

HIT Policy Committee Final Transcript February 1, 2012

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Good morning, this is Mary Jo Deering of the Office of the National Coordinator for Health IT. Welcome to the 31st meeting of the HIT Policy Committee. Actually, it's the 32nd meeting I believe and this is a public meeting. There will be an opportunity for public comment at the end. I would ask all the members to identify themselves when speaking because a transcript will be made. I'll begin by taking the roll? Farzad Mostashari?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Present.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul Tang?

Paul Tang – Palo Alto Medical Foundation

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Madhulika Agarwal? David Bates? Christine Bechtel? Neil Calman? Larry Wolf for Richard Chapman? Adam Clark? Patrick Conway? Art Davidson?

Arthur Davidson – Denver Public Health Department

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Connie Delaney?

Connie White-Delaney – University of Minnesota/School of Nursing – Dean

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul Egerman? Judy Faulkner? Tom Greig? Gayle Harrell?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Charles Kennedy?

Charles Kennedy, MD – CEO Accountable Care Solutions - Aetna

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

David Lansky? Harley Geiger for Deven McGraw? Frank Nemec? Marc Probst?

Marc Probst – Intermountain Healthcare

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

David Sharp for Joshua Sharfstein? Latayna Sweeney? Rob Tagalicod? Scott White.

Scott White – 1199 SEIU United Healthcare Workers East

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Natasha Bonhomme for Sharon Terry or is Sharon Terry on the phone? Okay, no. I'll turn it back over to you, Paul or Farzad.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Thanks. There was a report from the Bipartisan Policy Center recently that many, actually of the members of the Policy Committee and some of the Standards Committee also participated in, and it was I think a thoughtful look at where the current state is of our Health IT journey. It acknowledged a lot of the successes that we've had on adoption and on really beginning to move the needle on Meaningful Use and it pointed out the areas that are going to be priorities if we are to reap the greatest benefits from this Health IT movement in terms of really enabling the infrastructure for healthcare transformation and delivery transformation. And they pointed to a lot of the discussions that we've had here in the Policy Committee, I don't think there was really anything we hadn't discussed, but it was nicely put together, I think, and it highlights the need for a lot of the things that we're going to be embarking on in 2012.

The first is around really a big push on information exchange and interoperability and we're going to hear from Doug and Claudia today about our strategy and some actions underway to accomplish that. I've actually asked Judy to also make some comments about the interoperability and exchange activities that they're doing and how it fits into the broader strategy that we're going to be laying out.

The second thing they point out is around the engagement of consumers and really a lot of activities that we're doing in that domain in terms of making sure that people really do you have access to their information or are engaged and we even have the ability to include patient recorded observations into our clinical systems. And, I think importantly, linking what we're doing on Health IT to the ability to improve care quite explicitly and that includes some of the discussions we're hearing about goal setting around specific targets like Million Hearts and Partnership for Patients, we'll hear about that, and also quality measurement. If we are to really reap the benefits from Health IT not only as tools for improving care but also for monitoring and eventually serving the role in terms of accountability and payment that rewards quality, which I think is a critical element of the question why is this time going to be different than the last decade's attempt? I think one of the keys is that we're going to be looking both on the Medicare side, Medicaid and commercial plans not only a total cost but also quality, and we need to have better tools for monitoring quality and Health IT must play a crucial and critical role in that.

So, I do want to say these are actually, you know, very much in line with what the discussions of the Policy Committee and the Standards Committee have been and I think it serves as a good reminder to us that as we celebrate our progress and we'll do some celebrating as usual in terms of looking at trends that are consistently and persistently headed upwards, but reminds us to keep focus also on what more needs to be done and I think we've engaged that agenda aggressively and will continue to do that. Paul?

Paul Tang – Palo Alto Medical Foundation

Great, thanks Farzad. So today we have an interesting agenda that begins with an update on the status of HIE, Claudia and Doug are going to provide that input, and as we all recognize where Stage 2 is

headed towards, if 2012 the year of Meaningful Use that Farzad has talked about, then certainly soon thereafter we want to get that data spread around in a safe and effective way. So, that's why we're talking about HIE and that was an idea that Deven brought forth last time. So, we plan to have at least quarterly updates on this activity.

Then we'll continue our discussion about the work plan, laying out sort of a policy roadmap there and continue that discussion and look at the amount we have on our plate and prioritize. After lunch we'll get an update on the Million Hearts campaign which is an important CMS initiative, well CMS and CDC initiative.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

CMS, CDC and ONC.

Paul Tang – Palo Alto Medical Foundation

And ONC excuse me.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Thank you.

Paul Tang – Palo Alto Medical Foundation

So, this provides one of the goals and objectives, and vision for what we're doing within the HIT programs and then conclude with an update on the quality measures that David Lansky and Doug are going to provide, and then conclude, as always, with public comments. Any other additions to the agenda? If not, you all have the meeting summary from last time distributed, I submitted some edits to that. Other comments? If not, a motion to approve?

M/W

Aye.

Paul Tang – Palo Alto Medical Foundation

And second?

M/W

Aye.

Paul Tang – Palo Alto Medical Foundation

Any further discussion? All in favor?

M/W

Aye.

Paul Tang – Palo Alto Medical Foundation

Opposed or abstained? Thank you. So, we'll begin right away with our update on Health Information Exchange that Claudia and Doug will lead.

Claudia Williams – Director - Office of the National Coordinator

Hello everyone, it's great to be here and thanks for this opportunity. Just wanted to take us back to the last Policy Committee meeting for a minute where I think there were the beginnings of a really important discussion about where are we today with exchange? What's going on in the grant program that was funded by HITECH working with every state and territory to advance exchange? And where's the sort of strategy and roadmap both from a standards perspective, from a policy perspective and from an implementation perspective this year.

What I want to propose and with indulgence from all of you is that what we'd like to do today is have the first step of the conversation. I really wanted to start with an update on what's happening in the state HIE program. What kinds of patterns are we seeing among states, what sorts of activities are they engaged in, what's the sort of framework and sets of goals that we've established for them. But I'd like to be able to come back in March with colleagues and talk more broadly about our HIE strategy that spans well beyond the grant program and at that point I think we'll be able to have a fuller discussion looking at things like governance and Stage 2 Meaningful Use and have the full array of pieces in place that we can point to, to say here's where we are headed.

So, today I'll be focusing on an update on the state HIE grant program. And Doug will have sort of a complementary presentation talking about the key standards work that's been going on. Because these two presentations are really linked, what we'd like to suggest is that folks ask clarifying questions perhaps after mine, but let's hold the fuller discussion until both presentations have been made. I've also asked David Sharp standing in for Secretary Sharfstein to just give a couple of words of comment about the progress that's gone on in Maryland to date. So, he'll do that immediately after my presentation.

This is challenging whether you use the reading glasses or the eyeballs. Just stepping back, where are we today? Not just with the grant program but broadly for exchange and here are just a few data points, but I think they are really instructive in helping us think about the world that we're in. First of all, clearly there's, as people say, the future is present it's just unevenly distributed, and we see that there is a lot of exchange activity going on across the country and a lot of reports have talk about RHIOS and regional efforts, and even private efforts, but it's clear that a small proportion of both doctors and hospitals currently have the capability to exchange outside their own system. AHA reported last year about 19, it was exactly 19% of hospitals reported this capability, and I think we'll see an uptick in 2011 but it'll still be at a fairly low level.

We know that there's a lot of, for those who have the battle scars from doing this, and I'm sure David has a few of his own, it's a slog often to build the interfaces to EHRs, they are often quite expensive to build in part because each one requires its own tailoring and I want it to look like this and I don't want it to look like that, and some of that is frankly from the client end, and some of that is from the vendor end, but expenses are quite high, and the time it's taken traditionally to build the kind of, you know, query-based exchange that we think of traditionally as the exchange model, it's several years.

I remember talking with David Sharp and his colleagues when I was at Markle about three or four years ago when they were in the beginning stages of CRIS, so it takes time. But we see some real evidence of, really driven, I think, by the capabilities folks know they're going to need to be able to manage care the way that will be required for new payment models. So, if I'm to be held accountable for re-admissions, I need to make sure that my patient doesn't get lost when I refer them. If I need to be able to be accountable to a quality improvement using my system, the motivation I think in the business case frankly for exchange really lies at our doorstep, not just with the payment reforms that are already in place, but with the care transformation that we really think is going to be the driver over the next few years.

So, when you look at the marketplace, the CapSite report, 70% of hospitals report that they plan to invest in HIE services and the number of so-called private exchange entities which would be often driven by ACO type models has doubled. So, I think we are seeing, and I think the BPC report really reflected it, a great sense of urgency and also a great sense of momentum and the question is how we harness that urgency and momentum in a direction that's going to be affordable and in the patients, and in the public interest over the next couple years.

But I think, whereas two years ago an article about exchange would have focused very much on RHIOS and regional exchanges and are these occurring or not, now we're seeing a diversity of models to enable exchange some based in provider organizations, some based in vendors, Epic being a case in point, some being still at that sort of regional local model that we're seeing. And I think we're also seeing a full portfolio of exchange options meeting different needs ranging from the more kind of directed exchange option that is often really what's required for Meaningful Use to be able to find patient information to

allowing patients themselves to aggregate their information. So, this is just a quick kind of 10,000-foot level view of what the world looks like.

Now, so reflected in that we've really seen a definition of the state HIE grant program that reflects that environment and that reality. So, whereas I think if you would ask folks prior to the passage of HITECH what the state role would have been in every state it would have been to say to build that public utility function that's going to help us find patient information everywhere it is. And we saw a lot of work and a lot of effort going into that. I think in light of the environment we are in, in light of the investments that are going on in the private sector, and frankly in light of the fact that in some places a state level, think about New York or California, or Ohio, or Pennsylvania, you can't really get your head around what a state exchange would look like to support that incredible diversity of needs and partners, and people in the state. And really the evolution of our thinking about this program has been the role of this program is to catalyze exchange focusing on Meaningful Use, filling gaps, lowering costs and enabling trust. And, I'm going to walk through examples of the kinds of activities we're seeing.

Now, that's a lot messier than just saying we're going to have a public utility to serve the state. It would be really nice to have that first because it's really clear what you have to do. But this is a reality-based approach. This is where we are, we are in the world we're in, these resources are incredibly important and scarce and we need to advance the ball rapidly but in a way that's based on what we see to be the reality of where we are. Okay, next page.

So, we've put out a couple of rounds of guidance to our grantees and we put out a famous guidance in July of, gosh I'm mixing up the years now, that basically said the role of this program is to rapidly enable exchange to meet Meaningful Use and to build the infrastructure of trust and governance and other things that will allow you to advance across the full portfolio of exchange services. So, we have asked every single grantee to have a really clear strategy for how they're going to advance the participation of pharmacies and ePrescribing, how they're going to allow for two docs to have a safe transition when they refer a patient, so kind of care summary exchange that's built into Meaningful Use, and how to rapidly enable the electronic transmission of structured lab results.

This should look very familiar to this group because you guys came up with these priorities really and they're embedded in Meaningful Use. But what we've said is this is what is the same across everyone, this is our job, this is what we have to do. How you go about that will look different. But this is our job. This is what we have to do. Now, clearly there a lot of other fabulous wonderful things that have come forward as priorities for states whether from payers or from health care transformation and those can also be knitted into the approach, but critically importantly, we need to move the ball on the capabilities that you've laid out as priorities for exchange through Meaningful Use.

So, we are asking that our grantees make rapid progress. So, if you've laid out a strategy that five years from now will allow two docs to exchange information, that's not going to cut it. We've asked that they build on existing assets rather than, you know, in some cases attempting to say if we just move quickly enough we can ignore the stuff going on in the private sector and we've said no, your job is to leverage those investments. These dollars are not enough to do everything, so how do you leverage the private sector investments and make sure they're in the public interest. We recognize that there's a diversity of not just cultures but approaches and investments that have been made across states. And importantly, we are asking that our grantees leverage the full set of national standards. So, if you're doing something that looks a lot like transitions of care, we point to the work of the consolidated CDA and the transition work that is supporting Meaningful Use and through the S&I Framework. So, this is sort of the basic framing we're seeing that is sort of like everyone must do this.

And, I have to say that David can recount this, there's a certain amount of frustration where folks say "well, yeah great, those are all important, but what about this other stuff" and we do have a tendency to circle back and say let's hit the ball out of the park on this stuff and then let's integrate the other important criteria and important investments that you want to make as we go along, but we are far from hitting the ball out of the park yet on these basic functions.

So, just to recap, so here's where we are today where these commonwealth data, they actually, very fascinatingly, allow us to compare ourselves to other nations as well, but you see that only about a quarter of the time do doctors get discharge summaries within two days and only 19% of hospitals again, can share electronic information. This is where we are. Okay, this is 2009, so hopefully we're a little farther along, but basically this is where we are.

Here's the trend we've seen for ePrescribing. So, can we produce this trend for these basic important, critical, foundational elements in use cases that we want that are built into Meaningful Use. Will we see that care summaries are exchanged to support, you know, safe transitions this year, next year? We want to see this kind of trend that we've seen for ePrescribing. So, that's sort of the basic framing, but now I want to step back and say, okay so you have to focus on Meaningful Use, you want to rapidly engage. What are the kinds of things you might be doing? What are the problems you might be trying to solve at a state level? And, I just want to walk through these. What I'll be doing is walking through these basic core challenges then walking through the sets of tactics that we're really seeing and then give you a flavor of what we're seeing from states themselves.

So, first of all, white space and I'll just advance to this slide that's one of our favorites from Texas, which is this is actually literally the same pattern whether you're talking about broadband access or access to RHIOS, and Gayle you can give commentary as well. This is the white space in Texas. So, Dallas, Fort Worth, Houston, here in the blue where you have capacity, Lubbock, and West Texas and this important and critical mass of land you don't. So, this pattern is really duplicated across the nation where there are pockets of activity going on often in urban centers, often where there is more population and also more resources, and there are a bunch of folks who really don't have access to the developments that are occurring. So, one is this sort of white space issue.

Another is that you see a lot of efforts springing up and they're all kind of doing the same thing, they're all creating EMPI they're all creating identity services, they're all creating provider directories, and there's a challenge there around if resources are being sent over and over again for the same thing. We also see that exchanges are developing across states that aren't connected in any way, that don't have either the policies or the technical infrastructure to allow information to flow across them. We also see, and this is the Siamese twin of the white space, that critical access hospitals, independent labs, rural pharmacies they have not gotten on the bandwagon. They do not have a way to do this and often they need some extra resources, some extra attention to really get on board.

