must from our perspective. Because there's no standard required for transmitting the C-CDA to the patient, it's easy for a tethered PHR solution to accommodate or tethered EHR solution to accommodate, but not so much for untethered. So the issues we've seen is third-party hospital systems that want to use the NextGen patient portal in their community to provide discharge summaries to their patients, we ran into, for each different systems there's a different method that they want to use to push that C-CDA. We've been pushing, since they're using direct for ToC, we've been pushing that; however, we're finding that many systems have not developed the capability. So we're running into NextGen has the capability to take in third-party C-CDAs to our portal for the patient to view, but the variety of technologies out there that the third-party systems want to employ is causing a delay in the implementation of these.

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

Thirty seconds.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

Thank you. So the lack of transport requirement is necessary – requirement is a necessary non-requirement, we're okay with that, but it has caused some issues. We haven't had issues with the training aspect because it's a patient-centered piece, and we've had successes with the transmit; however, we haven't had much feedback from provider organizations whose patients are looking for this functionality. Summary, timely access, we're with ONC, CMS with this and we're ready to move forward with helping our clients reach this milestone. Thank you.

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

Thank you, Bob. Sean Nolan.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group - Microsoft HealthVault

Hey folks, thank you for having me here, I really appreciate the opportunity to chat a little bit. I'll start by saying a little bit, Microsoft HealthVault is a free, worldwide, online service and provides the consumers to collect, store, share and most importantly use their personal information. In addition to our website and mobile apps, consumers can connect that HealthVault record to hundreds of third-party apps, providers, data sources and devices. If anyone was at CES, that was quite a place for devices. The goal really is to become a lifetime information hub that ensures families and caregivers always have what they need to make some important decisions.

Convenient connectivity, it's a must-have for a service like ours. There is ample evidence that manual entry never works, especially for busy families. And this imperative means we spend a lot of time investing in interoperability of all types, but recently most actively our work around Blue Button Plus and Meaningful Use Stage 2. We are certified for VDT, numerator reporting, quality system measures for both inpatient and outpatient, it's fully deployed, no cost for partners to use it. It's a little unusual in that, yeah, we have to partner with those EHRs to deliver the solution. Partners are responsible for giving us a compliance C-CDA file, using any of our integration channels. And then we provide the means for patients to view that information in its original form or in context with other information download, transmit and see a history of the VDT actions that have been taken on that record by themselves or others that have shared it. EHR partners can then download for any time period a report that has the VDT actions taken by their patient population, and they combine that with their own denominator information to report their level of engagement.

From a technical perspective, we've really seen surprisingly few real technical hurdles when we're interacting with EHR systems that generate CDA files that validate against the Stage 2 testing tools. This really is a dramatic change, so people should feel good about it. Stage 1 certified products really almost as a rule create invalid CCD and CCR documents, either at the syntax or semantics level. We do still see subtle differences in interpretation and they can have nontrivial impacts. For example, if a problem comes in and it's coded without – it's not coded in the SNOMED, very minor but still valid syntactically variations in the XML can cause receiving systems to miss the text. So the patient will receive a problem and it has no name. Amusingly, the best practice here for this situation, it's on Keith's – Keith Boone's blog, great blog, I'm not sure it should be our national documentation set. But as we often do say, these are great problems. It means that we're flowing data, we're seeing real issues and we're working out those last bugs. And I'm pretty confident that real world use will burn out these last challenges very quickly.

Direct as an interoperable transport has proved quite robust. Over the course of the last year, we've onboarded dozens of exchange partners and had very few truly technical issues. That's not to say things always worked great the first time, but we typically see issues around configuration and things that are actually falling away as people get more familiar.

