



**HIT Policy Committee
Meaningful Use Workgroup
Listening Session
Transcript
May 27, 2014**

Presentation

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

Thank you. Good morning everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup and this is the second of two listening sessions that we are holding. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Paul Tang?

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

Here.

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

Hi Paul. George Hripcsak?

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

Here.

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

Hi George. Amy Zimmerman?

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

Here.

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

Hi Amy. Art Davidson?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Here.

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

Hi Art. Charlene Underwood? Christine Bechtel?

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

Good morning.

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

Hi Christine. David Lansky? David Bates?

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

Here.

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

Hi David. Deven McGraw? Greg Pace? Marc Overhage? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Here.

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

Hi Leslie. Marty Rice? Marty Fattig?

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

Here.

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

Hi Marty. Matthew Greene? Mike Zaroukian?

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

Here.

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

Hi Mike. Neil Calman?

Neil S. Calman, MD, ABFP, FAAFP – President & Cofounder –The Institute for Family Health

Here.

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

Hi Neil. Patty Sengstack?

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

Hi, I’m here.

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

Hi Patty. Paul Egerman? Rob Tagalicod? Stephanie Klepacki? And are there any ONC staff members on the line?

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

Kevin Larsen.

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

Hi Kevin. And with that I’ll turn it back to you Paul.

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
Michelle, this is Charlene I'm on.

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

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
You're welcome.

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

Great, thank you very much, Michelle and thank you all for joining us both to our Workgroup members and to our presenters. This is the second of two hearing sessions not the only public input we've had throughout the process, but the second of the listening sessions we've had in the past couple weeks.

This is related to Stage 3 and we all know that the Policy Committee has sent in its recommendations last month, but we continue to receive public input. Officially this will inform our feedback back to HHS when the NPRM is released later this year. But of course people can always listen into this public meeting.

Our purpose here is to understand from various stakeholders, we heard from two provider groups last time, providers, EPs and hospitals. Today we are going to hear from different perspectives related to advanced care models as you know that's one of our guiding principles for the Meaningful Use Program is really to support the newer advanced models of care rather than chasing the older models. And also to hear from vendors since they have to produce the systems that generate both the functionality as well as the reports from the system.

So, we are looking at what are the benefits that your organizations had from your different perspectives in Stages 1 and 2, what are the challenges as well and really in a forward-looking way, what do you recommend for, based on your past experience, recommend for Stage 3.

As, I've said, we've turned in our official recommendations but it still goes through the NPRM process, they take more public input before finalizing the rule in 2015. And Stage 2 begins in 2017. So let me ask George if he wants to add anything to our introduction?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University NYC
Thank you, Paul, no, that's good.

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

So, we really appreciate your taking the time to both prepare the testimony and for your time today and we have just five minutes for each person to make their verbal comment and Michelle will keep us on a tight ship and then we have plenty of time to have dialogue with the Workgroup members, which has been very productive in the past.

So we'll begin with panel three the first one for today and this is from various perspectives looking at HIT support of the advanced models of care. And Brian DeVore from Intel is our first speaker. Brian, are you available?

Brian DeVore – Director of Strategy & Healthcare Ecosystem – Intel Corporation
Good morning can you hear me okay?

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

Yes, we can, go ahead.

Brian DeVore – Director of Strategy & Healthcare Ecosystem – Intel Corporation

Well, good morning from the West Coast it's still kind of early here, but Paul thanks for having me. Members of the committee thanks for inviting me to give you testimony, mine is going to be very limited and brief to my five minutes, but it's going to give you the perspective of an employer.

And I know that while this committee spends a lot of time in the Meaningful Use criteria, I can almost speak on behalf of the business community and say we have no knowledge of most of this. We don't track Meaningful Use, all we know is that most of our patients are getting suboptimal care because as they move their data is not moving with them.

The system is changing. So, we're seeing progress. New models of care are certainly emerging. But what I'm going to tell you today hopefully is not discouraging but rather informative. What I see is that the letter of Meaningful Use is being met but not the spirit and what I mean by that is when asked actually to deliver on what they say they can attest to in Meaningful Use most of them either can't or won't do it.

They'll do it with providers across the country, but my employees don't go across the country very often. Most of it is local community movement data exchange the same problems we've been trying to solve now for the last 15-20 years.

So, again when asked to exchange data amongst disparate systems for the benefit of a person who moves I'm just not seeing that. I'm seeing it is too hard, it is too complicated. We've actually given some technical expertise as to how to go do that, how to move it forward quicker.

I know that 2017 is Stage 3 but we have employees obviously that are sick and need a higher level of connected care that is necessary. So, while the Meaningful Use timeline is fine, again, I'm going to encourage the committee to move as fast as possible so when 2017 hits we really are at a higher level of integration.

What I've done at our care model at Intel we've created kind of a new...some people call it an employer-based ACO. It is sort of like that not so much but there are components of it that are pretty comparative to an ACO.

But, given the business case for data exchange and high use of HIT, there are some incentives but there are a lot of penalties and if you can't hit my criteria by delivering better more robust care across those disparate systems you're going to have to pay for it financially and that typically is enough to move the systems very rapidly toward implementation of higher use of IT.

And again, I'm not so concerned that a local system here in Oregon can exchange data with a system in Florida because it doesn't happen very often. I want them locally to exchange information amongst each other because that's how patients move. And again, the penalties are not huge, but they are enough to move it in the right direction. Incentives, again, there is an upside based upon what you can save with the shared savings model.

Quickly, advice for the committee, again, I would just keep your eyes open if there's a lot of meeting the letter of the Meaningful Use criteria, but some honestly have told me they have no intent to ever really meet the spirit of what it does. Again, they view data as proprietary and while publicly they'll say they want to exchange it, privately, they just say, they rather would not.

Again, we are pushing the use of HIT. We believe in it. Obviously our business uses it. My advice would be to stand strong. Make sure those dates don't move again. There's power in the network and the network effect. I think once folks get on board and see what they can do with the data once they get it exchanged amongst people the old paradigms won't make sense anymore with that I'm going to stop.

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

Thank you very much, Brian appreciate your perspective. Next, from New Jersey HITEC William O'Byrne and Bala and I'm not going to be able to pronounce the last name maybe you can help us?

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Yeah, you're referring to Balavignesh Thirumalainambi, everybody in the country calls him "Bala" however.

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

Okay.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

We are with the Regional Extension Center in New Jersey. In that capacity we were awarded the funding back in 2010, we commenced, we're part of the State University here in New Jersey for Science and Technology, NJIT and we have been fortunately very successful in doing quite a few things.

First of all, we have built out our membership to almost 9000 primary care and specialist providers in New Jersey that way exceeded our goal of 5000 primary care providers. We are also in the process of and have developed several revenue-generating assets, which we sell or market to the providers. It's quite successful for us and we believe that the future for this Regional Extension Center is quite positive.

Having said that, my observations regarding Meaningful Use are as follows, number one, I think that there are an awful lot of assumptions being made that certain things exist in looking at the Meaningful Use rules that are not necessarily a reality.

First of all, we act as if interoperability was a reality and that the standards for interoperability and common transaction and code sets for electronic health records exist, when in reality, most EHR vendor systems don't talk to one another and they don't interact with the HIE in the community.

More importantly, there is the assumption that the states have built the EHR systems that they have been promising to do, and I can only speak from New Jersey, but the reality is that we still are floundering here in the sense that there is really little or no interoperability with the hospital unless the doctors join the hospital hub and pay extraordinary amounts of money to do that and to do the mapping.

Consequently, some of this is I think just an illusion and not a reality. And that makes for very difficult application of the rules and requirements of Meaningful Use Stage 2 and Stage 3. We act as if patients have the ability to receive and to digest and use electronic health information that they receive from doctors and from hospitals, but the reality is we've done nothing to conquer the question of health literacy. We have no idea whether or not the doctors know or the patients know what to do with this information.

Consequently, just saying to providers, if you're going to adopt a Meaningful Use standard in which they have to achieve certain core measures and menu measures at a certain percentile and over a certain group of patients, it really is an illusion because you can send all of these records or deliver all of these records to patients but the reality is that they probably are not getting them or even if they did they have no idea what to do with it.

You should also know that we favor, at least here in my Regional Extension Center, the use of lists rather than just menus for core measures. So if in compounding the rules there is a clear list of what the core measures are, say, 20 or so measures, and then require that each provider make a selection within it. But the way it is right now it is pass or fail on way too many things and consequently, inability to do something because of a technology issue or an infrastructure issue becomes the death knell for providers who are trying to attest.