And next we see that, and Texas is again a good example of this, a lot of emergent exchange organizations that frankly need both funding and guidance about how to deploy in a way that reflects national standards. So a real need to kind of get folks over the starting line there. And then finally, the two final issues are lots of reporting needs of the state both public health and I think about the re-admissions reporting in Maryland that really could benefit from a more coordinated effort and from using electronic exchange to get critical data to state agencies.

And finally, as you think about that whole ecosystem, we are held back in making progress really by the lack of common approaches to both the technical problems as well as the policy problems. So, I'm sorry to be going through this too rapidly. But these are the sets of challenges that we see. And what you'll see then is a paired set of tactics and solutions reflected in our state grants that map to these problems. So, white space we're seeing a lot of interest in, what I will call in shorthand, is directed exchange, but it's sort of pairing up things like the direct protocol with the standards for lab and standards for transitions to enable the basic use cases of care summary exchange and lab exchange.

Fifty-one states, I won't say states, 51 grantees, because you'll see more than 50 in some cases, are doing something like this. Shared Services where we have provider directories and identity services almost all of our grantees are doing something in this area. I will say that what they haven't gotten to yet necessarily is the way to make that an open shared service. So, some are doing it, but some still have that kind of knit into their exchange network. We see several states doing things to connect the nodes, to connect the exchange entities, 25 are doing something in that area. This sort of REC for HIE where you're getting in and providing boots on the ground support for the less able exchange partners, we're

seeing about 20. And reporting needs of states, 28. Accreditation and validation about 17 and supporting local networks 5.

Now, these I would say I want to do a little QC with my team on exactly what we need in each of these areas. These are fairly generous definitions I would say of these kinds of models. But this gives you a good sense of the focus and the distribution of efforts across grantees to focus on these different issues. So, what we've also seen is that these packages of approaches are pulled together in some sort of recognizable models. I would say on the left side the concept we've seen is states like Wyoming and Montana where there's really just very little going on. What we're trying to do is jumpstart these basic capabilities on the ground really across the state. We see other states, and I think Texas might be a good example of this, where there were a lot of emergent, you know, kind of exchange-like entities that really needed support and guidance, and that's a strong role for the state HIE program in that case.

I think in the case of Indiana you see very well developed exchange activity but there really hasn't been a way for information to flow across, so they've really focused there. And, I think we're going hear from Maryland which has taken much more of a public utility approach which is a single state infrastructure that is serving the needs of a lot of different participants. But you'll see that as diverse as the state environments are we see models that fit each of them. Can I have a time check, Mary Jo?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Its 10:30 and you actually have quite a bit of time.

Claudia Williams – Director – Office of the National Coordinator

Okay. All right. So, I'll slow my talking down a little bit. Okay, all right. So, now I want to walk through some examples from states of what exactly they're doing and what they're learning, and what they're doing in each of these areas. So, we had an interesting, recently the case of Delaware, which is similar actually to Maryland, has had DHIN, which has been a fairly well developed exchange activities serving a lot of folks, but they still didn't have a way for two docs to easily share information with each other and this partly is based on the time it takes to build EHR interfaces and that it's hard to do that kind of mass outreach to providers, but I think this is something we see in a lot of places that have developed a sort of statewide infrastructure, you still may not have a way where Dr. Jones and Dr. Smith can refer a patient and share information with each other. Often the data that are in those systems are mostly hospital data.

So, what DHIN did was they launched a new service built on the direct protocol and literally in a month they had 500 providers and what was interesting is I think some of that was really helping describe how this could help a doc, a small practice do the thing they need to do to improve care and meet Meaningful Use, immunization reporting, sharing a care summary, and also the kind of long-term care transitions that we're seeing as being so critical for reducing re-admissions. But in addition, what we heard one hospital said "I think I'm going to get rid of the secure messaging thing I'm using internally because this thing is cheaper and easier to deploy and will help me actually connect with folks outside my system because it's an open standard." So, they actually said I'm going to scrap the service I have and start to use this just because by using the open public standard it's going to make my life easier over the long haul.

So, while we are going at this with the goal of getting to the last mile of docs for Meaningful Use, I think what we're seeing is that benefit of an open public standard that can serve many purposes and actually help folks reduce cost of what they're doing even at the enterprise level, which was quite interesting.

So Wisconsin has an existing provider directory that's really been spearheaded by the medical society. But what they're doing with their grant is really taking it kind into the next generation. So, what's interesting about this directory, and I always point people to...at Wisconsin when they sort of get into the haziness of saying I have a directory and my vendor is giving it to me and it's like, well, whose giving your getting your accurate data? So, what Wisconsin has done is created a statewide validation process that in their estimation results in 98% accuracy and this is done through hard work.

So, I think there can be a really important role of our grant program and standing up shared infrastructure if there's buy in from the participants who are going to use it and you're willing to make the investment in making the information really accurate, and validating it in a way that meets the needs of these different folks. So, look at this, quality organizations, the Medical Education Society, and The Wisconsin Health Information Exchange are all using this infrastructure to meet their needs. So, here's an example of an infrastructure that really set its standard by the business needs that are going to be needed by these organizations and has allowed for reuse.

Currently, it's more of a kind of white pages look up that doesn't really give electronic information, but they're moving rapidly towards including, I think it's like electronic addresses whether direct or otherwise in that directory. So, really great example showing the leadership that we can see in standing up a shared service that might be reused across many purposes.

So, Indiana, it shouldn't come as any surprise, they have five operational HIE organizations including HealthBridge and IHIE. But to date really have had no way that information could follow, I mean I would say there is a way, you can send it, you can mail it, you fax it, but no easy electronic way to share that information as patients move across the healthcare system and there's a lot of movement that occurs in the state. Some of these exchange organizations are based in Indiana, some are not. And what's been, I think very promising is that they've tackled this, not just as what's the technical piece that we need, but really what is the governance we're going to need to allow us to trust the rules and the policies, and infrastructure to allow this information to flow, and how can we build on both what we think of as the end of the NwHIN Exchange standards, as well as potentially things like Direct, to enable this statewide. And the other thing I think is really interesting is the state hasn't taken on the full responsibility for making this happen. They've said the governance for this is going to have to remain distributed but we're going to establish the basic rules and policies together that are going to make this work. So, very interesting model.

REC for HIE, so in many, many states what we see is the large labs able easily to connect and send results, especially to large practices, but frankly to a lot of practices. But the small independent labs and the hospital labs simply haven't been able, with their resources and time and attention, to make that next step. In some ways this has actually been made even more interesting by Meaningful Use because those same hospitals, you know, they have their eye on their prize, they're trying to get up and ready and get their systems in place, and I think the piece that we're trying to bring back to the table is you are also critically important for other people to get to Meaningful Use, so can we create a deployment such that you're able to adopt your EHR and meaningful use it, but also be a data trading partner for the providers, now let's remember that we estimate that 40% of ambulatory lab results are provided by hospital labs. So, this is a really, really critical area.

So, the kinds of things we're seeing are grants and technical support, and transformation services to create, take the message that's in proprietary code and turn into a LOINC message. A lot of focus on how you enable these smaller labs that have not had a way to deliver electronic structured results to send them to providers. And we are not going to be able to frankly get to the quality goals in Meaningful Use if we can't make real strides in getting those electronic lab results into EHRs quickly.

In California, and David can add his commentary later, one of the approaches they've taken is really to give connectivity grants to these emerging exchange entities. So let me just point to Redwood MedNet because I think they offer really interesting combination of things they are enabling. So the idea is that how eConnect gives enabling grants, but these come with strings, the strings are Meaningful Use and the strings are using standards and policies that are set both at the state level and nationally. So, for instance Redwood MedNet is supporting lab connectivity to EHRs, they're supporting hospital sharing discharge summaries with primary care medical homes, and also they're supporting providers sharing care summaries with patients themselves. So, again, you know, these are going to be discrete pilots but the idea is that they're going to both expand exchange capability in the state, but also offer models that could be replicated elsewhere.

I think this is a really critical area for our grant program, is enabling public health to take the strides it needs to take, and providers also, so that the public health reporting requirements in Meaningful Use become a reality in a couple years or hopefully, this year. We're seeing a lot of action in immunization reporting and a fair amount in ELR, but also the emergence of a lot of other important use cases like around newborn screening where the HIE capacity and the translation services are enabling much more rapid feedback to the docs, as well as reporting into things like the immunization registries.

So, in the case of Kentucky, for example, 55,000 babies are born every year and there are 48 metabolic screening test performed, but one of the challenges is those results don't get back quickly in electronically to docs, so they're really trying to tackle that problem so that the early intervention and treatment can reflect this important information that's feeding back.

And, then finally, the last sort of tactic is accreditation and validation of exchange entities. And I wanted to highlight Rhode Island here. So, Rhode Island saw that there was a need again to rapidly enable the kind of basic services that would allowed two docs to exchange care summaries to support transitions. But, rather than say we're going to contract with, you know, HISP entities and allow that to happen, and then maybe at some point we step back because other folks will come forward, they said "listen there are vendors out there providing these services very affordably, but we want to be sure that those services are offered in a way that meet our policy requirements in a way that folks can easily exchange across these HISP entities. So, they created a marketplace where they said, here are the requirements we have if you're going to be providing this kind of service in this state, and we will validate you against these requirements and then hold things like the certificate authorities at the state level to be sure that the same rules are being applied and you can easily discover the certificate. So, very interesting model that we're seeing reflected in several states.

Okay, so we have this strong focus on Meaningful Use. We have this set of challenges that states are really trying to tackle by filling gaps, by assuring trust, by reducing costs. But it's not going to really work to go to each of our grantees and say how many lab results did you exchange? Because often what they're trying to do is support a marketplace to do that. Sometimes they have infrastructure that is allowing for that, but sometimes what they're trying to do is enable that to occur in the marketplace by providing a little bit of a gasoline service here and there. So, the kinds of good questions you are asking around where are we today in exchange occurring are just the right ones. But we really had to step back and ask "well what's our best way to measure that" unlike with the REC Program it's not going to be having a CRM that all of our grantees enter into every day, because while they will in some cases be enabling services and transactions in other cases they won't. So we've worked closely with our evaluation team at ONC to say at a national level and state-by-state, what are the markers that we're making progress?

So, one of the markers that we're making progress is the national physician survey NAMCS, that those docs say that they're exchanging clinical care summaries. One of the markers for our progress is in the AHA survey, again those hospital say they can enable the capabilities of Meaningful Use. One of the markers is that through the Surescripts data we're seeing an uptick in the number and percentage of pharmacies that are enabling exchange. So, at a broad level what we want to be doing is really tracking nationally how we're doing against these key exchange metrics and we are going to be feeding those data back to our states and saying here's where you are today, what's your goal for this year and do your strategies and tactics really line up with moving the ball on that goal? But that leaves you sort of unsatisfied, because frankly we kind of want to know the transactions.

So, we are asking our grantees to report that to us and I think it would also be great to have a conversation with this group about whether through governance requirements or through other things that we're doing, are there other ways we should be measuring the level and kind of transactions that are occurring across this incredibly diverse and heterogeneous healthcare system so that we can leave with that more satisfied feeling of knowing what's going on and knowing where the gaps are. So, this is a conversation I think we'd like to reinvigorate when we talk to you in March. But these are a set of metrics that we have national sources for that also allow us to track state-by-state progress in every case that we are using.

This is more just a taste of the conversations I think we need to have with you over the next year. So, there's a lot of investment that's been made in exchange capacity that's resulted in very little adoption. And I think there are a lot of reasons for that, some around, maybe we haven't thought hard enough about the use cases, some around the fact that this is a new habit that hasn't had a business value attached to it. But we in our program, and I think broadly at ONC, need to tackle this. It's not our job to exactly figure out the workflow for every system, but we need to be able to describe what it is that drives adoption of exchange and do we have the right pathways forward because what we do not want is a lot of investment with very little uptick. And our job is not to provide the business case, but our job is to figure out okay is this kind of workflow to do a closed loop referral that requires this standard from Doug's office and this kind of capability from in EHR, and frankly this care process change, is this what's really working. So we need to dig deeply into this, this year.

I think we're also seeing a real flowering of interest in linking the exchange investments to specific kinds of payment reform initiatives, medical homes, ACOs and others, and I think we need to push our thinking on what that means for the exchange capabilities that are really needed in each of those models and they are sort of, Aaron McKethan, used to talk about the tribe, here's a case where the tribes are alive and well, you have the PCMH tribe and you have the HIT tribe, and you have the exchange tribe, and we cannot let those tribes be separate, we need to bring those together. So, we need to describe the pathway for really HIT enabled PCMH including exchange and what that looks like.

I think, you know, we have different models of exchanges for different uses. I think on what we're calling sort of that direct, you know, pushing a message and receiving a message back, there's some questions about scaling, those have to do more with the protocols that lie at the edges, things like certificate management, directories, trust frameworks that I think you all have talked about in the context of governance, but if we simply have sort of protocols to do this but we haven't figured out that bigger set of questions around if we want this to scale nationally how do we do that? I think we really need to tackle these basic questions around trust certificates and directories.

And I think for the query base exchange there are some really critical policy issues that we've talked about that you've put forward recommendations on and that we really need to take kind of back through recommendations and the policy process around, you know, all of the things from access provisions to RLS, the things that the Tiger Team has worked on so hard. Also, I think there's issues of scaling also very much in this model and I think we've been looking at a modular stack for the NwHIN exchange standards and what that looks like and how you deploy it which is critical.

On sustainability, one of the conversations we've been having I think with grantees, but also more broadly is to try to bring a kind of Clay Christiansen perspective to this question. So, if what you're saying is this thing I built cost \$10 million to sustain and who is going to pay for that, that's a very different question than what is the thing we can deploy that it is sustainable given the resources, capacity and standards we have today? So what we're trying to do is encourage that conversation that may have to do with disruptive cheaper ways of doing things, maybe not a zero to A- Z solution but you've solved this third part, the first third that's the most challenging, you've thought about ways to use the grant program dollars to bring down the cost of exchange through shared services, but we're trying to kind of, to some extent, flip the question so that we can, we're focused again on adoption and scaling and what are the models that are going to be rapidly adoptable and scalable to answer questions and then how do we get to the next layers of sustainability for the more robust services that we need.