From a cultural point of view, we've really yet to see people, said before today, widespread deployment of MU2 certified EHRs, it's a little early, but we have been engaged in a number of pilots and some early lessons are definitely clear. Number one, provider endorsement is the number one predictor of engagement. Patients need that trusted advisor to show some enthusiasm, bring life to the potential benefits of having data for emergencies, for sharing with other providers, using with applications and those kinds of things. And our best tool today to support that is the 5 percent requirement, which will be critical. I would really encourage the ONC to develop more tools, outreach, marketing pieces and such that might help providers understand how to talk to patients about it. because that relationship really is key.

There also are still significant gaps in the trust fabric again people said this before. The clear intent of the regulation is to allow patients to choose a location where the information is sent, but testing doesn't require that ubiquity and there really isn't an officially sanctioned mechanism to achieve it in any case. Blue Button Plus has the potential to be this function, but really right now it's just a recommendation and that leaves sort of every healthcare system, from some perspectives even worse, every vendor to judge for themselves what destinations may be appropriate for patients.

So the end of the day I would say, look don't accept any claim that VDT is technically hard, it's just not. But it is only the first step in a very fundamental transformation in the way people interact with their providers and patients, and that is really hard and it requires a lot of courage. So we appreciate the engagement that the ONC has taken, we're trying to play our role and I encourage you guys to keep the faith on it, because it's going to make a difference.

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

Thanks Sean. Jitin.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Thank you very much. Thank you for having me over here. I'm Jitin Asnaani, I'm Director of Technology Standards and Policy at athenahealth. As you may know, athenahealth is a cloud-based solution for practice management, electronic health records, patient communication and care coordination. Our vision is to become a health information backbone that helps healthcare to work as it should. And critical to this mission is the support and advocacy for broadly used standards that enable providers, patients, public health agencies, healthcare innovators and a variety of other healthcare participants to share the right information that delivers a better use experience, better health outcomes and lower costs.

To that end, athenahealth has been an active participant in several government and community driven initiatives, not the least being that S&I Framework, DirectTrust and the CommonWell Health Alliance. Athenahealth services delivered through a single instance multitenant platform, so all of our 40,000+ providers are always on exactly the same version of our software at the same time. What this means to VDT in particular is that when we certified as a Meaningful Use 2014 edition complete EHR last June, all of our customers were immediately using the certified product. All our customers enjoy the product upgrade as part of their service package and there are no additional charges for functionalities such as those required for VDT. The VDT capabilities are all natively built into our patient portal, including the ability to view and navigate across the summary, download the patient summary in both PDF and C-CCA XML formats, transmit the summary to a third-party as a C-CDA via Direct Project protocols. And view a history of all the VDT actions taken on their records – on their record, rather.

Our early findings in the course of implementing, piloting and releasing VDT to production over the past few months, and we've made quite a few interesting observations, even though we are very early in the process. And there's still certainly a lot more to come as the usage really picks up throughout 2014. First, there's been some clear evidence of success, the use of a single payload standard that is a C-CDA, has simplified and rationalized investment in building VDT capabilities. It is also enabling a simpler, faster and more reliable connectivity as we connect more and more HISPs to our network. The use of a single transport mechanism has been of slightly more limited help in this regard; enabling the usage of other broadly used standards-based transport mechanisms would have created a faster wrap-up of real-world usage in our experience, since some endpoint already use them. But on the whole this has not been a major issue and the silver lining for us is that it has required us to refine our technical capabilities to leverage Direct. Certainly, the move to interoperable electronic communications is a step in the right direction for these reasons.

There are some key opportunities for future improvement and I'm going to start with one that is particularly granular and tactical. The C-CDA, as you may know, is a sentinel standard that requires an appropriately constrained set of core data elements, while enabling the flexible addition of other useful elements. However, as part of certification, each vendor needed to validate the VDT message, that is the C-CDA, against the transport testing tool, and this tool, while it's a big step up from Stage 1, returned error messages when supplemental data is added to the C-CDA. So for example, we incurred as we tried to include percentiles for height among the vital signs. As such, our options as an implementer are either to limit the information that providers can share to the allowed elements in the C-CDA or to create a separate, human readable document that diverges from the more limited C-CDA implementation and allowed elements. The providers have enthusiastically made it clear to us that they cannot provide quality care by strictly following the data constraints of the limited C-CDA. So clearly, there's an opportunity here to enhance the functionality or redefine the role of the transport testing tool, so that the human readable and C-CDA versions of a summary mirror each other.