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

Thirty seconds.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Yes? Question?

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

No, you have 30 seconds.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Okay. One last thing that I would like to say, however, is that there has been a public recognition in the industry that there's a lot of value to this. Doctors are in fact, getting data that they never had before. It seems to be coming more useful to them.

More importantly, the patients have the ability to be able to experience the value of electronic health information in the sense that they can make appointments easier now, they can obtain records if they can understand them, they can get their referrals electronically and prescriptions are filled much easier.

So there's lots of value to it. I just hope we keep going but we understand that we are based totally in the technology that is in reality and not what we'd like it to be. Thank you.

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

Thank you, Bill. Next is Charlie Ishikawa from the Joint Public Health Informatics Taskforce. Go ahead Charlie?

Charlie Ishikawa, MSPH – Executive Secretary – Joint Public Health Informatics Taskforce (JPHIT)

All right, great, thank you and good morning ladies and gentlemen. Thank you so much for the opportunity to speak with you about public health experience with Meaningful Use and how it can better promote advances in public and population health care.

JPHIT is a collaboration of nine national associations that help governmental agencies build and enhance informatics infrastructure for public health assessment, policy development and assurance. We represent a broad spectrum of governmental public health practice and policy in the United States.

And my remarks today draw on the responses to your questions that we have collected from local state and federal public health professionals from across the country. Now it's based on that experience that I have four messages to share with you.

These are, one, public health agencies are ready and committed to receiving and using EHR data but it is difficult for providers to acquire accurate readiness information.

Two, implementing public health EHR data transactions benefits both personal and population health with better public health data quality and reporting.

Three, continuing the core public health objectives from Stage 2 into Stage 3 will be crucial to realizing the full population health benefits of Meaningful Use.

And four, Stage 3 rules must support efforts to build greater Health IT capabilities for immunizations and reportable conditions. I'll elaborate on some of these points here in the time that I have left.

Now, public health agencies are ready and committed to implementing Meaningful Use. Over the past three years, state and local agencies from across the country have made significant investments to utilize EHR data. Critical keys to public health success in building these capacities have been leveraging existing federal funds and the provision of technical assistance from the CDC and the ONC.

Now in the future and looking forward, additional and more stable funding to support public health informatics infrastructure will be critical to sustaining the public health gains we are making through Meaningful Use.

It is difficult for providers to acquire accurate public health readiness information knowing what health agencies to report to, their relative readiness and priorities for public health data and how to get into an on-boarding queue and anticipate wait times is a challenge. A national database that can be regularly updated by health agencies would ease this challenge.

Now implementing public health EHR data transactions benefits both personal and population health with better public health data quality and reporting. Meaningful Use provides a structure for public health and healthcare professionals to work constructively on ELR, syndromic surveillance, cancer and immunization registry data exchange. Stage 2 is especially effective in promoting these benefits.

For example, during 2013, providers with EHRs reporting to the New York City Centralized Immunization Registry for Meaningful Use had higher data quality and reported administered vaccinations faster than providers with noncertified technologies. There is other data that I have referenced in the footnote of my testimony.

Continuing the core public health objectives from Stage 2 into Stage 3 will be crucial for public health and healthcare providers to realize the full benefits of these investments made over the last three to four years. With time, ELR and syndromic surveillance data quality and reporting will lead to greater capacities for early detection and more real-time population health assessments during public health emergencies.

Now, the Stage 3 rules must support efforts to build greater Health IT capabilities for immunizations and reportable conditions. Bidirectional communication for immunization and reportable conditions is important for public health for assurance and control measures and it is important for clinicians so that they can address population health issues with individual patients and across patient panels.

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

Thirty seconds.

Charlie Ishikawa, MSPH – Executive Secretary – Joint Public Health Informatics Taskforce (JPHIT)

Real-time querying of immunization information systems for patient histories and clinical decision support should be required in Stage 3 it is a service that registries across the country are using and hospital and lack of physician compliance with laws that require them to notify public health authorities of patients with reportable conditions remains a national problem. Therefore, the development of such technologies that support that reporting must be supported under Meaningful Use. There needs to be room for that.

So, in closing, on behalf JPHIT and the public health community, thank you for your dedication to our nation's health, we appreciate your leadership and the commitment of our clinical care and vendor partners to health IT that improves and protects both personal and population health.

Thank you for the opportunity to appear before you today. JPHIT stands ready to work with this committee moving forward.

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

Thank you, Charlie and next Mark Savage from National Partnership.

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

Good morning and thank you for your invitation. Perhaps the best way to share with the Workgroup what patients and consumers say about electronic health records is to brief you on a national survey the National Partnership commissioned that way, in effect, you hear from millions of patients not just me. You have my slide deck and I'll just cover the broader points and refer you to it for the details.

Who are America's patients? We are diverse and slide three sketches some, but hardly all, of this diversity. EHRs and Meaningful Use of EHRs must be designed for this diversity in their data collection and electronic communications between doctors and patients and patient portals.

Slide four highlights how EHRs and portals need to connect to America's patients. Patients are online and they are engaged at all ages. They expect Internet access and they expect mobile access.

The National Partnership commissioned the Harris poll to conduct a nationally representative online survey fielded in August 2011. The survey took care to select a pool of respondents who had an ongoing relationship with a main doctor and who knew what kind of record system, electronic health record or paper record, the doctor was using.

Slides six, seven and eight present the responses of patients across America to three key survey questions. How useful do you think EHRs are regarding certain functions? How much do you think your doctor's EHR or paper system helps your doctor with certain uses? How much does your doctor's EHR or paper system help you personally with certain uses?

Here are the broad consistent themes. On slide seven, patients thought EHRs helped doctors far more than paper records did across-the-board on such functions as timely access to information, managing health conditions and treatment and finding and correcting errors. For example, 80% of patients in the EHR group thought their doctor's EHRs helped a great deal or a lot to ensure that all of the patient's providers have timely access to the patient's health information.

But only 29% of patients in the paper group thought their doctor's paper systems helped ensure timely access a great deal or a lot. And across-the-board patients in the EHR group had much more positive responses than patients in the paper group.

On slide eight, patients believed that EHRs helped them personally more than paper records on such functions as understanding their health condition, sharing health information with their doctors and keeping up with medications.

The survey also asked patients about online access. When patients have online access to their health information in EHRs 80% use it. Moreover, nearly two thirds of the paper respondents also wanted online access.

Now this hearing focuses on Stage 2 and 3 criteria so on slides 10 and 11 we have mapped the survey responses to some of the clinical and patient facing functions in Stages 2 and 3. To be clear, the survey did not ask about Stage 2 or 3 specifically but as slides 10 and 11 illustrate the survey did ask patients about similar functions and objectives and patients found them important.

Take medication reconciliation for example. The survey asked more broadly about avoiding medication errors, 75% of EHR patients thought EHRs helped a great deal or a lot while only 38% of paper-based patients thought paper systems did so.

Today we are also able to give the Workgroup the very first peek at a follow-up survey, just fielded on April 21st through May 8th. Again, Harris poll fielded the survey using the same methodology and the results are only just in and are too preliminary to quote numbers, but the trends remain clear.

Patients overwhelmingly believe that EHRs are useful across the range of clinical and patient facing functions in Stage 2 and 3. Patients continue to believe that EHRs help their doctors and themselves personally a great deal or a lot. And even greater numbers of people with online access to their health information in EHRs use it.

So to answer the hearing questions, do patient's care? Yes we do. Patients who had personal experience with doctors using EHRs believe that many functions captured in the Stage 2 criteria are important.

Similarly, they believe many functions captured in the Stage 3 criteria are important including criteria dropped from the transmitted recommendations such as patient reminders. And nearly three fourths of patients whose doctors used paper record systems wanted their doctors to adopt EHRs.

Lastly, there are some important ways you can improve upon Stage 2 and Stage 3 criteria. You can help remove barriers to access and provide better online access for 58 million people who speak languages other than English at home.

And just as you are paying attention to usability of EHRs you can help improve the usability of patient portals across the range of literacy levels especially for the functions that patients find important such as those set forth in the survey.

And patients want to share relevant health information too. There is great promise in the coming work to incorporate patient generated health data. Thank you very much for your time.

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

Thank you, Mark and thanks to all the panelists, very informative and I'm sure we'll have some questions. Let me open it up to the Workgroup to ask and make some comments or ask some questions of the panelists. And you can do that by raising your hand on the website tool or anybody on the phone want to make a comment/question?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie when you have time, I'd love to ask a question.