And, finally, business practices. There is a lot of finger-pointing that goes on around why it is that exchange isn't impossible today across different vendors or across different providers. And I'm sure there's a grain of truth in all of it from, you know, our standards need to be better and, you know, the deployment needs to be more regimented and we all need to adopt the same standards. But I also think the reality is that there has been an environment where business benefit accrued from not sharing information and that is changing rapidly as we look at payment reform, but we need to deal with and have open conversations about how to be sure that business benefits are accruing to folks who are able securely and privately and great ways to share, and also be able to sort of unpack the conversation a little

bit so that we can identify where there really is a standards issue or there really is, you know, an implementation issue and maybe ones where we need to have real conversations about how to create business models that support the care transformation that we really want.

So, these are just a taste of some of the issues I think we want to bring back and a broader conversation about exchange, but just wanted to touch on them briefly. So, our proposal is maybe just have clarifying questions now and then go straight to Doug before opening up.

Paul Tang – Palo Alto Medical Foundation

Let's go ahead with Doug now.

Claudia Williams – Director – Office of the National Coordinator

Okay.

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

Great, well thank you, that was a very nice introduction of all the work that's going on in the state HIE program and what I'd like to talk about a little bit is about some of the work that we're doing in my office to help support those efforts and all the stuff under the hood that tries to get us from point A to point B, and hopefully provide a mechanism to understand a little bit about what our strategy is, what our approach is, what are the activities that we do and where we are so far with at least a portion of our portfolio.

You've seen this slide before. There are three things I do in my office, we enable stakeholders to come up with simple shared solutions so we use the power of government to really kind of convene people and say we all share a common problem let's see if we can come up with a solution that we all can agree upon and that's a really critical step to getting towards standards and interoperability. Then, once we've got those we have a portfolio of different things to Claudia's point, we don't believe there's a one-size-fits-all. We believe that we're going to have to have different approaches that can be customized and that can be applied in different kinds of settings. And so that portfolio of standards, services and policies are the building blocks upon which we can create interoperability.

And then finally, the last thing that we do is enforce compliance and that's through our certification program. If we've got good specifications it means something. If somebody says I'm following that standard, it means that I might be able to exchange information with you at a lower cost without creating customized interfaces. And so, enabling stakeholders, curating that portfolio of solutions that work and then enforcing that people follow those rules is an important aspect of our activities that we think are going to be important to getting us to an interoperable healthcare system.

So, the thing I think that's important is we're going to talk primarily about transport and security, but our portfolio is broad, it has essentially five different components in it or layers, if you will, and each one of those layers answers a question. So when we talk about vocabularies and value sets, the question we're trying to answer is how should well defined values be coded so that they can be universally understood? So that when somebody says the patient has congestive heart failure and there's a code for that, that everybody understands what that is and so we're answering the question about how can we code things so that computers and others can understand that.

The second layer in our interoperability portfolio is something that we call content and structure. And the question we're trying to answer there is how should the message be formatted so it is computable? So, how do we create, how do we structure our message such that a computer can read that in and know what that information is and sort it out so that it knows when we're talking about medications or it knows when we're talking about laboratory test results?

The third layer is transport and that answers the question how does the message move from point A to point B. So, how do we get it from one system to another system? Paired very closely with that is security. And so how do we ensure that as that message is moving that they are secure and private, and

that nobody can take a look at it who isn't authorized to do that. And so transport and security are fundamentally tied at the hip and they need to be able to work together.

And then finally we've got a layer that we call services. So how do health information exchange participants find each other? That would answer the question about directories. How do they find things like certificates so that they can make sure that things are encoded properly? And so, when we think about enabling an interoperable healthcare system we have to think about answering all five of these questions. How do we define information so that it's universally understood? How do we format it so that it's computable? How do we move it from point A to point B and secure that it's private? And what are the additional services that we need to make sure that we've got all the pieces that we need and that all of the pieces work together?

Now, today I'm only going to really talk about transport and security because that's where the Direct Project, which sort of added to our portfolio, this sort of directed exchange and the NwHIN exchange, the participants who have been involved in some of the early pilots about how to organize information exchange participated. So, I just want to give the committee an update on what we're doing there.

Now the last time I was here, about a month ago, we ran through an example patient scenario and so I wanted to pull this up again and sort of show how that maps to the questions. So, this is a very common use case, a primary care doctor orders a lab test, gets the test results back from the lab and schedules the patient to be seen in the office. Based on the results of the test the doctor then decides to send the patient to a subspecialist. She sends a summary of care record to the subspecialist electronically with a summary of the most recent visit. And then finally, when the patient sees the subspecialist it becomes apparent that there are missing tests that were done at a different hospital that would be helpful in taking care of the patient. Rather than repeating the test the doctor then can query the outside hospital to get the test results that it needs. So, the issue here is, and I'm not going to go through every single one of those, but I'm going to map it at least to that first use case.

Each one of those use cases may require different kind of vocabulary, different kinds of message specification and different kinds of transport. And to answer even a simple question like this we have to be able to provide answers to those five questions. So, let's take a look at the first one. The physician orders an outpatient lab test on a patient and the lab sends the information to your office. The patient is now here to discuss the results. So answering the question about how should well defined values be coded so that they can be universally understood? We have vocabulary standards; something called LOINC that allows us to create an association between a lab test and a universally recognized code that every computer that understands LOINC will be able to interpret. So, it doesn't matter if you say complete blood count or CBC, or whatever it is there's a code that corresponds precisely to what that means, the content and structure, how should that message formatted so that it's computable?

I think one of the things that we've achieved with the community in the standards and interoperability framework is that we have now gotten national agreement on a single standard for laboratory messages. So, HL7 2.5.1 there has been essentially national agreement that that is a format that can be used for all laboratory test results reporting, public health reporting, and we have gotten laboratory vendors, we have gotten electronic health record vendors, providers, CDC, the public has all engaged and there is essentially agreement that this is the path forward. I think that's a tremendously significant event that I thank the community for coming together with this because it has clarified the path forward. And if you know kind of where you need to go it becomes much easier to build your strategies about how you're going to create your technologies. Our goal here was to reduce the cost of building customized interfaces to laboratory systems. So having laboratory companies engaged as well as EHR vendors and having them agree on what both endpoints are is a tremendous accomplishment that I think through the guidance of this committee and HIT Standards Committee I think we've been able to sort of get to.

Transport, how does a message move from A to B? Well, this is a situation in which you take the LOINC code, the universally accepted sort of content structure and you attach it then to a direct specification or a direct message that sort of allows us to securely e-mail that from the laboratory to the electronic health record, that has to be secured and we use a particular standard based on what are called certificates, it's

sort of like I've got a key and you've got a key and we can both turn it, and that locks it, and then you need both of those keys to unlock it as well, and it assures that both of those endpoints, not only is it assured it comes from the person who you think it came from, but only the person it's supposed to go to can open it as well, and so that's part of the direct protocol.

And finally, there needs to be services and one of the things that we've also been doing in the HIT Standards Committee and in the S&I Framework is identifying kind of standards around those directory services. So, we've come up with a draft specification that leverages internet technology the way in which the internet finds, when you put in google.com it actually can find the computer that is running that service. We've leveraged that to find certificates and also leveraged some of the common ways that people find directories. So, if you have a Microsoft Outlook server and you type in someone's e-mail and populates it with the name, that particular approach is also being used as part of this specification.

But I think what's important and I wanted to spend time going to this, but each one of the kinds of use cases that we talked about, the query model, the ability to send a summary of care has to answer all five of these questions and they will do it in slightly different ways, but they will reuse components. So you can send a care summary with different vocabularies and different content structure, but the same transport. And so we want to have these reusable building blocks. We are working now to try to assemble these into solutions so that you say I want to use directed exchange to send a laboratory test using LOINC codes, we want to kind of say if these are the ingredients we'll give you the recipe that says how these ingredients fit together to give you the recipe that you need. And so, I hope in the course of a couple of months to be able to report back on some of the progress there.

So, I want to talk primarily about transport so that it means I want to talk about Direct and I want to talk about the NwHIN Exchange. So, the Direct Project, as you know, began as an independent open government project to specify standards that would allow for secure, directed health information exchange. We have used our early experience with that to essentially form the foundation of what we do in the S&I Framework and so the nine initiatives that we've got within the standards and interoperability framework are based on our experience within Direct and sort of supersized by supporting that so we can accelerate the identification of standards.

As of this fall we have 35 vendors that had implemented Direct and several more, at least 10, and I think it's probably even more than that have publicly announced that Direct specifications are included in the product roadmaps. The thing that is important with that is that we're talking about really, about a year and a half from the kind of glimmer in someone's eye that we need to solve this problem to actually getting get into production. It takes in general, on average, about 18 to 24 months to take a standard and move it through the process.

What we tried to do with Direct and what we tried to do with the S&I Framework is to move adoption up front so we get the people who are committed to adopting these kinds of things engaged in the process and then to accelerate that. We actually went through three ballot cycles in HL7 and some of our other standards resolving over 2000 negative ballots which is what they do. It has to be unanimous, that's the only way you can get things through. And so, we have had tremendous success and I think community participation has been tremendous. And Direct now is part of core strategies of over 40 state HIE grants four of whom have already started to implement it. So, in the time it takes to typically get one standard through we've done three, 2000 negative ballots and we've actually got the states beginning to implement that in a very short time.

Here's some pretty graphs that talk a little bit about the survey. We are going to probably update this in the course of the next couple of months. But what it shows and I think one of the things that's interesting is we have the initial survey in September and then we did it by sort of the end of the year and you notice that those graphs have increased even in that short period of time. So, we're at that point in which there is significant uptake, the users that are using Direct in production or pilots include ambulatory and hospitals, there are some laboratory vendors. We expect that to increase as we've identified the laboratory use cases around the HL7 2.5.1 message and we've had an increase both in government agents and others that are using Direct. And so, we've been able to through this process accelerate the

identification of a problem, the creation of a solution, the standardization of that solution and then its deployment out there in the field.

The next thing I want to do is just give you an update on the NwHIN Exchange as well. And remember, the NwHIN Exchange is really a consortium of people and organizations that have come together and they actually started exchanging information and developing this process before HITECH occurred. And they were one of the early pilots that came out of the ONC that was really trying to tackle those hard problems. So, it includes federal agencies, it includes some state and local agencies as well. And so we've been able to, over the course of the last couple of years, begin to demonstrate value. It's taken us some time to do that and I think the experience of Direct tells us we have ways that we can accelerate that as well.

But the federal agencies have benefited, for example, SSA has been able to decrease the time it takes to do benefit determination. They've shortened the turnaround time by almost 45% and in the past it's taken up to three months to determine if somebody is eligible for disability benefits. In some cases they can actually determine that within two days. Now, that may not seem like a lot, you know, that there's a small percentage of that or a reduction by 45%, but if you are facing a very high medical bill and you are concerned that you're not going to be able to meet your mortgage and you might lose your house, the difference between, you know, doing this in three months and doing this in one month may mean the difference between keeping your house and not. And so, if we can accelerate this it's really important for the patients because this is a mechanism that we can provide that benefit.

We've been able to do improvement with SSA in terms of getting those payments out there and we're also beginning to see improved benefits in clinical decision-making including avoidance of prescribing multiple narcotics because of information that is shared. Now there are, at this point, 22 organizations that are exchanging data and are in production. That means these aren't pilots, these are wired into their ongoing systems that are actually supporting care delivery. That includes 500 hospitals, 4000 provider organizations, about 30,000 users and about 1 million patients that are covered. The population coverage if you can count all those organizations, and remember we have organizations like the VA and DoD which have very large patient populations, is about 65 million people.

Now, what is interesting in all of this is that there's only about 90,000 transactions as of September 2011. But we see that increasing. It may be that we've just gotten the pieces together. If you've only got two telephones there is going to be a lot of conversations, but when you get a lot of telephones there is going to be more of that and we need to track that and we need to figure out why there aren't more transactions and are there ways that we can improve that as well, but we've got a lot of the infrastructure laid.

Right now we're working with a coordinating committee of the NwHIN Exchange; ONC doesn't actually have a role in terms of having a seat on that coordinating committee. We have really given that to the community to make sure that they can drive that process. But they are right now developing a business and a transitional plan that will guide that to a sustainable, scalable and efficient private/public model. It's ready to sort of move out and do that. And we believe that this will serve as a basis for additional kinds of uses of information exchange.

If we take a look at the graph we've got 22 (14 federal partners, 6 HIEs and 2 Beacon Communities) that are currently exchanging information. And then we have a bunch of them that are in the pipeline as well. So, we believe that by the end of the year we should be having, we've got 33 organizations that are currently going through what we call on-boarding where they assure that they've got the technical infrastructure to support this. And we estimate the number of organizations and productions for Q1 2012 is going to be closer to 32.

There are also some interesting things that have happened as well. One of the things that was a restriction early on, because this was initially lead by the ONC and it really had a very federal imprint, we were restricted in that the only people who could participate would be federal organizations or nonfederal organizations that had specific contractual arrangements. As of this month, however, we've gotten updates to that, that says we don't have to have a contractual relationship. In fact, the NwHIN Exchange

is now open to any participant who can meet the conditions of the technical requirements and can follow the sort of legal requirements that are there to assure the safety and the protection of the information. So what this means is we now expect a lot of folks that had otherwise been unable to participate to now be able to participate and we've been ramping up our capacity to do the testing and do the other sorts things we've got so we've been able to decrease the time it takes. It used to take us weeks, you know, six weeks to sort of work through the bugs, we're now down to a couple of days to be able to actually get people from interest to actually having the technical infrastructure taking care of.

So, the nonfederal entities may continue to participate under their existing legal agreements if they signed the DURSA, if they've got a federal contract, grant or cooperative, but once those things expire, if people signed the DURSA that provides that legal framework and they follow the rules in terms of being able to do the technical infrastructure, nonfederal entities can participate just by signing that DURSA and that is a tremendously important milestone. It suggests that there's a maturation of the organization and their governors will be able to continue to provide those sorts of services as well.

So, the NwHIN Exchange is in the process of transitioning. They had this initial rollout, they have sort of growing and maturing, and we're working towards a sustainability model that will allow the participants in the NwHIN Exchange to continue to provide value to their community to enable that information exchange to occur and to continue to sort of transition from their current state to a nonprofit organization that will involve both a public/private partnership and that I think is a tremendous milestone and a tribute to the participants who have been in the exchange and have worked so diligently to solve a lot of the hard problems well before we had all the solutions or the like. So, with that I'm going to stop and will turn it over to questions.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

We're a little tight on time, I wanted to ask Judy to make some comments and observations based on some earlier conversations that we had, if we could add that perspective?