A more strategic consideration is the fact that there are different documents that patients are required to be able to access for Meaningful Use, namely the ambulatory summary with historical data and the clinical summary for episodic care. This not only creates the need for greater training of our providers and potential confusion for patients, but it's also required us to continue investing in making the use experience around these individual documents as noninvasive as possible to providers, while still meeting the MU measure requirements. I choose the word noninvasive because while both of these documents do indeed have a very important place in patient care, the problem is that they distract both providers and patients from experiencing and leveraging other aspects of the patient portal that are more critical, such as for example, effective engagement of population health campaigns. This really suggests to us a degree of caution is needed, as the early results in Meaningful Use are a clear reminder to us there are still harder problems to solve in the present. Particularly –

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

Thirty seconds.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

Thank you. Particularly for consumers, these problems are not interoperability related, but rather are culture and incentive driven. In fact, after one and a half months of usage of our VDT solution, which is built into our Class #1 ranked patient portal, there have essentially been no requests from patients to use their own Direct address or to send to a specific Direct address. This suggested in the future there are going to be opportunities for other innovations around PCMH and accountable care that can give the real organic business incentive for providers and other caregivers to influence consumer behavior, a good reflection of what Sean had also mentioned his previous testimony. I think I'll just stop it there, I know the rest of my testimony is submitted over here, so if there are any other questions, I'd be happy to take them. Thanks.

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

Thank you and thank you to all the panelists. To the workgroup members, if you have questions please use "raise the hand" feature and we will get started with Larry Garber.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you. Great testimony everybody, thank you. So it's – at least what I'm hearing is that certainly view and download are not really that big of a problem from vendor perspectives, the transmit is a little bit more difficult, although not impossible. And I can see that as this – these get turned on, as all the providers in the healthcare system are trying to set up their portals, their tethered portals so that their patients can use these tools and the docs can get Meaningful Use dollars. That a given patient will end up with multiple portals that they'll be logging into from different healthcare systems and that it's almost natural that they'll want to use the transmit functionality to transmit summaries from Cerner, NextGen and athenahealth over to their Microsoft HealthVault account. And so I guess I wonder, today I'm asking this to Cerner, NextGen and athenahealth, what percentage of your customers currently if a patient walks in with their HealthVault Direct address, would the physician be able to send – transmit a summary to the HealthVault?

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

This is Bob from NextGen, I can – I guess I can answer that if I understood it correctly. So, a patient who belongs – first of all, I'm going to absolutely agree with you on your first comment that that is an issue then the enterprise patient portals that are popping up are trying to address that but, not quick enough. So the single patient experience in their continuity of care to log onto 4 or 5 different portals to get their information to then push it to a central place is a challenge. We – for our patients that have actually downloaded CCDs, we've got close to 100,000 individual downloads, individual patients have downloaded. Sending them to their Direct address at HealthVault is certainly something that is part of the implementation that it's – they would enter this in, they would need to know their Direct address. But a login to have that single login or a single sign-on from the portal to HealthVault, to make it a little more seamless, is not something we offer yet, but it is certainly something we plan on embedding in the product for the major personal health records out there.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

And Bob, this is Sean. Just a somewhat amusing side note, as we've been on this call, one of your developers has been – I've been working with him on email about getting into the Blue Button bundle. So, it's all good.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

Ha, ha, ha, takes calls like this sometimes to get people moving a little bit faster doesn't it.