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

Go ahead, Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So, I appreciate all of the information this was great and I wanted to hear a little bit more from Intel. You mentioned the penalties that were not significant, but drove the market in your area to have providers interoperate more or better. Can you give us an idea of what kind of fees you're charging or penalties you're charging that is just enough to move the needle but not enough to dampen the market?

Brian DeVore – Director of Strategy & Healthcare Ecosystem – Intel Corporation

Sure, let me try to answer that. It's not so much a penalty for the use of the technology what we've asked for is a set of outcomes or outcome-based measures that you can't hit without the use of technology. So population health, community exchange, it's kind of an upside, downside, you know, contracts that they sign and so there's no specific, you know, penalties because you can't exchange data.

What we'll see is if patients get frustrated and let us know constantly that if they show up at a referring office and they're there but the record is not there yet or it's in some format that the doctor can't read and so extra time is taken. What that does is that actually impacts the patient satisfaction score and that affects their pay.

And again, not specifically on the use of technology, I didn't say go deploy specific EHRs or EMRs, or PHRs or anything else, I just said, here's what I want as far as expectations from the system on what the patient will experience, what kind of care they are going to get, what evidence, evidence-based medicine they are going to receive and to do that your really can't do that without technology. So, again, it wasn't a full frontal attack it was just here's what I want on the backside and I trust you guys enough to figure it out.

The data exchange piece has been a little more problematic and that's kind of what I alluded to. They get the concept, but, again part of it is, you know, we're all amongst friends here, part of it is there is a cost sometimes associated with exchanging records outside of disparate systems and they don't want to bear that or they are willing to absorb it but they're not sure exactly how much work they should put into it. Is it going to be 1000 patients that want this or is it going to be 100,000 patients that want this?

So, part of it is somewhat of an unknown and there is kind of an unwillingness to either go put the work in to make it happen. And when they do go put the work in to make it happen they sort of want to guarantee that this is going to happen quite a bit. So, and I never can guarantee that. I never can say, you know, you're going to have 50,000 patients who want to have their data moved back-and-forth across the community.

So, but to answer your question, the incentives and penalties are based on the backend on outcomes and not so much on the technology.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you. Would you be willing to share those outcome measures with the committee?

Brian DeVore – Director of Strategy & Healthcare Ecosystem – Intel Corporation

Yeah, those are being compiled right now. Unfortunately we're still...we're almost done. We almost have the first year wrapped up, which is the entire set including costs and so as soon as those are done and verified, I'll be happy to share the process.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

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

And this is Paul Tang. I'll follow-up on Leslie's question. The first two speakers and particularly you, Brian, were fairly strong in saying, look we've got...there's some people meeting, your words are, meeting the letter of the Meaningful Use but not the spirit and your advice to us was for employers to help push further and to stand strong.

I'm interested in what your experience is in terms of talking to other employers and what's your sense of how employees feel about this? Do they share your concerns and your desire to push further?

And the second question is, what other advice do you have for us? You are doing a great job in what we might call this pull, you're setting outcome requirements that, as you say, and that's what our belief is that you can't achieve without meaningful HIT.

But what other policy levers do you think that we on the HIT Policy Committee, for our recommendations to HHS, what could we do to help move your agenda forward?

So, one, what's your sense of whether other employers feel the same as you do? And what other policy levers might you imagine we could help pull?

Brian DeVore – Director of Strategy & Healthcare Ecosystem – Intel Corporation

I'll sort of be brief again because I think the New Jersey person may want to respond too. No not a ton of employers are pushing this, Paul. Part of the problem is they already assume this is happening.

Again, most consumers and I don't know what the folks from the Partnership for Women and Families believe, but most people believe that the data is already being exchanged electronically because their bank does it. So, they sort of are disappointed when they find out their healthcare is not doing it.

I think employers are in a similar spot. They do see the efficiencies because most employers obviously use technology in their own business so they kind of get the benefit, but again, a lot of it is an assumption that the market is kind of, you know, already doing that.

And, so we're kind of an anomaly a little bit because we're a technology company. We kind of have been involved in this space for a while. So, again, while most employers don't pay attention to Meaningful Use criteria, we do for a variety of reasons.

So, I certainly, you know, talk about the benefits and they kind of shake their head and say, it's important but a lot of them are working on the benefit side. They are just trying to figure out how to tweak what they offer and not so much go to the inherent structural problems in healthcare to help try to fix them.

The second question you asked was what can the committee do? So, I have a little bit of a storied history with the government. I was part of AHIC when that was going too and that was really around driving standards and data exchange, that was the premise of the group when they put it together and I think there was some real hope that there would be some quicker and more rapid movement towards standardization.

And again, anything that the committee can do to kind of help tighten that down. Again, I think there is a cadence and a drumbeat to go do that. But anything you can do to move that along more rapidly would I think...there will be some winners and losers and some folks aren't going to get what they want but that's sort of how the rest of the world moves in other areas where you...we don't use beta tapes anymore, we don't use other things other than Blue Ray, I mean, things kind of win and lost and certain standards and so that's our view.

At some point you've got to pick one or pick a couple, move towards getting them implemented and then I will defer to the other gentleman from New Jersey.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Yeah, hi it's Bill O'Byrne from New Jersey. I want to make it clear I'm from New Jersey but I can't speak for New Jersey. I'm with the State University and the Regional Extension Center and not part of the government. That's an important point because I can sit back and I have, in our membership, about 9000 doctors in New Jersey and we're able to assess where the pain points that the doctors are having in Stage 1 and Stage 2 of Meaningful Use.

And the reality is that things are being required, at least in this state, for testing the Meaningful Use that are not as easy as they are to say. Saying, send out electronic health records or any kind of record to a group of patients or to all of your patients, or a percentage of your patients is really a wasted gesture.

It is absolutely essential that we do it, but I think it should always be coupled with programs to incentivize the patients to find ways to use those records. And to very well adapt their lifestyles and their choices to augment the suggestions and the content of the electronic medical records we're giving them.

I should also point out that on another issue the largest single employee in the State of New Jersey is the State of New Jersey. And one thing that I think would be extremely helpful is if the State and the New Jersey State Health Benefit Plan were to adopt a requirement that all electronic health information records be interoperable with say, the New Jersey HIN in which case you'd have a much larger environment for interoperability.

So, those two issues are the kinds of challenges that are going to be faced and just willy-nilly adopting rules and regulations and saying, these are the boilerplate requirements for Meaningful Use Stage 3 or 2 for that matter, make an impossible task for a lot of providers and they are never going to be able to reach it as long as the facilities are not adequate to handle them. I hope that answers your question.

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

No it does. Thank you.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Thank you.

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

Christine Bechtel has a question.

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

Thanks, Paul. Actually, I was wanting to follow-up on a comment that Bill made earlier and that I think he just reiterated, which is a question about whether patients and families, you know, know what to do with the online health information and I think he made a great point about health literacy certainly.

But beyond that, my question is actually for Mark and whether there is any indication or evidence in the newest survey around how patients are using information or anything that would give us a sense that in fact they do or don't know what to do with it that would point us to the value of the effort that it takes to get it out into their hands?

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

Thank you, yes, there is. We added a new question in the 2014 survey that asked how patients were using their online access. And again, the precise numbers, they are too preliminary, but what I can tell is that there are at least substantial majorities that are using their online access to review their doctor's treatment recommendations and care plans, to review test results, to e-mail their doctors or staff, to schedule appointments, submit medication refill requests, access immunization results. Clearly, the people who have online access to doctors with EHRs are using it in a variety of ways and that's exactly what we need.

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

Great, thank you.

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

Thanks. Any other questions?

Arthur Davidson, MD, MSPH – Director – Denver Public Health Department

This is Art.

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

Go ahead Art.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Yeah, I have two questions. One is, first for Charlie, regarding your first point, this is the HIT Policy Committee. Do you have any recommendations regarding policy that would help inform or better inform vendors and providers, and hospitals about what sort of public health readiness there is? I mean, is there some way that we could share that information and maybe through some policy, we might be able to get that to occur earlier?

And the second question is for Bill. It's great to have someone who has worked in an HIE and trying to show us the real experience and since there's this whole discussion that Charlie had about readiness, can you talk to the readiness of the Health Department in New Jersey?

And Charlie's testimony, the written testimony, there is a map there that talks about ability to transmit 2.5.1 messages for immunizations and a query and I just wondered, maybe you could tell us a little bit about your experience with that and what your readiness is in your state?