Judy Faulkner – EPIC Systems Corporation

Sure and I really appreciated what you folks said. Doug your different things about authenticity and security and stuff are just exactly what we see. We started what we call care everywhere, that's interoperability many years ago and it actually began because of a tragedy we experienced on a personal side with someone who did not live because her record wasn't available. So, in the month of November we exchanged 800,000 documents going back and forth between organizations. They went from Alaska to Minnesota, Hawaii to California, the State of Washington to New York, California to Ohio going pretty good distances. We're also planning, by the way, to do it overseas, which I think is going to be neat.

The transaction is really simplified when you have a Direct query rather than broadcast. So, there is no intermediate repository. It just goes back and forth and we are told all the time that it saves lives. Just a few days ago someone contacted us to say that they had a patient show up who they hadn't seen before, she was going to give birth and just before they were ready to have a normal delivery for her someone got a hold of her record interoperably and they saw a scar on the uterus which showed that she had had a C-section that was likely to burst her and she may have died if they hadn't seen that. So, we get those stories regularly.

I had to go to the wrong ED when I broke my wrist and it was so neat to just be told, do you want your record over, yes, click and it was over and everybody said "oh, we saw your record" and that was very, very nice for the patient. It provides responsibility for the match through identity checking like you do in any EMPI and then the provider then checks with you, are you living at the address, etcetera, and the patient, depending on how they do it, the patient can sign. They gave me something to sign and I didn't read it, because of my wrist, so I thought that was interesting. If it's done this way it doesn't just have to be the vendor to the vendor, it can be the vendor to everyone else if those things that you mentioned are there.

First of all, I think the standards are critical. It drives the vendor not to have to write a code for every single place that someone wants to interoperate with, you can't do it and still sustain life as a vendor. So we say the other side has to have filed a standard and if so, going from us to ourselves or us to another vendor is almost equally simple, it doesn't matter as long as you're following the standard. So, that is absolutely critical. Often what that means is the organization that you are transferring to might have to get an upgrade to get the release that the vendor has to be on those standards.

The second is, as you said, you need the certificate for authenticity. You need to know that who is asking for this information is really who they say they are so that there is trust. Now, what we do is we gave everybody a certificate for authenticity, but that's not scalable, that needs to be done in a national way so that it can be standard and scaled. Then you need a phone book so you know how to contact everybody, which again is what you mentioned. And then the last thing you need is governance. You need rules of the road because things are slowed down if the lawyers and compliance officers have to create a legal document for every situation and then if you do that it's really easy, KLAS says that it's the number one product that customers like, so you just turn it on and everything goes back and forth and it works easily and I think once you get those standards all out there it will make such a difference.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Thank you. The reason I asked Judy to speak was one, to give us hope that we can see a hockey stick curve for information exchange as the pieces start to come together and they are. And second, when we had the conversation where we said you're doing a great job exchanging within Epic and what's it going to take for you to be able to do that same outside of Epic interoperability and the four things that Judy listed are all pieces that in one shape or form in 2012 are going to be available and we'll talk more about kind of the grand HIE strategy, but it very much rests on having the standards, having certificate interoperability, having the governance in place and as a side product of that, the availability of open directories and phonebooks to be able to do that. So, I think that the pieces then we will be able to serve whatever whether it's directed push, directed query, those foundations will be in place. There will be more work to be done, but I think we really do have the pieces coming together for a big win on interoperability and exchange in 2012. Gayle and then do we want David to give some comments?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you and I couldn't agree more with what Judy said, I think that's essential and when I see it across the states and as Chair of the National Foundation of Women Legislators we're starting to have the conversation across legislators, state by state, and states are so different, and the level and the examples you gave, Claudia, of where different states are is so classic, you know, from Wyoming to California to Rhode Island and I think Rhode Island is smaller than Palm Beach County, you know, so you have to put things in context. The entire state has fewer providers and less square miles than Palm Beach County, you know, so we have differences and I think that is key to what we have to do and looking at what's happening within a state.

One overarching thing and Judy brought it up, but I didn't hear it in your conversation particularly it was mentioned is those governance issues that really have to be addressed so that the public can be secure and understand that the privacy and security elements are there and feel protected. So, I think we need to add the federal level think about standards and governance that we ask states to participate in and those local HIEs that are standing up and I know in Florida we are seeing a variety, it's a 1000 flowers blooming in Florida, we have RECs getting very involved in HIE. We have our state medical society and hospital association getting involved in HIE. We have RHIOS that state gave some grants to developing after some years of not doing anything. When the money ran out in Florida they kind of dropped off but now there is some more money so they're coming back. So, there's a variety of things going on. Certainly the standard certificates of authenticity, the provider directories, but essentially for the public to buy into this, there's got to be that governance element that is so, so critical and I'd love to hear some comments on that element.

Claudia Williams – Director – Office of the National Coordinator

We actually had some great discussions at the end of last year, there are several states including Minnesota, Rhode Island and others that have dipped more than a toe into this area by saying can we have statewide rules of the road in this state and Minnesota has probably gone the furthest, it is actually regulated. So, one of the things that we heard back from them is when we said, do you see this as a core function of the state? They said to be honest; we would be more than happy to give this up. We think that it would be very helpful and in fact allow us to focus on other things, where there is a national set of expectations that everyone could abide by and that would reduce the cost of all these negotiations that occur in contracts, etcetera.

So, we heard loud and clear that they see this as critical and they are jumping in where they see a need, but they would actually prefer, in many cases to defer to a national level set of guidelines. And really this is the problem that I think we're trying to solve through governance, through NWHIN governance, which this group has discussed very broadly. I don't know if Jodi wants to say a word about it or Mary Jo? No.

So, I think you are absolutely right and I think it is something that states see a need for and they would actually, from the conversations we've had, like to defer to something that's more national. David, do you want to just say a word?

David Sharp – Maryland Healthcare Commission

Sure, David Sharp from Maryland Healthcare Commission representing Dr. Joshua Sharfstein today. So, it's a real pleasure to be here and just real quickly to highlight some of Maryland's activities around what Claudia was mentioning. First and foremost, for us it started with strong leadership at the state level. We have a very active administration, a governor, a lieutenant governor, very strong involvement from the Secretary of Health, Dr. Sharfstein who sits on this committee and a wonderful partnership with the folks from ONC and that's really important for us because we couldn't have done it alone. We have a lot of stakeholders, a lot of real good insight from the stakeholders, but you need a partner and it took us a few months to recognize that we were probably a little slow realizing it, but once we did we developed, I think, a fabulous relationship with the team at ONC and it's been enormously helpful to us in strategizing and implementing the HIE.

Just a few key points to note, 46 hospitals in the state, all 46 are connected to the HIE publishing ADT information, so it's really an accomplishment for us. I think we're one of the few states, maybe the only state, that has 100% hospitals participation. Our governor is going to be holding a press event at the Hospital of Holy Cross on February 17th, highlighting that accomplishment. We have about 1167 pharmacies in the state and all but about 50ish are supporting electronic ePrescribing. So, we have quite an accomplishment there.

We have a lot of secondary use cases that are being deployed now to support public health through the HIE. And we are adopting the Direct strategy that's been discussed; we think there's value in that as well. I would say, for us, most importantly in terms of challenges is trying to find the value for ambulatory practices to want to engage the HIE. There's lots of value, but it's really, really difficult trying to bring 7000 practices to the table. It was easy to convince, I say easy, but it wasn't, 46 hospitals, and help them find value, but we're struggling, as I suppose every state is, in trying to get the ambulatory practices to want to engage. It's a tall order for a small state of people who are focused on this initiative to adequately reach all these practices. And I suspect that's much the case around the nation.

So, we're very thankful to be part of this and again, thanks to Claudia and the team at ONC for their leadership and I'm happy to answer any questions if I can.

Paul Tang – Palo Alto Medical Foundation

Well, I just wanted to say what an excellent presentation this was. Really Claudia, you laid out the overall program, you talked about sort of the heterogeneity and so you helped analyze the different kinds of approaches, and what we started out with in assumptions, and where we are, and where we're headed, and the stories were very illustrative. I mean it was just really, really helpful to bring us up to speed there. And Doug has this gift of being able to describe the standards that are required to achieve this

interoperability. So, really very informative and very clearly presented, so thank you very, very much. Others? Christine?

Christine Bechtel – National Partnership for Women & Families

So, I completely agree very helpful presentation, Claudia, I appreciated how strategic and sort of big picture and this is a very complicated field and a difficult challenge that has a whole lot of things that feed into it and you guys really have a grasp on those so I appreciate it. It was just very clear, very helpful. I have two questions. So, I get Direct, but I am still stuck with the NwHIN or whatever we're calling it now and I think at a very basic level my fundamental question is what are they exchanging? You know, in my head I know I remember the Markle, you know, kind of model that they tested where there was the idea of a record locator service and you could query it and it would go out and get every piece of patient data that sort of existed and bring it back to you. What are they exchanging in the, what are we calling it NwHIN?

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

So, the Nationwide Health Information Network is the standards, services and policies that allow that exchange to occur. So, when we talk about the NwHIN we're really talking about that portfolio of which Direct is a component. I like to make a distinction between that and what is the NwHIN exchange, that is that consortium of folks that are using those specifications to try to solve some real problems.

Christine Bechtel – National Partnership for Women & Families

And that is actually what I'm asking about is the Exchange.

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

Right, right. So, Direct, again I'm going to answer questions because I find that's sometimes useful. So, Direct helps us when the question is, I have information that I think you need and so Direct provides a mechanism for me to take the information that I have and to send it to you. The way in which the exchange works is to say I have a patient here and I think you have information that might be helpful to me. And so, it allows me to say, I have a patient here's some information about that patient, do you have anything that would be useful for me in taking care of this patient? So, the exchange answers the question of I've got the patient, you've got the information, I may need to get some of that so that I can take care of the patient.

Christine Bechtel – National Partnership for Women & Families

Do you have to know who else might have the information?

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

The way it's architected is that you can send a broad query out to lots of people, realize it's a small number of organizations right now that have been participating, and in many circumstances you kind of know where that information might be. So, if you've got someone who is at the VA and they were in military service and you know what base they were at you can then send that query to that particular location. It doesn't prevent you from doing more of a broadcast, but it's much more efficient to be able to ask that question directly.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

In fact, the example that Judy gave, they can support in their 2012 release the directed push of say the referral use case but they can also, in the example that you gave about the document exchange, it's a directed query where the patient says I got my care at that hospital and they do a demographic query that is treaded with the return of the document. So, they are using the NwHIN on both the content that comes back, the C32 document, as well as on the directed query protocol that says here's a demographic query, do you have this patient? Okay this is a match. Here's the consent. Here's the document back.

Christine Bechtel – National Partnership for Women & Families

So, that's actually my second question. So there is a document, it's not sort of like everything in the EHR or everything in my system comes back to you so you can see.

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

And we're separating the transport from the content.

Christine Bechtel – National Partnership for Women & Families

Right and the content is my question.

Judy Faulkner – EPIC Systems Corporation

Two things. One, we do it just as Farzad explained. We also allow them, if they wish, to do an extra thing, which is you can link to others. So, if A goes to B, B already has information from C and D and it's okay then B will tell A there is also C and D, and then A will go to C, and A will go to D to get the rest.

Christine Bechtel – National Partnership for Women & Families

Is that the same as the NwHIN Exchange?

Judy Faulkner – EPIC Systems Corporation

No.

Christine Bechtel – National Partnership for Women & Families

No?

Judy Faulkner – EPIC Systems Corporation

So that all the links are maintained if they want to set it up that way. The other thing is that it's just the document if it's one vendor to another vendor for example, because those are the only things that standardize, it's just a CCD document. If however, it's the same vendor to itself then they can go deeper and then they can look at lots of other stuff.

Christine Bechtel – National Partnership for Women & Families

So, I think I'll have to a hallway conversation, but that's all right. So, my second question, I actually probably want some guidance from Paul and Farzad because it is the larger question and I think we're sort of out of time, but, you know, one of the things I think was striking, Claudia, in your comment was your looking at exchange as a tool for meeting Meaningful Use and a lot of people have called for Meaningful Use to be a tool that drives exchange, right? And what I saw you say in your presentation was that it is really payment reform, you know, the sort of delivery system changes that happen things like ACA that will drive exchange and create that business case. So, at some point I feel like we need a more robust discussion of what's the right strategic direction? You know, I personally don't think we've done enough in our recommendations around Stage 2 to really drive exchange, but it maybe that you are saying to us, that's not the vehicle. So, I don't know how to have that discussion because I think it's probably a longer one, but.

Claudia Williams – Director – Office of the National Coordinator

Let me respond just a little bit. I actually think what Meaningful Use does powerfully is point to some immediate use cases that are the sort of building blocks. So, things like getting lab results into your EHR, having a transition be safe and secure with the right information, public health reporting, these are the right first steps and I think Meaningful Use by putting in place the standards and the way you do that, and the workflow can make huge strides. When it comes to saying I'm going to devote a significant capacity of my human resources and my business efforts, and my strategic alliances around getting information flowing in the healthcare system, which speaks not just maybe to these basic building blocks but other use cases and things, that's where I think reform really needs to step in and say, you're not going to be able to succeed in this new world if you don't take this perspective. So, that's maybe my two cents on that, where I think there's a really key role for Meaningful Use in laying out some sort of clear directionality and things that need to happen and building on the standards we have and sort of a clarity around those next steps.

Where I personally see payment reform coming in and saying, you will not succeed as a business or as a participant in this world if you don't put both feet forward into this space and that is going to not only build some of these basic building blocks but also I think be the motivation for sharing patient data with patients, for creating shared care planning and care management, and those kinds of things that require deeper coordination, and deeper work on everyone's part. So, I don't know if others from ONC have a different perspective on it, but that's the way I think about it.

Paul Tang – Palo Alto Medical Foundation

Well stated in a nice complimentary arrangement. We know that we have to dovetail with the reform agenda. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

I think I'm echoing Christine and Paul's comment. Claudia, I thought your presentation, and Doug yours were just fantastic, really great synthesis of really complex material, very valuable. Three quick points. One, on the California exchange work that I'm involved in, we have a very strong sense of the clock ticking. We feel like we have 22 months and 27 days left on the federal grant. So, there is a sense of anxiety that the federal investment, which is much appreciated in jumpstarting HIE, is very fragile and short, and so the question of sustainability and business case, and so on are really pressing. So, I think this committee as a public input committee should do some thinking about how short that timeframe is and what happens after we fall off the cliff in 24 months?