Doug Wager, MS – Director of Personal Health Innovation – Cerner Corporation

This is Doug, so I – Doug Wager. I'd say there's a relatively small percentage right now that have implemented the transmit piece, they're all in line to do it and plowing forward with those plans. But from the portal, absolutely that'd be the easy path for someone to go in and do that functionality. So percentagewise people walking in I'd say not a huge percentage yet, but it's more just due to – getting those things rolled out, not be a technical limitation that we have.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

This is Jitin from athenahealth. So, I have two reactions to that question. In terms of the number of – the percentage of customers of ours who would be able to send their summary to HealthVault, the answer for us is 100 percent, since it would be our one, single-instance, multitenant cloud-based platform. So in that sort of scenario, it really is once you've connected to a HISP, we – all our customers automatically have the ability to send messages to that HISP. So there we have 100 percent. One point I'd like to – I think I should add on to the remark was, yes the transmit part is the harder part of the VDT requirement, that's technically the harder part. I don't think behaviorally that's necessarily where all of the eyes should be. The reality is, there is so much more that we'd want patients to be able to do with a patient portal.

I mean, the number one problem with patient portals today, across the board or almost across the board I should say, is that patients don't actually go to them. So if patients are going to them, and I know there are between incentive programs such as ACOs and sort of inorganic incentives like Meaningful Use 5 percent requirement that Sean alluded to, there is more push for them to go to those portals. But once they get to the portals, there is so much they can do to manage their health and to lead to those great objectives of the Triple Aim that just thinking about this as the technical issue and the technical challenges is kind of limiting the kind of power that we can give consumers in engaging with their healthcare. So to that extent, I think view and download is actually a very ripe and open area for continued innovation and potentially continued policy discussion, even as the technical challenges of the transmit piece continue to get worked out.

Doug Wager, MS – Director of Personal Health Innovation – Cerner Corporation

Yeah, this is Doug. So just to clarify, if we were using that same measure, we'd say 100 percent of our clients can do that as well. They have the ability as soon as they connect to the HISP, it's just that all of them haven't connected to the HISP, they haven't implemented Direct completely as organizations.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

And to add to that, this is Bob as well, from NextGen, that the patient's ability or the – to request their summaries has been up for a while. And again, any patient who is a member of a practice that has the NextGen patient portal, they automatically have access to the record by just logging in and saying it. And I agree that view and download pieces are important, but I think that one of the pieces with MU3, at least for some thoughts that we've had on our end is the patient engagement factor with their care plans. So in an ACO or PCMH, in an environment where you want the patient to be involved with the care plan that their various care providers are coordinating on, doing that through the portal seems – we just seem to have a gap. Where we want to have a portal for providers to be able to login to, to be able to see what each caregiver's care plan is, have it melded into one care plan and at the same time, be able to measure the patient's activities against the care plan as part of incentivizing the patient to be more involved.

And so there's a disconnect between a single care plan when you take in multiple providers that are caring for a patient, and the patient's ability to see that care plan and their C-CDAs from multiple healthcare providers, but not have it in an aggregate view, like the providers might have. There seems to be a disconnect as far as taking the next step take patient engagement in their own healthcare and following the care plans of their providers. And if we can find a way to meld some of these requirements into MU3, additional requirements may be from a tethered portal perspective that – not just to show in individual practices C-CDA and care plan, but to be able to show an aggregate care plan view, or aggregates, you know meds, for a patient to view. So I think there's some room for some requirements without adding standards – new standards and new transport protocols, but adding functionality at the portal level, at the view level of this objective.

I think if you do that, you really have to give the providers the equal requirement, right, so if the patient can see everything aggregated around care plan, that's great, if the provider can only see their small window, then that's a problem. Inasmuch as a patient could physically share with the provider, but yeah, I mean it really does come down to we need to have an aggregate picture of a person's health both to the provider and to the person.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

If I can throw in – this is Sean – really quickly. One – this – these scenarios of care management are really, they're the ones that light up, that really are happening with HealthVault today. And really what we've found is that the – it's not so much the need for a unified toolset, and I mean I think that's what people are getting at, as it is a need for the right information to be in the tool sets that each member of the care team uses. So very often we'll see HealthVault used in fact as effectively a little mini-HIE where somebody's working in their EPIC system, and that's what they do, but they have more context to do what they do. And if they want to put a message or change a care plan than that will flow through to the ambulatory space, where people are using a different approach.