Charlie Ishikawa, MSPH – Executive Secretary – Joint Public Health Informatics Taskforce (JPHIT)

Art, thank you so much for your question. So, most certainly, as I said in the testimony I think, the provision and, you know, sort of following through on what was hinted at and stated in some of the, I think it was, the final rule last year from CMS that they were going to set up a centralized repository or registry for public health readiness information, I mean, certainly having that resource would be really important to bridging and information sharing around this public health readiness issue.

You know I think that, you know, given that resource there could be stronger language added to the rules around, you know, the CMS objective so that resource is the resource that eligible professionals and hospitals need to turn to in order to find out what the readiness levels are.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Thank you.

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

Thank you and Marty Fattig?

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

Hi this is Marty Fattig I'm a CEO of a small rural hospital...

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

I'm sorry, Paul, I just wondered if Bill would respond to the...

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

Oh, I'm sorry, go ahead.

Arthur Davidson, MD, MSPH – Director – Denver Public Health Department

Yeah, thank you. Bill, are you there?

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Yeah, I'm speaking. Can you hear me?

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Yes.

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

Now we can.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Okay, yeah, I want to make it clear that I'm not with the Department of Health and it would probably be a real challenge for me to say anything about what they can or can't do or to criticize them. So I'm going to kind of dodge that question.

But if you're looking for policy that would help, just last week there was a SIM funding announcement that came out for state implementation models. It would really help if there was a SIM policy to build specific state exchanges for public health information records. Right now it's a convoluted and disparate process, every state is different.

I'm looking across the Hudson River right now in New York and the rules over there and the ability to transfer public health information back and forth is virtually nonexistent. Not for any fault of anyone it's just that the barriers are there that are artificial at best.

So I think that using...if you are going to use policy it would be best to use the state implementation funds as ways to cultivate the development of networks between the states that would enhance things like public health records. So that's my opinion. And on the other part, dealing with the Department of Health, I don't think I should talk about that. Thank you.

Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health

Thank you, Bill.

William J. O'Byrne, JD – Executive Director – New Jersey Health Information Technology Extension Center (NJ-HITEC)

Sorry.

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

Okay, next, Marty Fattig?

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

Thank you, Paul. I am Marty Fattig CEO of a small rural hospital in Nebraska and we had a similar listening session last week where we listened to eligible providers and hospitals. I have visited with my colleagues and my own experience and all have indicated that it is very difficult to meet the requirements that 5% of our patients view...use the patient portal to view, download or transmit and yet, Mark's testimony says that a very high percentage of patients want and view their data. How do you account for this discrepancy?

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

Well, I don't know what the sources of your information are. I have the survey and I did not cover this in my oral testimony, not everybody...not every patient whose doctor was using an EHR had online access at that time in 2011. So this was a subset of patients, it was 26% of the patients who actually had the online access to the doctors who were using EHRs and within that 26% then we got 80% number who were using it.

This was a nationally representative study so I've looked at the demographic breakdowns. It was all regions of the country. There was not a breakdown by rural/urban, but I think I conclude from this that people in rural areas who had online access to doctor using EHRs were using it for similar purposes.

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

Thank you for your comments.

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

Sure.

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

Any other questions or comments from the Workgroup or on the phone? Okay, well, I thank this panel for your testimony I think has been very helpful and we appreciate you're putting your comments together and answering our questions. We're going to go to the next panel and we are earlier so I hope we have the panelists available. Let me just call out names and see who is available. Leigh Burchell?

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

Paul, I think everybody is here.

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

Great, okay. So, why don't we go ahead and start with Leigh Burchell then from EHRA?

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

Paul, before we go to Leigh can I just remind people that there are 5 minutes and I will give a 30 second warning and when we open up to questions if everyone could restate their name when they're asked a question for the transcription. And one last thing, we've gotten a lot of interference in the first part of the call so if you aren't speaking if you could please mute your line it would be appreciated. Okay, sorry.

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

No, thank you.

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

Okay, well this is Leigh Burchell I work for Allscripts and today I am here testifying on behalf of the Electronic Health Record Association where I serve as Vice Chair. Thank you so much for inviting the EHR Association to speak about our experiences with the EHR Meaningful Use incentive Program as we work toward our shared objective of making sure that it remains relevant to providers and delivers maximum value for their investments in EHRs and other Health IT.

We remain committed to delivering innovative EHR technologies to support the Meaningful Use Program and its increasing focus on interoperability and quality measurement having largely succeeded in accelerating adoption and achieving effective utilization of EHRs.

We were asked to comment on two main questions related to the challenges and success factors associated with Stage 2 and the advice we would give to the Policy Committee based on experiences with Stage 1 and Stage 2 to inform Stage 3. So our responses will integrate our perspectives on these two questions.

First and foremost, we believe we must design Stage 3 of the program in such a way as to avoid and also reverse many of the unintended consequences created during Stage 2. As everyone knows, CMS and ONC announced a significant relaxation of the 2014 participation obligations on May 20th and explicitly acknowledged that the Stage 2 timelines were simply too short given the extensive scope of the requirements.

Indeed, the thinking underlying this proposal aligns well with what we've learned from Stage 1 and Stage 2 and is a primary reason we've begun urging a more focused and prioritized approach to Stage 3 of the incentive program. Along those lines we applaud the recent work of the Health IT Policy Committee in making recommendations for which objectives should be included in Stage 3.

We believe that it has been refined in many ways towards the areas that present the greatest potential for return to value and the greatest opportunity to affect improvements across the healthcare system. However, we still believe the scope is too broad and recommend that further narrowing needs to be done by CMS and ONC in writing the proposed rules.

The emphasis in evaluating what to keep from the recommendations should be on greater and more effective use of the far-reaching and robust Stage 2 requirements and associated EHR capabilities as well as any needed enhancements for interoperability, care coordination and more effective and less costly quality measurement.

A highly focused approach will enable vendors to meet other customer needs and reduce the degree to which extensive prescriptive Meaningful Use requirements squeeze out development requested by our customers, impose costs and implementation on certain providers, slow certification implementation and interfere with usability.

It is essential that we take advantage of the opportunity that we have to avoid repeating Stage 1 and Stage 2 timing challenges for providers and vendors including allowing at least 18 months before a new stage of Meaningful Use takes effect from the final versions of all associated provider and developer specifications, ensuring thorough quality assurance prior to the release of quality measure specifications, the accuracy of the specifications, the Cyprus quality measure certification tool and associated test data and methods.

We refer you on this topic to the materials that the EHRA submitted prior to the May 7th Policy Committee Certification Hearing on this topic and establishing a 90 day or quarter reporting period for the first year of each new stage as was done for Stage 2.

Also, as we examine Stage 1 and Stage 2 learnings we would emphasize the following in addition to timing and scope issues. The importance of clear and consistent specifications, guidance and FAQs, there continues to be significant room for improvement here, the complexity of the program increases exponentially with each new requirement and keeping up with this accelerating flow of information has been costly and confusing for all stakeholders. And as stated earlier the focus on measurement and compliance has absorbed disproportionate vendor and provider time and in some cases negatively affected usability.

Additionally, we note that members of the EHR Association are highly driven to continue rolling out new and emerging technologies to enable value-based payment and accountable care such as those that support population health management, care coordination, quality improvement and enhanced revenue cycle capabilities.

We believe strongly that the evolution of such new and innovative products should advance in a market-driven innovative manner outside of Meaningful Use and certification. We also urge early active and real consultation with EHR software developers on development of Stage 3 Meaningful Use requirements, certification criteria and test methods and tools.

I'd like to end our testimony by highlighting the fact that the incentive program has, despite the many issues that we've outlined here in great detail, in fact served as an effective spur to adoption and use of EHRs into the much broader digitization of healthcare.

We've also made real progress in the building blocks of standards-based interoperability and quality measurement. There's more to do and lessons to be learned but the Stage 1 and Stage 2 certified capabilities and Meaningful Use measures should place us in a position for much more robust interoperability. Thank you.

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

Thank you, Leigh. Jon Zimmermann?

Jonathan Zimmerman – Vice President & General Manager, Clinical Business Solutions – GE Healthcare IT

Hi, yes, I'm here let me begin. It's really a privilege to be here with you all today. I'm Jon Zimmerman the Vice President and General Manager of GE Healthcare the unit responsible for our EHR revenue cycle and integrated care solutions.