Secondly, this is I think germane to that, I really appreciated the state use cases you described or the case studies and they suggest that the states are approaching this with an analysis of the local business case, in effect that the local participants find value, and then they're architecting a solution that makes sense for the local community, which obviously makes sense in the short-term, but may not lead to the sustainability more broadly I think because of this payment reform question. So, as you mentioned the private exchanges are developing quite rapidly in response to perceived market trends. Those maybe sort of the dominant mechanism for providers to engage in exchange for now. You also said it's a very pluralistic environment, which is very informative.

We didn't talk much about Medicare payment policy and the trends in Medicare payment policy, but it strikes me again, as a public committee that we may want to think about a dialog around what's happening in payment change and provider response to payment change, and what are the implications for the HIE strategy, because we're going to have to really wrestle with this economic ecosystem again on this 24-month timeframe, whatever it is, we need to have an understanding of how to mobilize those responsible for payment in a way which generates support for information exchange and every opportunity conversely where payment reform doesn't support information exchange potentially will inhibit the growth of IE generally and that would be really unfortunate. So, I guess I'm encouraging us to think about some mechanism we might have for a dialog of how reform and payment reform dovetail with HIE development, and do that fairly quickly.

And the last thing, on your slide of measuring progress, I understand that the transactional measurement you're proposing is very useful just to track clicks of what's going on out in the environment, but I just happened to be talking to a large employer who is very interested in this topic just recently who is very worried that we are not demonstrating value back to the community, the public interest sector who sponsored and really believes in HIE as a key part of all the things Judy talked about improving safety and quality and value, that these metrics don't get us there and so these are not really policy relevant metrics to those on the outside of our little bubble.

So, I think it would be worth another round of thinking about a higher level of abstraction of the measures to demonstrate progress of IE, you know, obviously we'd love to say how many lives are we saving and something that abstract, but even if we can't quite get there, can a patient go from Nebraska to Seattle and have their record available, how many patients can do that, that's a much more powerful translation than the fact that a hospital is capable of doing something, we'd like to see how many records are really being transmitted and what clinical benefit is being achieved. Thanks.

Paul Tang – Palo Alto Medical Foundation

Great. Thank you. Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

If I can just make one more comment and I think Christine hit the nail on the head talking about where we're going on strategic thinking and what the role of this committee is and really in promoting health information exchange I think it's very clear we need to look at it in a bigger framework and look at where we are going in changing the dynamic of patient interactions with healthcare providers and looking at those payment models in particular that are really making strategic differences across the country in how healthcare is going to be paid for, healthcare is going to be provided as well as paid for.

So, I think this committee really needs to have a better, perhaps take some time out and look at that payment reform that is going on and look at how to promote HIE or at least ask the questions about what is necessary to make sure that HIE takes place in that payment reform. I don't know that this discussion has been held outside this committee at the federal level and if there is an in depth understanding that this is a core element of really promoting better care across a spectrum. So, I think there is a role for us in perhaps bringing some people in, holding maybe a separate hearing at some point to really discuss that and push for that exchange of information being a key element.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I will say, I was in New Orleans yesterday and in Austin, Texas on Friday, and everyone of the conversations included that question of what is the, not the generic, but the specific ways in which specific health information exchange transactions are going to dovetail with various bundled payment, re-admission adjustments, ACO, shared savings, patient centered medical home and other payment reforms, and to whom does value accrue, and how that value can be monetized? These are conversations that are happening in every state HIE program with every Beacon Community and increasingly outside. So, this is not breaking new ground in thinking. I think there is a need to maybe have a forum where we can synthesize and crystallize what some of the implications of it are, but the good news is, this is not, you know, there is a lot that is happening in thinking very concretely about these questions.

Paul Tang – Palo Alto Medical Foundation

Excellent thought and it also refers back to David Lansky's point about if we have not only the process measures, some of which Claudia has talked about, but some of the outcome measures will push the industry forward I think. Thanks so much for a wonderful presentation, very illuminating. We'll be looking forward to future, every 2 or 3 kind of a thing. Thanks. And we'll go to our next topic.

Okay, this is a follow-up of the presentation Jodi did last meeting where she talked about some of the areas that this group is requested to provide input into and so this is an update from that, didn't get a whole lot of feedback from the group. What we thought we'd start out with is sort of a policy roadmap, it's not complete, probably limited by time and day, but it at least shows how it might map out into the kinds of activities that need to transpire, and I think it builds upon the earlier discussion we just had. So, just to remind ourselves, we have this progression in the Meaningful Use Program up through Stage 3 of one, getting information into the EHR in a structured way, so that it can be operated on and reported on. Second is to get it passed around in a safe, secure and effective way serving the needs of care coordination, transition of care and the things we just talked about. And finally, the end goal is really outcomes, measurement and improvement, and dealing with the information. So, that's the path we set for ourselves in Meaningful Use.

So, if you look at some of the policy questions that come out of moving along that path, so approximately these three stages, for the stages we currently have on the roadmap. So, the first is Stage 1 and there is a long list, not complete again, of things that we've been tackling. One is how do we get people to adopt EHR in HIT. Second, how do we help them make Meaningful Use of that technology? Third is how do we protect that information as it is stored and accessed, thinking much more internal to an organization.

Fourth, the topic of safe use of HIT came up and ONC had an IOM report on that. Fifth is how do we provide this same information to consumers and in Stage 1 it's more of an access download kind of functionality and fifth the HIT workforce to put this into place, both the technical workforce, but also the ability of professionals to use this technology appropriately and effectively.

So, if you move towards Stage 2 where it's the share information to the appropriate users in a safe and effective way that automatically calls on the topic we just had, which is there has to be, if we're going to work with multiple organizations, some form of governance, some set of uniform rules, uniform standards and the ways to get information from where it is to where it's needed. That means now HIE organizations are sort of more like an "HIE Program" that's a lot of what Claudia and Doug talked about. There's got to be an agreed upon, and the more uniform it is the less work it is for everybody and the more efficiently the transactions can happen. But that calls into question other privacy and security questions and policy issues and need for policies that don't currently exist. So, now we're talking about privacy and security update as sharing.

Consumer e-Health takes a different approach. So, in Stage 1 it's more can we get access to it? Can we download it? But in Stage 2 we're saying can we make this information more useful to consumers as they make their own decisions in much more of a shared way. And finally, but not the final stage, Stage 3 is really how do we use this information to measure and improve outcomes that clearly motivates us to have much more relevant quality measures and we've already talked about that. It calls for us to take advantage of all this structured information, provide clinical decision support to both clinicians and patients, and look much more where the payment reform is going which is dealing with population, not with individuals in one organization. So, you can see that sort of makes sense in the future of not only healthcare but payment reform that we're expecting.

Now, we're not constrained by looking just in the first box for Stage 1, you see that we're already working in the third box with next generation quality measures because it has that kind of lead time both from a developing the quality measure itself as well as to get it into the system. So, you can see this forms a bit of a start of a roadmap in terms of as the technology and the adoption plays out, here are the policies that we're going to need to govern the new world dealing with information, at least this is a draft to put before you. So, what Jodi is going to do now is take us quarter by quarter just through 2012, which is the focus of this current work plan for your comments.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator for Health Information Technology

Great, thank you Paul. And so I'm going to talk about sort of a quarter by quarter plan for 2012 based on conversation working with Paul and some of the input we've heard. This is by no means exhaustive. We very much expect that things will be iterative as new issues come up when workgroups are tackling particular things or as new issues come up and, you know, as we learn more development policies and programs, etcetera. So, this is sort of a guideline, an outline for us to start from. You'll notice that the first half of the year is a little bit more fleshed out than maybe the later half, which is somewhat intentional to leave some room for those issues that do emerge.

I think it's also really interesting that, as Paul just laid out, the three stages, that right now I think the Policy Committee needs to be thinking about sort of all three stages simultaneously. There is Stage 1 and how it's going and how we can improve adoption and Meaningful Use and what's working and how we can tackle real life implementation challenges that folks are facing today. There is Stage 2 looking at the proposed regs that will be coming out shortly and getting folks feedback on that and if we're in the right place and what kind of input you all have on the direction that we're proposing for Stage 2. And then looking ahead at Stage 3 and making sure that we are starting to think about that ahead of time, particularly the areas that do need more lead time, like quality improvement, quality measurements, as well as some of the new issues that may be coming down the pike and now that we've actually gotten some traction on Meaningful Use and we're on our second stage of that, trying to chew on some of the newer issues that we may want to address as well.

So, Q1, the first quarter I really believe will be consumed a lot, the Meaningful Use Notice of Proposed Rule Making. We anticipate that this will be out in February and we will have many Workgroups, most importantly the Meaningful Use Workgroup, but we expect other Workgroups as well will be involved in looking at the NPRM, the Quality Measures Workgroup, the Privacy and Security Tiger Team, you know, there will be a lot of Workgroups that are going to be taking an interest in that. And what we hope to do is try to figure out how, and we did this the first time around, how to coordinate that. So, we'll likely try to pull together the chairs of all the relevant Workgroups pretty early on to figure out how to make sure that we're being both effective in the Workgroup activities and that we can try to connect all of it so that we can present back to the Policy Committee some recommendations that could get forwarded to HHS.

We're also, as I had mentioned previously, we're working on the governance Advanced Notice of Proposed Rule Making for NwHIN governance; we also hope that will be out in the first quarter. We're working on getting that out as soon as possible and that's an area where we have gotten a lot of feedback from the Policy Committee and we really want good feedback that's why we are doing this extra step of an Advanced Notice of Proposed Rule Making, and again there will be a number of Workgroups that will have a role to play in looking at that, most notably reconstituting the Governance Workgroup but also Privacy and Security Tiger Team. And then third is quality measures, as Paul said, this is an area where we want to sort of get a jump on some of the issues here both as they relate to Stage 2, but also looking forward to Stage 3.

So, Q2, this is a little small, but I'll walk through it. So, we expect, hopefully if we hit our targets of getting out the rules in February that we'll have recommendations coming to the Policy Committee in April, so at the very beginning of Q2 we'll be wrapping that up and getting recommendations into the departments for us to chew on with all the other recommendations and comments we get from the public. But other things that will be high on the list, we are expecting to hold a hearing on patient generated data with the Meaningful Use Workgroup to start again looking at some of the Stage 3 issues that are coming down the pike.

We plan to have a joint hearing of the Health IT Standards and Health IT Policy Committee to look at the lifecycle of quality measures from development, implementation, to maintenance, and try to get a better handle on the whole process and where we need some policy input, where we need some standards input. So, we're going to try to pull together the Policy Committee and the Standards Committee so we can have a joint discussion about that and kind of get that all coordinated and then figure out how we can proceed and where are the areas of greatest opportunity for the future.

The Information Exchange Workgroup, we'd like to start looking at some of the on the ground implementation issues, particularly as we are trying to move from data capture to exchange of information in Stage 2 and really get a handle on some of the key exchanges of information in the areas of transitions of care, ePrescribing, labs, etcetera, and public health. And so we're going to be looking for some guidance from the Information Exchange Workgroup on that.

We've also talked about having some input, as we're thinking about Meaningful Use and we talk about care transitions, some of the issues that are coming up with long-term and post-acute care to make sure that we have thought through the issues of transitioning from the hospital setting to long-term post-acute care and that the information that we are putting forward is part of Meaningful Use for those who are eligible to participate in the incentives program is also aligned with what the recipients on the long-term, post-acute care side, who may not be part of the Meaningful Use Program are needing and how to make sure that works in an effective way.

So, going to Q3, by this point we are looking for at least a draft set of recommendations on Meaningful Use Stage 3, this is a fairly aggressive time-table particularly with everything going on in Q1 and Q2, but the Meaningful Use Workgroup has met very tough timelines before and we expect we'll continue to be able to do so. We will also, since we're doing the ANPRM on governance, the Advanced Notice of Proposed Rule Making, we will then follow-up with a Notice of Proposed Rule Making on governance. We are trying to do this quickly because we realize the importance of governance for health information exchange and the importance of aligning that with Stage 2 Meaningful Use since we're trying to put a

greater priority on information exchange in the next stage, so we will be trying to push that through very quickly, so I've targeted that for Q3, where we'd like some input on the actual Notice of Proposed Rule Making and we'll be working pretty hard internally to meet that timeline.

And then, as was mentioned before, at ONC we're spending a lot of time and effort thinking about safety in a Health IT enable environment in light of the Institute of Medicine Report. We have been recommended by the Institute of Medicine to develop a surveillance and action plan within a year. We have said we'll beat that deadline, so we will have something for folks to react to by the third quarter of next year, that is the target we're putting on it and we will very much like the input of the Policy Committee on that plan to help us think through ideas, things that we may have not thought of, that we might have missed or other, getting the wisdom of this group. We had originally gotten input through the Certification Adoption Workgroup on Health IT safety and we would like to kind of circle back and get some input as we start rolling out a plan in this space as well. We see this as a growing role and a growing issue that we need to be on top of and that we need to be helping to lead and coordinate.

And then going to Q4, so we talked about the draft Meaningful Use Stage 3 recommendations, we would have recommendations for the committee at that point from the Meaningful Use Workgroup to pass back to the department. And then also looking at some of the more kind of forward looking issues we expect to start taking on in Q4. So, we will have already gotten some input on implementation issues on Meaningful Use Stage 1, on our proposed rules on Stage 2, on recommendations looking forward to Stage 3 and then there are all these other issues, and a lot of folks had raised some different areas of interest that we would like to bring forward to the Policy Committee as we kind of get through some of the pressing things on Meaningful Use right now. So, consumer e-Health was one that jumped high up on the list. We of course have the Meaningful Use Workgroup that has a subgroup on patient and family engagement and has both chewing on it from that perspective, but a narrow perspective on the consumer e-Health space, and there are clearly other issues that folks have raised to us as an area of interest, and that we are thinking about internally that we may want some input from the Policy Committee on as well.