And so it's an interesting – very interesting dynamic to watch evolve in that there are certain things that happen locally and certain things that happen globally. And I would expect we should see this sort of emerge not too – it breaks down pretty quickly, but it's a useful analogy to think about how I still have bank portals with my individual bank accounts and that is a really useful and meaningful part of my experience with those transactions. As well as a broader view that's more aggregated when I'm working with different folks, like advisors and things like that. So I think they all sort of play their role in an interesting way and it's been a remarkable couple of years to see that start to really happen.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

I'd like to add to that Sean, would love to see more of that, I know from looking at the different ACO organizations that I've dealt with and, probably the same as everyone else on this call. Multiple, multiple organizations that having a care plan that is shared by caregivers that is actionable within their respective software platform that they're running versus a patient having actionable pieces of that care plan such as here's patient education that needed to be read. And tracking when that patient actually read it and have they done the activities in their care plan that they're required to do and have the caregivers done it.

Finding that common ground just doesn't seem to work either in a – obviously in an integrated EHR at this point or an integrated PHR system, such as HealthVault. So, marrying the functionality that each of those allow which is the actionable items in a care plan, which is ultimately part of the patient engagement to improve their – to lower cost and improve their health. That's really the point I was getting at is a merger of functionalities that allow the workflow at the EHR perspective and allows a workflow for a patient perspective.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

Couldn't agree more, I think that you said it extremely well. That's exactly what we see more of and more and more's got to happen.

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

Thank you. Just reminder to our speakers, if you could please state your name before speaking. And Charlene Underwood has a question.

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

Thank you Michelle. And again, this conversation has been – the last part of the conversation relative to how we migrate from the current kind of venue specific views to the integrated view in support of collaborative care has been like a huge topic of conversation in the Meaningful Use Workgroup. So again, what it sounds like – and again, I would like your advice on that as one question. But more im – another aspect of that was, one of the things – and again, you could hear that conversation emerging from your discussion was, to make sure that in Stage 2 that if there was the advancement to that more integrated view that each of the venues would still get credit for the fact that a patient actually did look at the portal. So specifically in that area, are you seeing any issues with that interpretation? Because again, that was kind of the intent of how it was written, but sometimes the translation gets lost. And then secondly, coming back to the broader conversation relative to how we kind of advance the model of that more collaborative care plan in light of these two distinct kinds of domains starting to emerge.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

This is Sean, I'll just really quickly say that certainly the idea that a collaborative space, a space that's contributed to by multiple providers, can actually accrue back Meaningful Use metrics to those providers in a more shared way is actually probably one of the most – the reasons that people actually probably look to us for Meaningful Use. Many people have used us for transmit targets, HealthVault, for quite some time. But download and view, those ones really are, as folks have said, relatively straightforward to implement and when folks look at us, it's – one of the reasons is because they hope to make those part of a larger experience and a more collaborative experience for sure.

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

Right. Other comments in terms of kind of how to move this forward in the context of what's happening today and kind of the next stage?

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

Well, I think – this is Bob Barker with NextGen. From the patient perspective, in an ideal world the patient would be able to see all of their data, from all of their providers in a human readable form. And in addition, I would add, that for them to take action on a care plan that is included, I mean care plans are included in CCDs for a reason. So for the patient to not just take action, but to have that – to require that action to be reportable, I think that when MU2 first came out and there was the requirement that patients actually view or download or transmit that we heard some feedback from the providers that, hey, we can't control our patients. And the idea was, well, if we need to get patients involved, it needs to start with the people they trust, and that's their providers.