We are very passionate about how Health Information Technology can help providers enhance the quality and efficiency of patient care. We're committed to the success of the EHR Incentive Program to providing products and services that facilitate truly Meaningful Use. I'm going to focus on two of your questions the key challenges and success factors and two the advice for Stage 3.

I'd like to first emphasize that the Incentive Program has helped our substantial documented increases in EHR adoption. We thank you for your leadership in this area. Overall, we are in an increasingly digital ecosystem with the potential for greatly enhanced interoperability to deliver better care at lower costs. At the same time, the program has created challenges for all parties. We appreciate your clear intention to learn from this experience.

As confirmed in the proposed rule on certification last week timing has been very tight. Despite our best efforts there has been insufficient time between availability of key information and when our customers need certified EHRs.

Meaningful Use is complex. Each measure has detailed specifications which generate questions and frequently asked questions. This complexity hinders orderly development and implementation and expands exponentially with each objective.

The need to measure Meaningful Use has created provider uncertainty in some designs and workflows that seem to exist solely for measurement for some. Audits have complicated the program and at times created a focus on compliance rather than the intended spirit of true Meaningful Use. Some of the programs all or nothing basis offers providers a stark alternative of an A or an F and we think that needs to be addressed.

There have been many challenges with accurate quality measure reporting as well. Vendors and providers have additional priorities including ICD-10, new payment and delivery models, usability and additional regulatory requirements. Program requirements have constrained our opportunities as vendors to innovate and make changes requested by our customers. So what do we recommend?

First and foremost, we appreciate a much more focused and prioritized approach to Stage 3 and associated certification. This should extend beyond your terrific work to date and much focus and collaboration has been achieved, but more is needed.

Consistent with recent recommendations by the Certification and Adoption Workgroup, the emphasis for Stage 3 should be on greater, more effective use of Stage 2 requirements and associated EHR capabilities and of course the needed interoperability enhancements. We also urge CMS to accelerate its efforts to align quality measures across programs.

Second, continue to apply Stage 1 and 2 lessons regarding timing to Stage 3. CMS and ONC should allow at least 18 months before customers need the next edition of certified EHR technology for release of final rules and final versions of all associated provider and developer specifications. We also urge a 90 day period for the first Stage 3 as with Stage 2 to enable the balanced deployment of the next edition of certified technology.

Third, for certification, add as few new requirements as possible and look for opportunities to eliminate existing ones that don't have as much impact. New and revised items should focus on interoperability using more mature standards.

Consider impacts on usability and development and implementation costs. We point you to the excellent work on the EHRA on these costs. Ensure thorough quality assurance before release of new and revised quality measures, test tools, test data and methods.

Fourth, new and emerging technologies for value-based and integrated care should advance in a market-driven manner and in general not be included in Meaningful Use and certification.

Finally, as we shift to value-based and outcome focused payments it is time to shift the focus on adoption and meaningful outcomes versus detailed and prescriptive usage criteria. Market forces are driving products helping providers succeed in value-based and integrated accountable care.

I'd like to close by touching on the third provider focused question asked of the panels. What benefits have you realized as a result of implementing an EHR?

Having spent many hours with customers, I can report that they see great value from their EHRs some of them who have been using them for more than a decade plus more than almost two.

The Incentive Program has accelerated EHR adoption and is a signaled accomplishment in our industry's history. Together based on this foundation, we can do much more in Stage 3 which CMS has indicated will be the last stage.

We encourage interactive partnerships and broader participation of stakeholders in designing Stage 3 like today's session. Thank you.

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

Thank you, Jon. Catherine Britton from Siemens?

Catherine Britton – Product Manager - Siemens

Yes, thank you. Thank you for providing the opportunity to discuss Siemens experience with the implementation of the 2014 edition Stage 1 and Stage 2 requirements. We hope that this experience can be constructively leveraged in framing the 2017 edition.

We fully endorse the intentions of the program to meaningfully use Healthcare IT to facilitate high-quality efficient care within and across venues. We are challenged to endorse specific implementation details and with our clients request a focus on those activities that are one, prioritized and documented as line of sight to the intent of measurable improvements in health, quality and cost. Two, specified with high quality and without ambiguity and three, allow sufficient time for equally high-quality implementation.

I would like to elaborate this input regarding timeline, scope and quality. The 2014 edition provided 13 months from release to the start of reporting and 24 months to the start of the last reporting period. Clearly that 13 to 24 month timeline has proven to be too short.

Also the rule emphasized Stage 2 whereas the majority of the impact including CQMs and view online, download and transmit applied to Stage 1 as well.

The Stage 2 emphasis underserved the urgency for the majority of the market to plan for, process, redesign and upgrades in 2013. The timeline was further constrained by the lack of completeness and clarity of the rule and associated material.

The quality of the specifications including CQMs and protocol mandates remain a considerable challenge even at this date. The combined factors of a truncated implementation timeline underestimated urgency in the market, broad process scope and quality specifications unnecessarily challenged client's ability to deploy quality implementation and hampered their overall enthusiasm for the program.

Translating this experience to the 2017 edition, we recommend that first we provide at least 18 months and align that timeline among stakeholders. A final rule in July of 2015 should drive the start of MU reporting period no sooner than January, 2017 and be aligned among EP and EH participants as well as among relevant quality reporting programs such as IQR. The 2014 experience shows that this timeline was too short as well as out of sync with other objectives.

Second, the quality of the 2017 edition and associated materials should be secured upon its release so that the time allotted can be fully utilized by vendors and providers. The rule should be released in the form of tip sheets where CMS and ONC requirements are clearly and concisely represented without ambiguity.

Test specifications should be released simultaneously. Test tools should not require vendor alpha testing and protracted defect resolution time periods. CQMs should be consistent with clinical practice with each other and with related automated measure specification.

Thirdly, the impact to providers, all stages, should be fully considered to ensure the scope is manageable within the timeline and should be unambiguously communicated for appropriate planning. CQMs, public health, patient electronic access and transition of care are key enablers of measurable improvements to health, quality and costs.

Details in their definition and objectives that appear superfluous in comparison defuse attention from these priorities. For example, feedback is that more robust processes exist today for tobacco use, race and ethnicity reporting and patient education, and that clinical requirements are hard to align with prescribed definitions.

It is important to note that it is equally important to manage both the required scope and the quality of how it is specified to ensure success. Scope should not be design prescribed nor process prescribed rather outcome prescribed. As an example of recommended scope, HITSP includes an increase in CDS utilization and a broader focus on priority domains.

Conversely, certification only criteria for CDS response tracking is proposed without defined utilization. The 2015 edition proposes additional prescriptive design scope for CDS and CQM which the timeline clearly does not support.

Neither proposal addresses the fundamental current problem of definitional quality of these CQMs. Similarly, the proposal includes process measurement of lists and attributes of data that should be replaced with measuring the outcome intended or if it's lacking de-scoped entirely to emphasize the items that do have clear outcomes. If the data and processes in these proposals are relevant to an outcome indicator, process measurement and certification criteria are superfluous.

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

Thirty seconds.

Catherine Britton – Product Manager - Siemens

If criteria are in line of sight to an outcome measurement it may be counterproductive to mandate it.

In summary, we recommend maximizing the program success by providing no less than 18 months for implementation.

Releasing complete, high-quality, consistent and unambiguous specifications, managing both the scope of what is required and the quality of how it is specified, avoiding prescriptions for collecting lists of data, measuring processes and/or designing software, aligning reporting and interoperability priorities among all stakeholders and insuring the appropriateness and maturity of the standards proposed. Thank you for your time.

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

Thank you Catherine, and finally Dan Haley from athenahealth.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

Hi, good morning. Thank you for inviting me to participate. I'm Vice President for Government and Regulatory Affairs at athenahealth a cloud-based provider of Health IT services to more than 50,000 care providers in all 50 states, serving more than 50 million patients, all on a single instance of cloud-based software.

While I agree with some of the points made by my colleagues on this panel, I'm going to confine my remarks to the big picture on which our point-of-view could not be more distinctly different. Our first speaker this morning said it all when he said he knows relatively little about "Meaningful Use" but his patients are getting suboptimal care because their data does not move with them.

With all respect to subsequent panelists who opined that interoperability is overemphasized we could not disagree more emphatically. In 2014 halfway through the second decade of the 21st century it is ridiculous and unacceptable that the government certifies for Meaningful Use information technologies that cannot or by design do not communicate outside of proprietary vendor networks.