I didn't put a laundry list of issues here. As I said, this is not comprehensive, but we would like to start bringing some of those kinds of issues to the Policy Committee in the fourth quarter. The other thing I have here, that I wanted to highlight, is we are starting to look now at revisions to our strategic plan, which only came down in September, but the pace at which things change in ONC and in Health IT, it is something that we want to keep iterating on and subsequently we expect to sit on the shelf for 5 years and then review in 5 years, it's something that we plan to continue to iterate on and we're looking for approaches for doing that and we expect that by the 4th quarter we will have some thinking and some draft revisions to our strategic plan in key areas, consumer e-Health and Health IT safety being two big one that have already changed since we wrote the plans, but there may be others, so we would like to be able to come back to you all and get some input and feedback as we're thinking strategically about our direction and significant shifts that we're already making or that we would like to be making, or that we have heard from folks we should be making.

So, as I said there is going to be a lot of other work and I know Workgroup Co-Chairs have suggested areas of interest that they have and we will work with all of the Co-Chairs to try to think through what the best plan is for Workgroups and how to key things up and how to time it with the other key activities of the full committee. We also wanted to suggest, which is something we've been doing, but we want to make it more, you know, more of a process, more of a regular process, is doing regular updates on key topics of interest to folks and we would love your input on what some of those would be, but I've put some up here. So, we have been doing regular updates on Meaningful Use with CMS and I've heard from folks that has been really helpful, and people have been very appreciative of that, so, we will be continuing to do that. We've also started last year giving updates on ONC's programs, and again, I feel like it's great to have you all have a better sense of what we're doing, help us think about some of things that we are doing and how to shape them even better, as well as to have that as a context for some of the other deliberations that you're having.

Health Information Exchange particularly, which we just started with Claudia and Doug, is something that folks raised as an area of interest for some regular updates to the committee just on status, on progress,

etcetera. So, we will continue to do that. And then something which keeps coming up as a regular theme is health reform activities and thinking about connections of health reform and Health IT and so we have had some folks that have been involved with the ACOs and some of the other innovative activities, and CMS giving updates, and we will continue to make sure that as new things develop that we are continually providing updates to the Policy Committee so that you all are up to speed on what's going on and can think about the intersections of some of those activities, and some of the conversations we're having about health IT policy.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

On that last point, just to clarify, we're really talking about what's happening across the domain not just with Medicare but what's happening with commercial payers, what's happening with Medicaid, the broader kind of care transformation, delivery transformation efforts.

Josh Seidman – Office of the National Coordinator

On the Meaningful Use recommendations for Stage 3 the idea there is for the Policy Committee in quarters 3 and 4 to give recommendations to the Standards Committee so that we can have more of a iterative process and as much fun as I'm sure Doug had as camp counselor last year I'm sure he would appreciate having more time for that real more robust discussion.

Jodi Daniel, J.D., M.P.H. – Director, Office of Policy and Planning – Office of the National Coordinator

Josh, thank you for bringing that up, one point which I didn't make, which I think is worth re-iterating is that we're looking for how we can better integrate and coordinate the work of the Health IT Policy Committee and the Health IT Standards Committee providing both some more lead time for the standards folks to be thinking about, what they need to be thinking about, as well as to give feedback back to the Policy Committee where there may be some issues that are raised from the Standards Committee, looking at better coordination, particularly in the area of quality improvement and quality measures starting with this joint hearing, and then thinking about, you know, whose is on point for what so that we have complimentary activities in the Standards Committee and Policy Committee and we can figure out how to bring those together.

So, I think one theme you will see throughout this year is a real focus on both the hands off as well as the coordination points between the two committees and we'd be open to any thoughts or suggestions on how best to do that.

Paul Tang – Palo Alto Medical Foundation

Great. So, I think we'll open it up for discussion by the committee.

Larry Wolf -- Kindred Healthcare – Senior Consulting Architect

So, I was uncharacteristically quiet for the first go around, I had plenty to say, but it seems like it was being said. So, I'll jump in here at the beginning. So, I think it's a great overview of the things that we have to take care this year, but really clarified some things in a good way around Meaningful Use especially coordinating with standards, quality measures. So, let me jump in on quality measures. I'm really glad that there's attention being given to the whole lifecycle because, I think it's been painfully obvious to everybody going through the process for Stage 1, is getting good measures to actually come out of the EHRs is tough and just reworking existing measures has not been as successful I think as people had hoped, so there is work to do on that.

And sort of a lead in to a theme that I see coming up again and again, which is really a better data model. So, we've seen the issues around getting people to go to standards and I don't want to short circuit any of the effort to get people onto standard vocabularies, but just having the nouns in places isn't enough, we need to actually build sentences for some of the blog chatter that has been, when you have molecules of data, not just atoms of data, so it feels like that's an area, and Judy is shaking her head, it's not a fast roadmap, we're not going there quickly, but if we don't start to go there we'll never get there, so I think it's one of those areas that we need to start educating ourselves and not go too fast, because we'll have

success, we're going to have an existing installed base of systems that are working. So, we're going to need to build on that rather than try to tear it apart in some way. But, I think that getting good vocabularies and then getting the vocabularies organized in a way that we can make useful statements is really going to be key to the kind of interoperability that people expect.

So, if you step outside of this room and this table and you ask people, you know, so how's this information exchange stuff going, the good news or the bad news is we seem to be changing expectations. It used to be we were happy if we got lab results delivered and that was sort of the big use case everybody focused on and then the current topic seems to be transitions of care and moving a care summary, that's important work and I appreciate your comments to include the whole of the provider spacing at the post-acute and long-term care folks in the mix as well. But, now I'm hearing people want to move images and everyone has frustrated stories, I can't get the image from here to there.

So, I guess the good news is we keep raising the bar, but it also reminds me that, and this gets into the health reform piece, the ways in which people want to use the information is changing as well as, it's not just deliver the lab results or coordinate this one admission, but let's identify collectively our patients who are at risk of having complications or at risk of re-admission or at risk of, you know, recycling in the system or at financial risk as we get into new payment models all that becomes really key and it's not clear that the things we focused on directly support that. So, how do we actually understand what's it take to build a real partnership among providers, so it begins to shift the conversation out of just I want to move these bits from here to there, it's a refocusing on what are we trying to accomplish and what do we need to have in place to really build strong partnerships.

And then a final comment is one of the things that I see happening is that as we make progress, and we're making very real progress, that there is a tale a good tale happening of the standards are getting in place, they're not maybe happening as fast as we would like, but they are getting in place and they are getting adopted and so the pockets of people who aren't regulated to have things in place actually gives a roadmap. So, I'm now having conversations with vendors who are not tied into incentive payments about exchanging CCDs and two years ago they looked at me like I was crazy and this year it's in the product roadmap and they expect to have it this summer. So, we're making real progress in terms of truly building an environment where these things are accepted as this is how we're going to do things. So, I think we've got a great year in front of us; a lot of stuff has been done. I think you've got some key topics in the plan for us to talk about.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

It's not the full employment; it's more the full enslavement program for the Health IT Policy and Standards Committees.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you. I just want to make a few comments, first of all I just want to commend staff at ONC for the amount of work that you all are producing, you know, it's truly amazing, when I go on the website and I see everything that's going on I think "oh my God this is incredible" and I think where we were 32 weeks ago versus where we are today it's amazing and so I just want to say that off the top. But, I do want to say as we moved forward into this next year one of the holes I'm seeing and one of the things that I hear, and people call me all the time and e-mail me, and talk to me about a lot of people who are kind of still feeling left out, we've done so much and we're moving things so far, but we don't still have the whole universe in our sphere, and what I hear, again from specialist that we are having so many of our different specialties who feel left out, and they are not being able to qualify for Meaningful Use, and they feel like they are being left behind, and not just the specialist, but also one of the people I hear from on a regular basis are long-term care people as well, that they want to be part of this and that they feel left out as well.

So, I think we need a little broader umbrella as we go forward in our strategic thinking because the end goal is to make sure that every patient has that comprehensive healthcare model with a comprehensive healthcare record that follows them through their lifecycle and that all the information is there for the best decision making possible. So, let's not leave people out in our thinking.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

That's a great Gayle and behavioral health providers and other community health providers are other examples and I think given, you know, it seems unlikely that there would be a big new, you know, parallel Meaningful Use Health IT incentive payments for large new groups of providers, but I think some of the discussions we've had around health information exchange and the new payment models, so if you want to reduce re-admissions then that clearly implicates need to exchange information and coordinate with long-term care facilities. If we want to, you know, manage medications better it clearly implicates coordination with behavioral healthcare providers and so forth. So, I think some of those, as well as the consumer e-Health, increasing access for patients of their own data across a range of providers, those are some avenues where we can feasibly start to bring in the larger picture and conversation. David?

David Lansky – Pacific Business Group on Health – President & CEO

Just looking at the diagram with the Qs on it and I guess it's I think germane to Gayle's point as well, this question of architecture or intermediaries, or aggregators, we have a piece of it in HIE but then our HIE discussion ends up being very transactional and our standards discussions are very transactional, and the patient generated data discussion become very transactional, and I think this question, the policy relevant question that all of us keep touching on from different angles is where does data get brought together and processed for multiple purposes and we don't have a common answer, and it raises all kind of governance issues and the challenges around it, consent issues and so on. But all the action on the policy side and the payment side is around this continuum of care, and, you know, certainly the quality measurement and accountability, and payment piece of that as well. So, I think somewhere in this work plan we need a band to take up that question of architecture and integration in some possible and comprehensive way.

Paul Tang – Palo Alto Medical Foundation

Let me offer a response and see what you think of it. I thought the way Claudia answered Christine's question was helpful. So, in other words this is an EHR or HIT incentive program and what we tried to do with this committee and the Meaningful Use Workgroup is put in tools necessary to get the job done and the programs like ACOs and all of the CMS programs are what would create a change in payment reform, but also the way we look at what's the job to be done not transactions but more the patient outcomes, that's the pull. So, if we're sort of the tool supplier, making sure we have a written up tool then it's not Meaningful Use that actually creates the whole care system. Is that one point? I mean, that's a way of looking at it.

David Lansky – Pacific Business Group on Health – President & CEO

I actually agree with that from the point of view of the Meaningful Use task, but when I look at our original charter as a Policy Committee, which is broader than the Meaningful Use Program, I think we have a responsibility to not be reduced to an atomistic view of healthcare, continuum of care and the role of healthcare in the policy environment broadly. So, I think Meaningful Use is one tool we have and I agree exactly the way Claudia and you described the use of that tool to support other goals. In addition, I think as a Policy Committee we should take the broader view of is the architecture and conceptualization of the health information ecosystem found to achieve the foreseeable policy goals?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

You know, David, one of the challenges when talking about architecture is what Claudia eluded to that the environment and the business cases, and the policy issues are quite heterogeneous across the domains that you listed, and I think at some time in the past there was the belief or hope that there would be a single unifying architecture that would bring in the ability to do health information exchange or that same architecture would support quality measurement, that same architecture would correlate clinical and claims data, that same architecture could do clinical effectiveness research, and I think the general approach that we're taking, at least on the information exchange side, is that it's more like city planning than architecture. It's not that you can say this is, you know, every wall shall be built like this and so forth, it's more setting some general rules and some general principles and having reusable building blocks and

recognizing the heterogeneity, and kind of the large scale systems that we have in healthcare. That doesn't mean that we shouldn't be thinking about how some of the pieces like governance could be reusable.

That doesn't mean that we can't look for pilots or particular places where these functions can come together and I think maybe we can have a useful, you know, oxford style debate of saying, you know, yes there needs to be a single architecture and the other opposing side saying, you know, that's not going to happen, but I think the general issue of could there be a greater alignment between the different components that are building blocks that are being developed so that you can have multiple needs being met by common shared aspects of that is something that I think makes a ton of sense both on the services side but also on some of the policy and governance side. But, that's just my initial reaction to you laying out, you know, we talked about this vision of kind of serving multiple purposes, technologies and organizations, is that uncomfortableness with the heterogeneity of the world as it is. Judy?

Judy Faulkner – EPIC Systems Corporation

Two comments. One, continuing on with heterogeneity, I think it's interesting to think that the vendors develop their systems without looking at each other's so they all develop differently. We don't know how the other vendors develop their data elements and there is no one-to-one mappings because we didn't sit and work together. I think it took the US about 2 years to develop standards for 4 data elements and there are about 100,000 data elements in the repositories which leads us 25,000 years to work on the rest, that was comment number one, and not that I don't think the standards are good, I do think it's good, I think we have to have a reality check though on how much there is out there that's different and how long it takes to have agreement.

The second thing I wanted to talk about was bang for the buck. Sometimes when I hear politicians speak I hear them get mixed up between EHRs and interoperability and PHRs, and they mix them altogether and typically they just call them interoperability, that's the one that they typically pick on, but it's not necessarily interoperability. So, I've given a bit of thought to which saves the most lives and how do we get the bang for the buck out of there? I think the first thing that saves the most lives is the electronic health record itself and the worry I have here as we plan our future is that there are hundreds, if not thousands, I don't know, I just got contacted the other day by a head of a small EHR vendor/person I never heard of it before, but he wanted to do interoperability and I was listening to him, in the e-mail, I was reading, him describe his system and I was thinking how do these folks get an EHR that is a good basic acceptable EHR that will help save lives and do we sometimes go the direction of adding more features onto the sophisticated EHRs and by doing that do we remove the ability for so many of those other EHRs to get to where they will supply their users with a much better system, because we raised the bar too high for many of them. So, that is one of my concerns.

And I'm also concerned that the 1 to 4 doctor office must find the Meaningful Use money valuable enough to go through a change of EHRs and therefore still we'll have too many physicians not using a system that would give them the greatest amount of value and saving patient lives.

The second thing on interoperability is that when we work with Direct the vendors have to do very similar stuff to sending information to an HIE as to send information to each other, a lot of the same code, so why put a repository in the middle if they have to do the same work anyway because that adds to the complexity of everything. So, those were my thoughts on this. And so the value order I think is first the EHR and making sure we get good functionality out, but not so much that it keeps them from building it and the users from using it, good functionality out. The second saving of life is interoperability and the third is PHR in that order.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

On the phone? Any comments?

Charles Kennedy, MD – CEO Accountable Care Solutions - Aetna

Yeah, hi, this is Charles. You know, I'd like to kind of follow-up what David and I think it was Larry mentioned about this notion of data architecture, because I do think that is our more fundamental challenge, you know, I think if you look at, to maybe compare and contrast this with what Judy said, I mean I think if you look at the clinical literature on the effectiveness of EMRs in and of themselves and improving quality and, you know, saving lives, reducing costs, you know, the literature is quite mixed, and so I don't think we can just make the blanket statement that, you know, EMRs in and of themselves save lives. I think that the much more important thing is the ability to share information that is actionable and efficiently delivered so that physicians can take a course of action different than they otherwise would have. I think that's kind of the fundamental thing which I think highlights the importance of health information exchange and highlights the importance of interoperability.