So we were, in essence, putting it on the physicians and the caretakers in the industry to help push the patients to participate in their healthcare. So by requiring, I'm in EHR vendors, so I'm going to be careful I don't –

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

Yeah, you have to be careful.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

– yeah, I don't want to suggest something that's going to give all of us heart attacks and more work to do. But requiring that patient-specific action items in a care plan can be tracked as to whether a patient is working those care plans to the extent that they should. And putting the percentage on that to say that you need to have at least 2 percent of your diabetic patient-base that you're tracking their care plans, that they're accessing. And that they are indeed doing – that they're at least accessing the care plan specifically and taking action on that, I just – it sounds like the next step to patient engagement that is tied to provider reimbursements. So to take it to the next level –

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

This is Jitin Asnaani –

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

– go ahead.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

In one sense, I agree that that seems like a very logical next step; on the other hand, what I'd caution is that the right – the step comes from the right source. What we're experiencing at athenahealth is we have a population health management product, which integrates into our EHR, as do many vendors. And, of course, we have a Meaningful Use Stage 2 certified EHR. And it's interesting that we see that in situations where there's a population health business incentive, for example within the context of an ACO, these types of interactions happen because they need to happen for the provider to be – to get paid and for the health system to do well against its quality metrics and meet its cost metrics. And so they find innovative ways of making that happen, they come to us to help them find ways of making that happen, and there's not necessarily the same cookie-cutter approach for every single type of ACO, every type of provider or patient out there.

But what we have from Meaningful Use Stage 2 with this 5 percent requirement, which is great and it's actually a reasonable threshold, is an inorganic requirement to go and do a specific action as required by Meaningful Use Stage 2. And it's not necessarily obvious to the provider why they're doing it except that they have to follow government mandate. So it's interesting that there are two different types of government mandates, one that intrinsically motivates and is in alignment with the provider and one that is more viewed as work for the provider. And it takes a ton of education on the latter one to get provider buy-in and patient engagement. And it takes a lot less work on the former one, because there's a very natural incentive to make it happen. So it's not really to argue the point that was just made, but to realize that there's actually maybe more than one way to skin that cat, even though it's clearly logical that that's the next thing we want to do is to keep pushing the boundaries of patient engagement.

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

Okay.

Doug Wager, MS – Director of Personal Health Innovation – Cerner Corporation

Yeah, this is Doug from Cerner. That really is a fantastic comment, put the incentives in the outcomes and let people creatively figure out how to change those outcomes, that's really important. But I think there still is value, we wouldn't be having the conversation, we wouldn't be having thousands of clients across our various organizations using patient portals if something weren't put in to get that infrastructure in the hands of patients, I think, in a lot of the organizations. Now the usefulness of it, I think then begins to potentially emerge as they see what the opportunities are, but I definitely agree with you, there need to be more incentive around the outcomes that help drive versus just pushing the buttons.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

Yup.

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

Let's hope by 2017 they're there.

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

Okay. Thank you. Deven McGraw has a question.

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

Yes. thanks Michelle. I wanted to follow-up on what – the point that Sean made and I think several others of you have made about the technical issues are one piece of this, but education of the provider community about how to best engage patients in using the view, download and transmit capability. And even educating patients, too, about the value of this. Is there anything more that any of you want to add to that? It's sort of an issue that slips sort of more into the policy stage than the technical space and in fact, we may not have any tools at our disposal within – in terms of the Incentive Program to make of a difference on this. But, we're on a public call and it'll be interesting to hear from all of you what you think might be helpful or needed.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

This is Sean. I'm not sure I have too much to add, I wish I knew the silver bullet message. But I will say that we are most successful in helping both providers and patients understand value when we can attach it to specific, very specific, very simple elevator pitch values. Of which things like keeping your family safe in an emergency or making it easier to register for camp or sports teams or things like that actually that can actually really hit very quickly are valuable. That said, I'm not sure that – I think that's more my responsibility and sort of the PHR and the patient engagement's responsibility to bring those alive. So I would hope that we would have a communications channel through ONC and the government to may be reach to providers, but I'm not sure how far we really can expect that to go, truthfully.