In our opinion this sorry state of affairs is a direct result of the government's repeated acquiescence to the demands for reduced standards and delayed deadlines of vendors whose technologies cannot or deliberately do not meet the most basic expectations of information technology as they are used in every other sector of our economy.

Consider CMS now defines as a quote "hardship" provider use of some of the very technologies that the government subsidizes. This is an unacceptable state of affairs. It is an unnecessary state of affairs and it is a direct result of the policy failures in implementation as opposed to conception of the MU Program. With that in mind I look to the first question posed to this panel.

Our challenges are very different than most vendors in our industry. While many of them fall short of MU standards and advocate consistently for longer implementation timelines, we financially guarantee MU attestation. If our clients are unable to attest, we make up their subsidy. Happily that is not a frequent occurrence.

We recently announced the 2013 Stage 1 attestation rate of 95.4 %. A number that speaks volumes about the practical implications of our cloud-based services model, more, while other vendors convince CMS recently to effectively delay Stage 2 yet again, our cloud-based EHR software has been ready for 2014 attestation since before the calendar flipped.

Every one of our providers began using the same 2014 edition certified version of Athena clinicals in June 2013. Because we're in the cloud there was no need for disruptive updates or add-on modules. All caregiver clients receive our single instance of software at one time at no additional cost to them.

To be clear, care providers do not have "MU timeline challenges" vendors do, which they impose upon their provider clients.

To the extent that we experienced challenges related to MU, they come in convincing care providers that the delays and reduced standards consistently demanded by many of our industry are both unnecessary and harmful in the long run both to the providers investing their own and federal dollars in underperforming technology platforms and to the bipartisan health reform imperatives that animated the MU Program in the first instance.

I realize that much of this sounds like an Athena commercial but the point I'm making goes beyond that. Our results disprove beyond any reasonable refutation the argument that MU standards and timelines are unattainable. Using the correct tools they're not even particularly difficult.

It is profoundly frustrating to us to hear care providers and their advocates opine that interoperability in healthcare is an illusion it is not. The technology to bring interoperability to health care exists. As we heard in the first panel, the will to interoperate exists.

Government needs to stop setting policy goals to cater to technology laggards and formulate policy to bring more providers into the modern information technology age that starts with setting standards appropriate to 2014 and beyond.

So our advice to the HIT Policy Committee is simple. On the big important questions of Health IT policy, pay less attention to my friends on this vendor panel and more attention to the people we heard from on the first panel this morning.

Stop reducing standards. Stop extending timelines. Stop subsidizing technologies that do not meet the most basic standards of the program under which those subsidies are funded. We understand the need to legislate to reality to some extent but the effect of that is to perpetuate a reality that all observers deem unacceptable.

Demand more of vendors and many more of them will deliver 21st century functionality. Keep reducing and delaying and those same vendors will be more than happy to continue to sell annual licenses for non-interoperable static software that frustrates care providers, drives up systemic costs and fails to improve care.

If that is the course we continue to take, then MU Program should simply be scrapped to save the billions currently being poured into systems that year after year declare themselves unequal to the task of delivering on the enormous promise of Health IT. Thank you and I look forward to the discussion.

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

Thank you. Okay. It's been a very informative panel. I'd say it's been quite...the message has been quite consistent...this last testimony, but let me open it up to Workgroup members for questions or comments. And anybody on the phone want to ask? I know Neil, you are leaving in a little bit. George?

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

Thank you Paul, this is George Hripcsak. So to all the panelists, on interoperability, so we are hearing over and over in the listening sessions that interoperability is the key piece of that we're moving forward less on than the quality measures and patient engagement.

And I'm hearing occasionally here or there that the problem is standards and that has not been my impression that there is a lack of standards at least not in the sense of, you know, terminology standards or anything we have. It seems there are other problems.

So, if we want to move...if the single most important focus of coming stages of Meaningful Use were to be interoperability, I'm asking each of the panelists, what is the most important thing that has to be done to get that to go forward?

And I'd rather not just hear, well we need standards, because I don't think that's what's stopping large-scaled sharing of data across the country.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

This is Dan. I'll start if that's okay. I think the single most important thing you can do to encourage interoperability in healthcare is to stop subsidizing systems that don't interoperate and that means stop subsidizing systems that cannot interoperate but it also means stop subsidizing the implementation of systems that deliberately do not.

There are very real market imperatives to create closed systems in healthcare. The terminology, the term of art that I've heard in the ACO context but I've also heard outside of the ACO context is that closed systems make care networks sticky.

So, you implement a closed system, you lock your doctors, your care providers into that system, you lock your patients into that system and that's good from a market perspective, but if the federal goal or if a federal goal of the Meaningful Use Program is interoperability in healthcare, then stop subsidizing those systems. We would never argue for outlawing those systems when there's a market demand for them but stop paying for them.

Catherine Britton – Product Manager – Siemens

So, this is Catherine Britton, at Siemens, while there's certainly a closed system dynamic in certain areas, in the context of the Meaningful Use Program, you are already stimulating the openness of standards, the requirement to transition all those things.

So I'm going to take in context of the program itself. One challenge that has existed is that not everyone is incented within the program in the same timeline. So, coordinating transition of care across EP, EH when the programs are offset is one just sort of very tactical challenge.

One more strategic challenge has been aligning privacy and security. States have different privacy and security, understanding how that privacy and security matches with transition of care has been something our providers have grappled with and understanding how to measure Meaningful Use and also support consent and all those kinds of things. So having some sort of alignment on truly understanding, you know, and implementing privacy and security is something.

Other further little nitty-gritty things like patient matching, IDs and truly interoperating in a really usable seamless way. Patient identity matching is, you know, no doubt a challenge. We don't have national identifiers. EMPs are built-in, you know, certain, you know, domains that are not as broad as you might want.

And I think one of the first panelists mentioned the sharing of information. We actually see that challenge less than before. Providers appear to be more willing to share information and not see it as a competitive challenge.

But what almost everyone seems to be aligning on is a continuity of care model where communication about the patient's stay or visit, or health information is communicated into a "cloud" and then folks come get it as they see the patient next time and communicated among known caregivers.

Transition of care was designed a little bit differently than that where it is a point-to-point transfer or referral that seems to have gotten in the way or convoluted with the usability of the continuity of care and using the HIE as a push into the cloud and pull when you need it kind of concept whereas transition of care is defined more as point-to-point. So, those are some of the operational challenges outside of a standards implementation that we've seen with providers.

Jonathan Zimmerman – Vice President & General Manager, Clinical Business Solutions – GE Healthcare IT

This is Jon Zimmerman. I'd like to make four brief comments. It was really a great question. So, first, workflows matter a lot and I think Catherine just did a nice job of articulating a few of them that are really important. So that's critical.

The second one is provider usability and I did not specifically say physician. I mean the whole practice and how each member of the practice, both within a practice and a community can communicate very easily and openly with any members and other stakeholders including health plans.

I'd like to call for maybe a little bit of a different set of thinking. Maybe consider looking at the problem a little differently and consider the value of the listener. And in terms of not just how to interoperate but what does the receiver of the information need to consume and do with that information with respect to their role, be it patient, be it provider, be it family member, be it health plan?

So, last but not least, I think there's a lot of great technology in the world today that facilitates systems of listeners. I mean, for example, Google translate comes to mind you don't have to know the listener's language, but you can communicate.

There are probably some new opportunities for us to look at this problem with a slightly upgraded lens. So, I encourage more public-private collaboration and experimentation to take interoperability to a new level to make the whole system more friendly for all stakeholders.

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

Yeah and this is Leigh Burchell representing the EHR Association, we would not argue that we are lacking standards. To George's point, I don't think that that's the problem. I think we have most of the standards certainly that we need. It's simply a matter of potentially matching those standards to each business model in a certain environment, right, so our message for some time now has been that we don't want overly prescriptive models to be regulated that don't reflect the individual models of care, models of connectivity, models of payment potentially that are being implemented in various geographies.

So what we advocate for is absolutely standards-based, interoperability approaches but that allow for a certain amount of flexibility based on what any given environment is doing because healthcare is such a local market.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

This is Dan at Athena and I'll just echo that that's one of the many, despite my opening remarks, that's one of the many points on which you will find I think most people in the industry in broad agreement. To the extent that you want to emphasize interoperability, and I agree that usability is a big part of that, you do need to get less granular with each new stage of MU requirements. The more granular you are, the more everything looks the same and the less creative focus goes into solving the bigger problems.