So, as we look to the future, you know, I look at that graph where we talk about capturing discrete data and I do feel like we need more of an emphasis on that. It feels like most of the data we're still passing around in the EMRs that I see, even though it may be an HL7 structure, is still largely unstructured and I think we're still going to have to find some ways to take that unstructured data, the pathology report, the radiology report, etcetera and look for ways to make that information more actionable, more discrete, more mineable for quality purposes, more algorithmically available for reminders and alerts, that feels like to me an important thing that we still don't have much of a focus on, and so as we look to the future I think we, you know, you heard it from Larry, David, I just want to support that. I think this notion of data architecture, discrete data is something that needs much more focus.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Thank you, Charles. I do think it may be somewhat the conversations we have here in the Policy Committee versus in the Standards Committee where I assure you there is a lot of conversations going on about that and maybe that's something we ask John to bring back to the Policy Committee an update on some of those conversations. Okay, anyone else on the phone? Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So a final comment about some of the things I'm hearing out in the world. This seems to have been the week when everyone starts hitting me up with you can get value out of unstructured data, I think I have five different examples in the past week of people who are doing something of some value, it may not be perfect, it may not always be successful for an individual record, but looking at a population it seems to be heading in a very good direction of using a variety of text processing tools combined with structured information and structured sort of kind of a cognitive map if you will. So, that's the different words that say the same thing can be all found together.

So, I sort of have to wonder having spent, you know, a lifetime of working with structured data, if in fact we're going to see, in the next year or two a real breakthrough in the ability of systems to work with unstructured data and we shouldn't lose sight of that as we go ahead.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

One more comment. I just wanted to open a new endeavor, as we're talking about planning for 2012 and that was the framework that we've been discussing, where are we going, what are we doing as a committee, what does this next year look like for us, and what are our goals and whatever, and one of the things I see lacking, and its part of our whole, when we set forth what our goals were, really and it's missing here is a whole conversation of research. We have not discussed what the value of an electronic health record is in research. I see what's happening across the State of Florida, Moffitt Cancer Center, Cancer Treatment Centers of America, a whole variety of things that are going on in research and they are keying in and using that structured data even more so than we see in the clinical practice and I think that conversation has yet to be had in our committee. So, I think we really need an update on that as well.

Paul Tang – Palo Alto Medical Foundation

Good point.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Great, well onto lunch. Thank you, Paul. Thank you Jodi.

Paul Tang – Palo Alto Medical Foundation

So we'll reconvene at 1:15.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Reconvene at 1:15.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul would you like to start? Operator would you open the lines?

Operator

This lines are open.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

All right, welcome back to the meeting of the Health IT Policy Committee. Paul?

Paul Tang – Palo Alto Medical Foundation

Great, thank you and welcome everybody. Fortunately we had a decent amount of time for lunch so people could get nourished. Thanks for a wonderful morning and we'll continue that with a very high profile and high impact project initiative called the Million Hearts Campaign that is a partnership with CMS, CDC and ONC. So, let's see Mat is going to present. Is Peter coming or?

M

Peter's on the phone.

Paul Tang – Palo Alto Medical Foundation

Peter's on the phone. Welcome Peter.

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

I'm here, thank you.

Paul Tang – Palo Alto Medical Foundation

Thank you and why don't I turn it over to you.

Mat Kendall – Office of the National Coordinator

Great, well thank you very much for having us today. I think what we're going to do is Peter is going to begin and he has a deck that we're going to go through then I'm going to go through this and then we'll be happy to answer any questions. Peter, does that work for you?

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

Works terrifically, Mat, thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Would you like to say advance the next slide or Mat are you going to do it for him?

Mat Kendall – Office of the National Coordinator

I can certainly do it Peter if you want to just tell me when you're on and we can go from there. So, we're on the first slide.

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

So, that's terrific. So, I'm Peter Briss, I'm the Medical Director in the Chronic Disease Center at CDC, I'm delighted to be with you today, at least by phone, I'm sorry I couldn't be there in person. I will take just a few minutes and tee up the big picture of Million Hearts and then Mat will follow with more specifics about detailed implications for Meaningful Use and Health IT. So, next slide please.

So, Million Hearts is intended to prevent a million heart attacks and strokes over the next five years in the United States and so the first question is always why heart disease and stroke, and this slide basically tees up the fact that by essentially any measure of burden these are the leading health issues in the United States, so 1 out of every 3 deaths, more than 2 million heart attacks and strokes every year, 800,000 of those die, and many or most of those are preventable. Healthcare cost of about 450 billion dollars a year. Treatment accounts for 1 dollar of every 6 dollars of healthcare spending in the United States and the largest portion of racial disparities and life expectancy. Next slide please.

We in the United States have made a lot of progress against heart attack and stroke since the 1960s and against cardiovascular risk factors, but we have much more work left to do, so more than 100 million US adults smoke or have high blood pressure, or uncontrolled high cholesterol in the United States and since 2000 we've had some improvement in prevalence of these issues but because of growth and population essentially no progress in the numbers of people affected. Next slide please.

And this is an area where the primary problem is not an evidence gap. We know many proven effective and feasible clinical and public health interventions that are being underutilized. This slide shows, on the vertical axis, numbers of lives that could be saved and the horizontal axis is what happens with moving delivery of clinical preventive services from sort of current levels of use to optimal levels and the highest levels in the states are more like 80 or 85%, current levels for all of these services are less than 50% if you took all of these services from current levels to ideal levels that could save more than 100,000 lives per year in the United States. Next slide please.

So, this slide is just a little bit more on current US baselines on the ABCS, these are an aspirin, blood pressure, cholesterol, smoking and again in spite of the fact that we have known effective, known feasible clinical preventative services to address all of these issues current national performance levels are less than 50%, some of them are well less than 50%. Next slide please.

And it's not just about healthcare there are similarly known effective, known feasible community interventions that are similarly underutilized. So, in communities nearly 50 million Americans still smoke and after decades of improvement progress has generally stalled in the United States. Too much sodium is a major contributor to high blood pressure and 90% of us consume too much artificial trans fat, in spite of progress, is still an avoidable hazard in packaged and restaurant food and we can do better. Next slide please.

So, Million Hearts has teed up some serially ambitious goals for improvement. We'd like to take delivery of aspirin, blood pressure control, and cholesterol control from approximate current baselines to more like 65% in communities, because everybody doesn't interact with the healthcare system that sort of requires that clinical targets be more like 70%. Where we'd like to take smoking prevalence down from its current baseline of about 20% we'd like to reduce sodium intake by about 20% and reduce artificial trans fats by an additional 50% by 2017. Next slide please.

And so how are we going to do that, this is where Million Hearts comes in. Next slide please. So the very ambitious goal of the Million Hearts initiative is to prevent a million heart attacks and strokes over the next 5 years. We are in the midst of a very assertive public and private campaign to do community interventions that reduce the number of people who need treatment to do healthcare and systems

interventions to improve the quality of treatment to those who need it and both of these will maximize current investments, public and private sector investments in cardiovascular health. Next slide please.

I've given you already our primary targets of change in communities; these include sodium, artificial trans fats and smoking. In healthcare systems these include aspirin, blood pressure, cholesterol, smoking, these were chosen because they were thought to be high value targets in the sense that they accounted for a substantial proportion of morbidity and mortality, that they were amenable to change in a relatively short timeframe and that they allowed us to focus on a few things that complimented and didn't duplicate other big federal initiatives. So, for example, Million Hearts tends to be relatively adult focused and to some extent relatively healthcare focused, this allow us to compliment for example the First Lady's Let's Move Initiative that focuses more on children and more on upstream issues like obesity and nutrition.

We recognize that there are a number of other complimentary initiatives going on in the public and private sectors that will also help support Million Heart's goals. These include things like other community prevention initiatives, things like early recognition and treatment of acute events, things like other healthcare quality issues. Next slide please.

So, the key intervention components of Million Hearts will include community prevention and clinical prevention. Next slide please. So, in the clinical space this includes an enhanced focus on the ABCs, so this includes a lot of work on clinical quality measurements, it includes making clinical quality measurement more consistent than it currently is. It includes other things that are likely to focus the mind like payment initiatives for example. In the second major pillar of Million Hearts will be Health Information Technology and Mat will talk much more about that both in Meaningful Use and other supports and it includes things like team based care that makes our approaches to improving clinical prevention much more systems based and less dependent on the heroic efforts of individual providers working one at a time. In the community space it includes a number of interventions to strengthen tobacco control and reduce smoking and to decrease sodium and artificial trans fats in the food supply. Next slide please.

So this continues a drill down into specific Million Hearts related activities. I won't read all of these to you, but beyond the 30,000 foot view that I just gave you there are a number of much more specific intervention activities that are happening in both the public and private sector. So, for example, when we talk about reducing tobacco use and exposure to second-hand smoke this will include a number of specific activities like FDA health warnings on cigarette packaging and ads, community transformation grants managed out of CDC that will significantly address tobacco use prevention and cessation, aggressive mass media campaigns to reduce smoking initiation and promotes cessation about to launch in mid March for example. In terms of sodium contents of food, menu labeling of requirements in chain restaurants, public and professional education, additional surveillance information to track progress in any applicable short falls and for trans fats CDC and FDA collaborative efforts working with industry. Next slide please.

On the clinical side we are doing all sorts of activities to optimize treatment for those who need it. There are a number of things that I think we know about the current state of the world that are informing our intervention activities. So, for example the barrier to hypertension and cholesterol control in the United States is generally not screening. Most all American adults are screened within sort of recommended ranges, but they may not be treated or they may not be adequately treated. The gaps include both the healthcare system side, things like lack of focus, clinical inertia and the patient's side, things like lack of knowledge or motivation or lack of access, or lack of information. It's likely we think that solutions will require coordinated efforts addressing both the provider's side and the patient's side. Next slide please.

So, for some specifics about clinical interventions on the focus side, we're doing a lot of work to incorporate simple consistent ABCS indicators in many federal systems. So, the physician quality reporting system, Medicare Part D, Meaningful Use criteria that Mat will talk about in much more detail. On the clinical innovation side for example CDC is launching now a pharmacist led campaign, which will provide materials and facilitate patient counseling. The CDC and the agency for research and quality will identify and disseminate strategies that are innovative and improve ABCs delivery; we're having a big

meeting in April on that topic. And I will seed my time on health information technology to my colleague. Next slide please.

Across the Department of Health and Human Services we're doing a lot of work to try to coordinate approaches to clinical decision support. So, on this slide, as you sort of think about a cascade that looks at what happens in an initial patient visit and what happens between provider visits, and what happens in follow-up visits, there are a number of clinical decision supports that could be brought to bear, those are reflected in the second row and across HHS we're working to develop a coordinated strategy to sort of bring as many as possible of these clinical decision supports on-line. We're also working to facilitate population management that doesn't just think about one patient or one visit at time, but looks at registries and groups of patients. Next slide please.

You heard in the introduction that CDC and CMS, and ONC are all working very closely together on the Millions Hearts Initiative. The support for the initiative is actually department-wide including Food and Drug Administration and the Indian Health Service, and NIH, and many others. The public sector support is also extending beyond the Department of Health and Human Services including the Department of Defense and the VA, and many others. Next slide please.

And we recognize that much or most of the healthcare that actually happens in the United States happens in the private sector and so there is a large and daily growing cadre of private sector supporters for the initiatives that are also pulling their share of the weight. Next slide please. So, that is the general overview and I will now hand the baton to Mat to talk more about the details of Health IT and Millions Hearts and I'd be happy to take questions either now or at the end of Mat's talk.

Mat Kendall – Office of the National Coordinator

So would people like to ask questions now or go to the other presentation, what's your preference?

Paul Tang – Palo Alto Medical Foundation

Keep going.

Mat Kendall – Office of the National Coordinator

Keep going, okay. Well thanks to Peter for that great overview of the Million Hearts Program. And what I'm going to do today is talk a little bit about how we at ONC are partnering with other folks to think about using Health IT to really support Million Hearts. I think there is clearly a synergy, there is a way in which we can really empower both providers and consumers using Health IT, we see it in a number of our different programs and we're currently piloting a bunch of different things. So, today what I want to do is give you an overview of a lot of different things that are happening, happy to take questions, but also link you back to some other experts at ONC who really know this stuff inside and out. And before I get going I want to thank, you know, ONC has got a great team that has been driving this process Seth Pazinski really has helped pull this altogether, put these slides altogether, so I want to thank him and recognize him for the work that he has been doing.

So, really, you know, we think that Health IT can enable a variety of great things, you know, that can in turn really benefit Million Hearts. Quality improvement is something that we've been really driving for. I think that is really one of the reasons why we really have Meaningful Use it's a great framework but, you know, thinking about things like registries and reminders, clinical decision support, these are all great functions that when used properly really can lead to better outcomes and I think what we've been really trying to do is think about how Million Hearts ties into things like Meaningful Use. So we spent a lot of time for instance doing the crosswalk between the Million Heart's measures and what we're talking about with Meaningful Use and there is a natural alignment because, again the things we're talking about, these are sort of core to what we were thinking about earlier on with Meaningful Use. We continue to grow them as we get going.

But our concept here really is that by helping providers get the right information in the right way they can really have positive outcomes. One of the ways in which we're trying to help those providers is through the extension centers, you know, and there are a number of them across the country that are providing a

variety of different services that are aimed at supporting providers to implement electronic health records in a meaningful way. And Million Hearts is a powerful tool in motivating providers because it can give them focus to the implementation, because it's not just about getting technology in place it's about how you're using it and what you're using it for and we found that it's a very powerful focus with the regional extension centers in other works that have been done.

So, as the extension centers continue to grow and, you know, we're currently working with, you know, over 30% of all the primary care providers, ambulatory primary care providers in the country, we are closing in on 40%. We think that the Million Hearts is a great way in which we can work through the extension centers to get this out to a large number of providers and have them begin working on things. And I think one of the focuses for us is that, you know, we're finding that a lot of the extension centers are already beginning to do this work. We recently did a survey of them to look at how they are supporting the three part aim, really looking at improving health care quality, improving healthcare efficiency, population health and we found that a large number of folks are working on Million Hearts, but not as many as there will be by the end this year. And I will talk about a great partnership that we are working with CMS in a moment that's going to bring this number to 100%.