Robert Barker – Vice President, Community Connectivity Solutions – NextGen Healthcare Information Systems

This is Bob from NextGen. And I guess to that, I stick, I think to the smaller examples that to have some empirical data that says that a patient that was provided patient education based specifically on a diagnosis of diabetes or COPD, obesity. That the specific patient education material provided to them to validate that it was read, so let's say they stayed on the page that was submitted to them electronically for 15 minutes, which would be considered a reasonable time to read and understand. And to be able to do a comparative analysis on the empirical data of patients who are confirmed to have read their patient education are more in control of their A1c levels versus those that were provided the care plan, but did not read the material. I think this is the type of empirical data that the physicians are looking for to motivate them more. And again, I'm not a physician so I don't want to speak too much on that perspective, but to motivate them to say, I do have a healthier patient when I can incentivize them to do the things I'm telling them to do. Whether it's a five dollar Starbucks card because they read their patient education materials or a gift certificate to 10 percent off to a local restaurant, something of that nature. Just finding a way to get some empirical data to show that patient engagement is making a difference in the health of a cohort for a practice organization I think is key. So again, without putting regulatory pieces on this, but incentivizing in some way, and not just from the individual vendors but from an industry perspective seems not to be a bad direction.

Jitin Asnaani, MBA – Director of Technology Standards and Policy – athenahealth

This is Jitin from athenahealth. So I'd add another complementary perspective to this. Being cloud- based and having all of our providers on a single network gives us the advantage of being able – be able to train our providers virtually in a very consistent manner across the board. And – but what we realize is that even if you do good virtual training and you actually do good in-person training as well for practices that need it or practices where there are more complications, for whatever reason. The reality is that in implementing Meaningful Use Stage 2, or any other set of requirements, you will not always get it right the first time and particularly transitions of care and view, download and transmit, where we're doing something fairly new, something that should have been done in the industry for years, but it's only being done now.

There certainly we've realized that there are workflows and workflow adjustments there that providers are getting used to and in some cases, do not really get used to. And its detracting from metrics that we care about, which is, are they spending a ton of time with their patients – enough time with their patients versus how much time are they spending documenting that encounter? And so it's – I mean, to make a long story very short, a large part of the improvement of the experience for the patients and for the providers is just iterating on the solution that you've already built to make the Meaningful Use requirements. And in our case, we run on monthly updates. So we see that in February, at the end of February, the end of March, end of April, as we update the workflows and prove them every month, we'd love to kind of see what they did, it comes back to us in terms of how well are our providers and patients meeting those requirements. And I think that's just an important part of the process of getting data back from a program like Meaningful Use, it just – it won't come in the first month, it will come back iteratively over time, as vendors can improve their solutions and adjust to that feedback that we get from providers.

Doug Wager, MS – Director of Personal Health Innovation – Cerner Corporation

This is Doug from the Cerner. I think, I mean, those are all fantastic comments. In the end, we're trying to change people's behavior from unhealthy habits to healthy habits and from not taking their medications to taking them. These are things that are challenging to do. I don't know how – maybe incentives from a provider to patient is certainly a way to go. There are going to be intrinsic reasons people are going to want to do these things. But I think opening the channels and providing the venues to have these collaboration, have this communication and having the data understand what changes are having an impact is just critical.

So from a policy, practice, technology standpoint – even simple things like people's behavior will change if they know that they're being watched or feel they're being watched. And so we talked about, did you complete the education and motivating them for that. But even having a provider simply an automated message that goes out and says, hey, did our treatment work? Or, hey, are you following through on your care plan? Just some of those touch points, and I don't know how you – how that gets built into any type of a measure necessarily, other than follow-up. But those are some concepts I think would be important as well.