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

Yeah and I would add to that, you know, I think a lot of people have said, this is Leigh again, that Stage 2 once it is fully embraced and implemented should deliver much of the way of the capabilities that we've been talking about.

So we're interested in allowing the Stage 2 capabilities to really come to fruition and to be used and then build on that using query approaches in Stage 3. That's certainly an important step that we need to move forward.

So we would certainly counsel against reacting too early to, you know, claims that interoperability isn't going to happen because we haven't seen what is capable based on, you know, some of the ideas that are included in the Stage 2 requirements.

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

That's very helpful, thank you. This is Paul Tang. I'm going to build on what George asked and thank you to the panelists for their responses. I heard a couple things. One is in addition to maybe technical or standards-based interoperability, we need policy interoperability. I think that would address some of the things that Catherine raised like patient matching, core dating, transfer of care, aligning the states privacy and security regulations, etcetera. So, there's some work we need to do there.

There is, even aside from policy interoperability and standards issue, we have certainly heard a theme both in our ACO hearing and our certification hearing and it was described by Brian DeVore from Intel, so I'm going to use his quote because it's coming, at least from a non-involved either vendor or provider, talking about meeting the letter of the Reg, Meaningful Use but not the spirit and we did hear this in multiple of our hearings about some impediments to either vendors working with other vendors or providers working with other providers. So it still is an issue and that's probably not covered yet by either technical interoperability or policy interoperability.

Maybe you want to offer some suggestions again what policy levers could we apply that would help equalize, you know, level the playing field, either on the vendor side or the provider side?

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

Well, this is Leigh Burchell for EHRA. I think we can already see that ACOs and other delivery system reforms and payment reforms are driving demand for some of the things that we're talking about.

I think what we need to look for is ensuring that those ACOs continue to connect outside of their own systems and that the other market drivers outside of the ACO model or similar models push that behavior. So, you know, I think we want to of course continue to be on the lookout for any patient lock-in, any efforts along those lines.

Certainly, I think, you know, what we hear is that interoperability continues to be something that requires a significant amount of investment and, you know, it's a simple statement, but it's very true that people are going to adopt the behaviors that are rewarded. And in healthcare of course, one of those rewards is the payment model.

And so, you know, I'm not sure it's within the scope of the Policy Committee, but we really need to continue as a healthcare industry to reward the behaviors through continued innovation in payment models that we desire to see. I think it's simple, but it's true.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

This is Dan at Athena I'll pile on to that and say that we talk about interoperability. The obvious question is, for what? And a big answer to that is to coordinate care to track patients along the continuum and achieve those efficiencies and cost savings that everyone is always saying that Health IT is eventually going to bring.

And in order to do that, we need to...policymakers need to broadly recognize what they've already recognized in narrow context. And that is that in order to coordinate care, you don't just need technology you need permission.

To coordinate care effectively and reduce cost you need relationships between care providers, some of them financial that today, outside of specific government defined contexts, like ACOs, are illegal. They are violations of Stark Law, Stark Act or they are violations of the anti-kickback statute and it's already been recognized in those contexts in which government has blessed care coordination that in order for that coordination to happen, there need to be waivers and exemptions to enable that.

We continually argue that those waivers and exemptions need to be broadened and made more widely available to allow again, creativity in provision of coordinated care outside of the specific defined context where government has said, here you shall do this.

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

Thank you. Any other comments or questions?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I have a question, this is Leslie.

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

Go ahead Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hi, thank you very much, all of you. I'd like to hear your thoughts on some of the industry collaborations that have gone on for instance with Allscripts and Cerner, and Athena, and others participating in CommonWell in an effort to come up with a technical solution to address the patient matching as one example or some of the work being done by those and other vendors trying to work on a solution, a more API-based solution like FHIR. What can we do in policy to help to foster these continued collaborations that will help meet specific needs in interoperability?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

This is Dan at Athena, embrace them and let 1000 flowers bloom. Don't in the impulse to help end up setting standards or creating rules that effectively inhibit one or more of those efforts. And there will be more. We are, you mentioned, involved in CommonWell and CommonWell is achieving tremendous results very early in its life cycle.

We worry sometimes when we hear about the need for the government to establish standards that ultimately what will happen is standards will be established that in some way impede or inhibit what we are achieving with CommonWell and what others are achieving in other venues.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Could, I follow that up? Dan, what you would say warrants a specific standard or successful use of standards? Because we've heard in the conversations in both early and in the panel that sometimes standards are absolutely necessary and sometimes they might be cycling. Where is that fulcrum?

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

I don't know where the fulcrum is but I think the fear stems from the recognition that these technologies are evolving continuously. They are evolving rapidly. And that's not different I think we kid ourselves sometimes that we are in this new technological age where everything moves so fast. Everything has always moved fast in technological innovation.

And the fear is that government has a propensity to, this goes to my introduction remarks actually, has a propensity to set standards and rules based on current reality that end up inhibiting progress going forward.

And so the standards, to go back to what other several other panelists said earlier, need to be flexible enough to account for everything we don't know about tomorrow and the day after tomorrow.

Jonathan Zimmerman – Vice President & General Manager, Clinical Business Solutions – GE Healthcare IT

So, this is Jon Zimmerman. I'd like to support a couple of Dan's remarks and go back to something that was talked about earlier, which is I think the focus on outcomes and some potential harmonization of different aspects of outcomes and what we're actually trying to achieve, higher-quality, more consistency, more understanding, and more efficiency.

So if we could harmonize from a policy perspective, what outcomes that the various stakeholders are looking for and be broader in our consideration of what a standard is, I think we'll, as I guess Dan put it, let 1000 flowers bloom.

You'll see meaningful innovation take it to where it needs to go, because as Leigh points out, payment models are pushing us there anyway including CMS's payment models. So I think there's a lot of payment innovation. If we could get some decent harmonization on outcomes, technical innovation will help us get there pretty fast.

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

This is Leigh Burchell. I wanted to add, because I can't strongly emphasize enough what we believe to be a really important opportunity for greater more of, I guess, public-private partnership approach to some of this and we've seen it in some recent work coming from ONC, the FDA and FCC in the FDASIA report where they have suggested the benefit in establishing a new Health IT Safety Center with that approach, the public-private partnership approach.

And I think there are opportunities here to do the same thing, you know, I have to go back to some of my testimony where we point out that we were, as the EHR Association, flagging concerns about exactly some of the challenges that we're facing quite a while ago and unfortunately, you know, had to wait quite some time for those to be addressed.

So where we can contribute more, where we can partner more with the Policy Committee, with ONC, with CMS, we're more than happy to do it to provide input that might be useful and might help us avoid some of those challenges.

Additionally, I think that if we are able to do that, we can also potentially balance some of the challenges maybe a little bit better around the intersection between where we're trying to go, what are we trying to achieve and the how so that we can take responsibility for the "how" and still be allowed to innovate in a way that we have been unfortunately limited recently, and also potentially avoid some of the challenges with things like usability.

Because if you, you know, speak to a lot of providers the EHR Association has been engaged recently in some pretty in-depth conversations with some of provider organizations around usability and in a lot of instances many of the challenges that are coming up are because of responses to the Meaningful Use Program and being, you know, forced in some ways to put things into the products or in places where they don't naturally flow and I know, you know, this committee of course has talked about that a great deal.

So, you know, those are things I think we could potentially avoid if we increase some of the engagement between private sector at a more detailed level and in a more consultative level based on some of the experiences that we've had in developing and deploying the software.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you, Paul, I have one more question if that's all right?

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

Yeah, sure, go ahead Leslie.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So switching gears a little bit, we know that the emphasis in the next phase of Meaningful Use are around care collaboration, coordination and patient engagement, what advice would you have as vendors as you look at some of the successful implementations we've seen including patients in their electronic digital environment?

What advice might you give us to continue to promote patient engagement and care coordination in a meaningful way?

Jonathan Zimmerman – Vice President & General Manager, Clinical Business Solutions – GE Healthcare IT

This is Jon Zimmerman, I would encourage to think through how we can publicize effective models. Who is doing it right? How did they do it?

I think a series of case studies and white papers, both from a workflow or all from a workflow, from a technological support in order to do it and from most importantly an outcomes perspective, I think the more that you can help promote success, it will beget more success. So I strongly encourage us to think through how we could do that to facilitate adoption.