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

Great, thank you very much.

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

Larry Garber had a question, did you change your mind Larry?

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Well I guess the question is, before I ask my questions, do I have time?

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

Go ahead.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Okay. Just a wanted to touch – we had spoken with the prior vendors on transitions of care about some of the issues with developing trust and exchanging certificates. And I just – you talked about Blue Button Plus, and I guess I just wanted to give any last opportunity to talk – to bring up any issues that you've had either exchanging certificates to be able to process Direct messages, or whether there have – of trust anchors, whether there have been any issues with that?

Greg Meyer – Director, Distinguished Engineer – Cerner Corporation

So this is Greg, I'll address one key part of that. I've heard kind of peripherally some folks having hesitations of incorporating the Blue Button Patient Trust Bundle into their system. I think mainly that's due to the requirements to get into that bundle, basically there really aren't any. So the technical pieces, policy, governance or whatever behind that Bundle just probably isn't where it needs to be at this point. However, as part of that implementation guide, there are pieces inside of there that try to address some of those, I believe there's an Office of Civil Rights document inside there that speaks to that. But going forward with that I know there are efforts to try to curb some of the issues with that in terms of trying to get a minimal set of governance inside of the Bundle to address the issues that providers may have with sending that information. So I think going long-term with the Bundle, that where they're headed is probably going to take care of a lot of those issues.

Sean Nolan – Distinguished Engineer and Chief Architect, Microsoft Health Solutions Group – Microsoft HealthVault

This is Sean, I'd concur pretty much 100 percent. We really were very much, what is out there today was a collaborative conversation and there was lots of perspective and opinion about what the level of how challenging should it be, how much self-attestation versus something else should there be. And we took a stab that felt like it would inform, I think, what we should be doing in this space, but was never, I don't think really envisioned to be the end state for that Bundle. And it is sort of left out a little bit hanging today in terms of what's next and who gets to choose and what – sort of those types of things. That was sort of my second point in terms of that trust fabric. Somehow, and it's a very challenging balance, and one I really do see both sides of. But somehow we need to get it so that it's not a decision point at each implementation whether it's okay to share with patients in certain ways or not and so that definitely is work that needs to continue.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Thank you.

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

Thank you. And thank you to all of our panelists, we greatly appreciate you spending the time to share your insights with us. Mickey, I don't know if you have any closing remarks that you want to make?

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

Yes, always be ready to turn off your mute button when you need to. And no, I mean, I don't. I want to thank all the panelists, first off. I think it was a terrific discussion and very wide ranging so – and on fairly short notice for a lot of you, so I really appreciate it. And also, all of the workgroup members who joined in, especially the Meaningful Use Workgroup members who joined as well. It seems like we covered a lot of ground related to technical issues and the importance of resolving technical issues, but also workflow and culture kinds of issues as well, which as we heard, are if not as important, perhaps more important. And the overall context of how that fits into a broader landscape where everything is changing and Meaningful Use is just one part of sort of the patient in position dynamic going forward. So want I want to thank everyone and I look forward to synthesizing these comments as we heard today and also using those as context for the provider listening session we have next week.

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

Thanks Mickey. Before I open to public comment, Deven did you have anything else you wanted to add?

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

No, nothing to add Michelle, thank you. I thought it was absolutely terrific and I want to also add my thanks to all of the panelists and all of the members from both workgroups who were able to attend today. We got a lot of terrific information, thank you.

Public Comment

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

Thank you. And with that, operator can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

– who would like to make a comment, please dial 1-877-705-6006 and press *1. If you are already dialed in, please press *1 at this time to make a comment. We do not have any comment at this time.

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

Okay. Well thank you again to all of our panelists, we greatly appreciate your participation. Sorry Micky, were you going to say something?

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

No, I was going to say thank you Michelle for your help as well.

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

Yeah.

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

Okay, well thank you all and we look forward to our conversation next week with the providers on this same topic. Thank you.