Catherine Britton – Product Manager – Siemens

This is Catherine Britton I completely agree with that. The question you just asked is a fantastic question and I think absolutely should be a question for a provider panel as well. As technologists, we may know that customers are ordering care and contributing to HIEs and scheduling appointments and, you know, doing all those things, but from a workflow perspective, what processes the providers put in place that they know through their own evidence work? Because they can use multiple capabilities in our systems today and they do, and they use them in, you know, fascinating and surprising ways sometimes.

But understanding how they have utilized existing capabilities and capabilities they wish they had but from a very process flow perspective and a success-based perspective not only would help influence the policy but then would influence the enthusiasm of the other providers knowing what their peers did and worked, you know, so that they don't have to, you know, invent as they go.

Leigh C. Burchell – Vice President of Health Policy & Government Affairs – Allscripts

Yeah, this is Leigh Burchell. I think those are all very important points. And, you know, again, I think it comes down to incentives. And again, maybe outside of the scope of what this committee can do. But, you know, we need to get patients and employers engaged. So a lot of large employers are doing very, very innovative things to get their employees to care.

So the company that I work for, we have different tiers of insurance with different co-pays, different monthly premiums, etcetera based on, you know, whether we're satisfying certain requirements around preventive care. Of course, what needs to happen is we need to extend that in broader ways to even more and more people to get the patient's engaged as well.

I know there was some debate earlier as to really how much patients are actually engaging when they have the opportunity and I think another thing there is, you know, improved data as to really who is engaging, who isn't, you know, which audiences don't take advantage when they have the opportunity so we can evaluate what their motives might be that are different, you know, I'm always a fan of the more data, the better. So I would encourage more research in that area as well.

Dan Haley, JD – Vice President for Government and Regulatory Affairs – athenahealth, Inc.

This is Dan at athenahealth. I would just again go back to the opening themes and say that while it's good to be focusing on patient engagement and some of these more aspirational goals, at this point, so long as there is continual revisiting of Meaningful Use timelines and standards, some thought ought to be given to focus on the really big picture.

Patient engagement is wonderful using technology but if you haven't built the foundation to allow providers to use technology "meaningfully" in the colloquial sense, not the regulatory sense, then you are redecorating the bathroom before the foundation of the house is complete.

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

Thank you. Any other comments or questions from the Workgroup? Well, I want to thank the panelists from both panels today. I think it's been very, very helpful. It's been informative. I think there's been a lot of consistency, which is also good and not just in this listening session but across the multiple public input forums we've had.

I'm going to go ahead and try to do a little summarization of some of the points we've heard since we do have the time and also ask the Workgroup members to chime in.

It began from an employer's point-of-view looking...observing that sometimes the letter of the Meaningful Use requirements are met but not the spirit and making the statement we have heard before that proprietary business interests may still impede interoperability or exchange, effective exchange of health information and that's both in the vendor community and provider community.

You also gave the example that some employers, which does represent payers more broadly, are driving the outcomes through ACO-like incentives or program requirements. Multiple people have talked about how we really need at this point, you know, we've asked the question what other policy levers are there and it seems like we need to...as we've described in earlier conversations, hand the baton off really to payment reform, to pull the interoperability behaviors that we are seeking and really that leads to how health information is exchanged. Again, that probably does cross both provider and vendor cooperation and behavior.

We've heard that Meaningful Use should avoid being prescriptive to avoid the unintended consequences of overly specifying certain either certification or provider behaviors and to allow more market driven payment pulled innovation.

That we need more than just technical interoperability sometimes standards is not really the highest impediment that we need policy interoperability such as between states because all of us cross state boundaries. Patient matching is another example of that.

That timing alignment, not only the time it requires to both develop and to implement certain functions, but also the alignment...it's sort of the Swiss cheese, aligning all...because in transfer of care or transition of care for example you have to have a sender but also a recipient that aligns in your marketplace and that gets in the way. Another kind of alignment and timing is with CQMs, having all the programs or at least, you know, a lot of the programs aligning around the same CQM at the same time.

Multiple people have talked about focusing MU3 on high-priority areas where we do have to move the entire infrastructure and this has come up in multiple hearings, interoperability is one or health information exchange for the purpose of care coordination and CQM is really the harmonizing and focusing on outcomes oriented CQM.

Patient engagement from where it exists as the survey described is highly appreciated by patients. One way to move this more collaboratively would be to work more in a public-private partnership. An example was the FDASIA recommended HIT Safety Center and the "ask" was to involve vendors earlier in that as part of the public-private partnership.

Another example of collaboration and it's interesting to hear this from the vendors, is to publicize successes such as, an example was in patient engagement successes. Now interestingly, that's also a part of what was discussed in the IOM recommendation and FDASIA recommendation around the HIT Safety Center. Better information to the entire industry about what works and what doesn't work in HIT safety or patient engagement I think would benefit all and it's nice to hear the vendors say that as well.

And finally, that not only is sharing information with patients or consumers necessary, but helping them have the health literacy to be able to understand and to act on that is important.

So, I've tried to capture some of the high points. I know I haven't captured everything, but please Workgroup members chime in on things that I've missed.

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

Paul, it's Christine, I think we heard a lot on the timing and the delays, and the extensions, etcetera. And I think it was really from both viewpoints which we had not heard in a while so I wanted to make sure that we recognized that some people really, you know, support and want the additional time and others including employers and at least one of the vendors say that's a challenge. And I think the consumer view highlighted some things that, you know, are potentially either delayed or dropped because of those timing changes. So, I think that is an important point.

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

That's a good point.

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

And Paul, this is Charlene, the other piece I think that was pulled out pretty nicely was the public health aspect in terms of the kind of broader readiness of the states and transparency like, you know, that communication piece. If we had transparency of when the states are ready and that type of thing, that piece falls under that kind of access to information and maybe where some successes are so that might couple in there.

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

Excellent point, yes, I actually...yeah, that's great.

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

Yeah.

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

Thank you.

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

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie. I think the discussion might be worth handing to the Standards Committee about what are the philosophy or rationale for when standards are highly specified or when they are not, when we're silent which could be helpful.

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

Okay. Anything else?

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

So, Paul, this is Mike Z, I did hear comments around the issue of the sort of all or nothing pass-fail.

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

Right.

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

And kind of what we heard last time, the notion of whether there's anything between an A and an F.

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

Right.

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

The other thing I guess I also just wanted to reinforce, you went into some degree and that's the issue of the Meaningful Use letter but not spirit and I think one of the things I crave to hear more about is the issue of what would meaningful interoperability look like to providers?

I heard terms about interoperability at a more granular level. I can imagine as a provider myself how certain degrees of both presentation of data and availability at a more granular level might help push it, but of course, don't want to be naïve about either standards or policy that would be required to help make sure that works.

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

And it might tread on the "how" not the "what" or "what" not the "how."

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

Right.

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

Okay.

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

And Paul this kind of...this is Charlene again. This kind of comes back to just to pile on a little bit on that, on Mike's comment, was that, you know, the piece that Bill gave to...was about, you know, there's a lot of assumptions that pieces are in place that aren't in place when it comes to interoperability I think we heard that from the provider community too.

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

Yeah.

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

So, it's just, you know, how does the program meet the reality on the ground basically? And, again, having functions in place like RHEX is certainly one mechanism that does that. So, I don't think we want to lose that. I think that's a powerful one.

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

Great, thank you. Anything else?

Well, I want to express our appreciation again to both panels. I think it was very helpful. It was at times clarifying and also reinforcing...and I think we've...through these two listening sessions we've actually gotten some more ideas that have gelled in terms of feedback we can watch out for in the NPRM or concepts we can look for in the NPRM and feedback we can provide if some of these issues are not adequately addressed but it certainly has helped inform our view of this.

I want to thank the panelists very much for the thought you put into behind the testimony, your oral presentations and the answers to questions, really appreciate it. Anything else from the Workgroup before we open to public comment or Michelle? Okay why don't we open to public comment, please?

Public Comment

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

Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press *1 at this time. We do not have any comment at this time.

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

Okay. Thank you very much and Michelle can you update, do we have anything, any other calls between now and the virtual meeting in June?

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

We did have a Workgroup meeting next week I believe it was, but we rescheduled it, Caitlin if you...

Caitlin Collins – Project Coordinator – Altarum Institute

It's June 20th.

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

Thank you. So, we don't have a meeting until June 20th.

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

Okay, so we'll use this summary that we just enumerated as part of the presentation for June, because the June HIT Policy Committee is going to be virtual this time. Thank you everyone for your participation, appreciate it.

M

Thank you for having us.

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

Thank you.

W

Bye-bye.

M

Thanks for having us.

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

Bye.

M

Bye-bye.