But, I think that there's a huge emphasis among the extension centers about really getting people not only to Meaningful Use but beyond and 2012 is going to be a big year for this. We think there is going to be a big shift of people coming on-line doing these things and we think that Million Hearts is going to be increasingly important to people as we move ahead. One of the ways in which we're trying to help get these best practices and knowledge spread is through our Health Information Technology Resource Center, the HITRC, and you're going to see us begin putting a lot more of our tools and information on the web at healthit.gov, that is going to be one of the primary ways we take this warning system that we've developed, take the lessons learned and begin pushing them out so more people can understand and take advantage of what we're talking about.

One of the things I sort of alluded to earlier is that the RECs that have a really close working relationship with the QIO Program and under the CMS tent scope of work there is really a focus on Million Hearts and what we've been doing in the last couple of months is really thinking about ways in which we can operationalize this partnership between the QIOs and the RECs so that in every part of the country we can have a program that's operating to really focus on Million Hearts, bring people together and I think we've seen a huge uptick already among a lot of our programs. We're going to continue to grow this and I think this is a great opportunity really to think about the partnership between ONC and CMS to in actually helping spread some of these best practices.

You know, we've been looking at all the different primary care setting environments that RECs are operating in and the QIOs and RECs across the country are already closely aligned, this was a natural extension of the work that we're doing. And through using things like clinical decision support, data reports, registries, we think we can really begin helping them to focus in on these Million Hearts measures and begin to spread some of the best practices across the way.

You know, we're also working on the clinical decision support and this sort of alludes to what Peter was describing, but, you know, trying to think of the ways in which we can, you know, be strategic about how we develop and implement this work. There are lots of different ways in which we're working on this and we've got lots of people in our team that are looking both at the quality measure aspect and also the CDS aspect and there are sort of two sides of the same coin and I know you guys will be having a discussion about this later on today. So, I think this is an area where we really think that there's an opportunity for us to really partner with folk to think about how to do this more effectively and move some of the discussion specifically around the Million Hearts measures into practice quickly.

We've also been really thinking about other ways in doing challenges to tap into the innovative spirit of the country. We've done one on a Million Hearts where we're really looking to get innovators and developers to create an app that can help empower patients to improve their heart health and, you know, we've got lots of people going forward. We actually are in the process, we delayed the announcement until March because we have a lot of exciting things here, but we think this is a great way in which we can

really tap into innovators and other people to bring together ways in which we can get consumers working on this as well, because as Peter eluded to in his slide there's a lot more that's happening than just in the practice office and if we can figure out ways of leveraging that information to support consumers as they work on these issues, we think that will be something that will be very positive and has a huge outcome in the future.

This is also something that is a big focus of our Beacon Program. So, you know, we have 17 Beacons that are working on a variety of...across the board and I think that this is also a really great opportunity for us to look at ways in which things like Million Hearts can really focus a lot of the activities that the Beacons are doing. And so we have been very fortunate to work with the Beacon across the country and here is just sort of a map of 17, and beginning to think about Million Hearts as a way of focusing a lot of their activities and there are some great examples of different things that they're working on right now, whether it's, you know, using tools like our committees to do risk stratification around heart health or thinking about ways in which using technology to do better home monitoring, we think there are a lot of predictive programs out there. We're doing a lot of text-based smoking reminders or stratification that is there. We had a great event yesterday in New Orleans to talk about some of this stuff. You know, management, it's really important for us, especially through transitions and thinking around that with cardiovascular disease and then also thinking about some of the more acute care initiatives sort of getting the, you know, EKGs to providers quickly for better outcome.

So, through the Beacon Programs, you know, we're already piloting a lot of these ideas looking at the outcome of trying to save thousands of hearts as we go forward, but I think this is just the beginning and I think the power of this program is it's bringing together people from different ways and different walks of life to focus on one issue and I think there's a lot of power in that because it allows us to partner with other people, coordinate different programs and I think that as we move forward we're going to be seeing a lot of other ways in which we can be using health IT to really support this initiative and to really give folks the right information, the right time, and the right way. So, I think that is a quick summary of what we're doing here, but we'd be more than happy to take folks questions, both myself and Peter.

Paul Tang – Palo Alto Medical Foundation

Great, thank you very much Peter and thanks Mat. Questions? Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Hi, so great presentation both Mat and Peter. So, this has me thinking, and you sort of gave this away in the first couple of slides, this is not for lack of screening that we have these problems it's for lack of effective interventions and a lot of interventions require consumer patient engagement. So it seems like this is a great place to actually be exploring what are the effective tools that do that. I see you've got some of those up there, the text messaging, the home health monitoring tools, but I sort of wonder if this isn't a great place, and I don't have specific answers here, but more, you know, to look at the world of smart phone apps and the things that people are doing to help themselves manage their weight, manage their blood pressure, and to look at and actually use this as a laboratory to create the engagement that I think actually is going to be the big thing to actually bend the curve on health, is to get this out of the doctor's office where everyone's been told, you know, you need to manage your weight, you need to get more exercise, you need to get the salty foods out of your diet, to okay, so that was great, that was my 30 second intervention, you know, what happens in the other, you know, 23.5 hours of my life that is actually going to change those things you know.

Mat Kendall – Office of the National Coordinator

I think we're in complete agreement. I think the app challenge that we're doing right now and we'll be announcing the results soon is exactly in that area and I think that's something we're very interested in exploring more.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Also might be a place talking about partnerships to look towards partnerships outside the traditional medical partnership space, you know, I'm thinking about sort of the non-stop ads I see for weight-loss

programs is that there are folks out there who have a commercial enterprise around helping people manage their health and this might be a place to create some bridges.

Mat Kendall – Office of the National Coordinator

So, I will say though that while you're absolutely right and the consumer engagement piece of this is going to be a real opportunity. What we've seen is that even with existing patients, patients as we have them today, health systems that implement consistent processes for delivering standards of care can get 10, 15%, 20% point increases in things like LDL control, blood pressure control using medical interventions that we know work if applied consistently and monitored and protocolized. So, I think we're working with the extension centers and with the QIOs to implement those as we look forward to the other aspect of the consumer engagement.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Just a quick follow-up, my sense is that is an area where health providers have a lot of learning to do, is how to actually manage a population. The technology is beginning to give them tools to find the patients who are at risk and the tools in terms of CDS to say "oh this person is here, don't forget they also need this" but to actually sort of bring all that together is an area for great learning I think within the provider community.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Dr. Agarwal?

Madhulika Agarwal – Veterans Administration

Yeah, I just wanted to emphasize that, you know, the Department of Veterans Affairs is a partner with you all and we are fortunate to be in a position to actually offer some of the best practices because this is no longer a significant gap for us because we have been working on it for quite some time and just as Dr. Mostashari here said, the focus has been very much targeted on interventions by the providers using the electronic health records and being able to use the population health model and knowing who the patients are who are coming in for care, and who do not have, you know, the ABCS, so this is a phenomenal opportunity for us. Thank you.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Thank you so very much and I think the program is absolutely fantastic as far as going out and informing and reaching the public and it takes that patient engagement aspect that we all want, one of our goals is patient engagement, now how do you operationalize that? How do you really use that in the provider setting and certainly within Meaningful Use we have a lot of ability to build in the necessary tools with decision support to help physicians do that.

However, it takes that personal decision making on the part of the individual patient to move forward and how do you do that? I think at that realm we need to make sure we do those creative innovative things and I have a couple of apps on my iPhone. I have one that is a fast food calorie counter and sodium thing on my phone so I can look things up. Also have a calorie counter and a pedometer. So, you know, those are the kinds of things that are truly going to reach out to the patient and without that patient engagement and encouragement it's not going to happen. We have a huge obesity problem in the country; it drives heart disease, its part of the problem of high blood pressure, cholesterol, heart disease, whatever, all related to obesity. If we don't deal with that, however, and I think the goals are admirable, the goals are necessary and we need to use the tools that we have built within what the ONC is doing with what our goals are of a committee.

What I want to caution us about, however, is trying to be too much to too many. The RECs have a function and a role and limited amount of resources to do it. Let's not put too many demands that are

perhaps outside our charge on the RECs and make it more difficult for them to do what their primary goal is and that is to really facilitate primary care providers to adopting and implementing, and appropriately using Health IT and meeting Meaningful Use standards. So, just a little bit of caution, don't put too much burden on those RECs with the limited resources they have and expect too much.

Mat Kendall – Office of the National Coordinator

I think that's an interesting point and that's one of the reasons why we did that survey, which I put the data up there. These are voluntary activities the RECs are doing already. And I think a lot of them see that as sort of extension of the work that they're doing, that getting to Meaningful Use is an important step and it's just the beginning of a process and once you've put that investment in place and you've engaged and developed that trust with the relationship it's going to the next stage. So, we're seeing a lot of natural interest and uptake among the RECs saying "hey this is why we're doing what we're doing" it's part of the continuum of care and they're growing into this area. So, I think by and large, I think we always have to focus on our goals and I certainly know my numbers very, very well, but I think it is sort of almost a synergistic effect that we're going to get to Meaningful Use, we're going to get them all there and then we're going to go on top of it as well.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Let me add a perspective on it. When we were trying to talk to providers about using registry functions, and this is pre Meaningful Use days, but I imagine there are similar conversations happening with extension centers across the country saying to get to Meaningful Use you need to make a list of patients, you need to implement one decision support, you need to, you know,...support. The conversation was a lot more productive when the provider wasn't treating it as a generic functionality, make up list and more where we said okay let's say that we want to do something that you all agree with, saving lives and let's start with cardiovascular prevention to do that, let's try to control blood pressure, now let's make a list of your patients who have high blood pressure who haven't been seen in the past 6 months, the office manager, the nurse, the doctor got that. So, it can be I think not something that is distracting from Meaningful Use but as a vehicle to make Meaningful Use meaningful to the providers.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

And I absolutely agree that you have to make the real-life case in order to get to Meaningful Use and this is the real-life case there's no doubt about it. And you get that buy in when people see the end result and that's what we're all about is the end result.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

That's right.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

So, it's a tool to empower people to move to Meaningful Use but I want to caution us, we have limited resources and we need to make sure that we're using this to empower the providers, empower RECs and are we going to make this measurements? You know, where do you go from there? And I just want to caution us as to what the original goals are, use this as the ultimate outcome but let's not forget we need to get people on board using electronic health records to improve those outcomes.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

David?

David Lansky – Pacific Business Group on Health – President & CEO

Thanks, I mostly wanted to give you an invitation, but focus on the Meaningful Use quality measures component of your presentation, slide 3. Most of what is here are still, with a couple of exceptions, the process measures and not yet the outcomes measures although there are a couple that point toward the control measures and I know our committee certainly wants to keep moving more towards outcome measures in this case measures of control or perhaps soaking abstinence or other things. So, one thing I

think we can probably do is move away from these being menu options and make them more universally expected. And secondly, I'm wondering if your team could come back to us at some point and propose what you would say would be the ideal Meaningful Use measures to assess progress against these goals and really, see whether they made sense to fit into our portfolio proposals for the next stage.

Then the last thing I just wanted, more as a question I guess, have you contemplated creating more public visibility for high performers against these measures? So, to the extent that their actual performance could be transparent to the public as part of all the other data...that's going on to the extent we can begin to measure performance on these particular metrics through any of the CMS or other programs, could we then have physicians individually recognized for obtaining the ABCS.

Mat Kendall – Office of the National Coordinator

I think to the last point; I think there are a lot of different ways we're exploring that right now. I think there's a sentiment among a lot of the RECs and QIO partnerships right now that it's really important to get those indicators out there and that, you know, working with those providers who get it, who are excited, who are willing to talk about it, sort of inspires others to follow, sort of more of an informal basis that we're working on currently, but there are other things that we can think about. Peter on the phone, do you want to make a comment about either of those, the quality measures of the future for Million Hearts as well as the highlighting the bright spots?

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

Yeah. So on highlighting the bright spots first, there are a number of public sector efforts like PQRS for example and private sector discussions like at NCQA that are about highlighting high performers and so there is all sorts of work in both sectors that's going to address that issue in terms of evolution of measures it's a great idea. I mean, we've tried actually to focus on control measures, so for blood pressure, which is our most important thing among all the kids today, our primary focus has been on blood pressure control, but cholesterol is a little bit harder for us and I anticipate that those will evolve in your direction after the new NHIBL guidelines come out soon. But we're temperamentally with you on those issues and we'd be delighted to continue to engage in those conversations with the committee.

David Lansky – Pacific Business Group on Health – President & CEO

A follow-up on that, on the blood pressure control measure, you know, there has been in the proposed de novo quality measures for Stage 3 a time 2 minus time 1 improvement measure for blood pressure control proposed conceptually and I wonder if you all have done some work on the technical specifications for such a measure, which blood pressure readings to use, how to score them and then how to take the delta between them? Is that work that has already been done somewhere that we could take advantage of as part of your overall attempt to measure performance?

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

Yeah, we have had conversations about the sorts of measures. We've not yet engaged in rolling up our sleeves about technical specifications.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

On the phone any questions? I don't know if Patrick Conway is on the phone yet, if he'd like to say something about the QIO collaboration with the RECs as well? Mat do you want to say anything more about that?

Mat Kendall – Office of the National Coordinator

I think it's a great opportunity for us to be looking at, you know, the good news is most of the RECs and QIOs are already collaborating as part of the REC program, but again, this is another focus and additional resources that we can really bring in to focus on the Million Hearts and I think a lot of it is about just bringing together providers talking about their experiences, helping with those care transitions, how to

work it through and that is sort of very consistent with the work that we've been doing, but we've had a lot of good success in a short amount of time.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

And Gayle to your point, the quality improvement organizations are now getting a pass off right, from the extension centers. So we have quality improvement organizations in every state that they are working with Medicare providers, I think it's 75%, Mat, of the providers who reach milestone two, which is a huge number of providers across the country, are going to be referred to the QIO to work specifically on Million Hearts, cancer screening and immunizations as being the issues they work on. So, it's actually a very nice example of federal programs actually aligning with each other and working together.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

That would be nice; I know a lot that don't.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Great. Thanks.

Peter Briss – Medical Director in Chronic Disease Center - Centers for Disease Control

Thanks everybody.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Next up and right on time we'll have an update on quality measures, David Lansky and Doug Fridsma.

David Lansky – Pacific Business Group on Health – President & CEO

Thank you Farzad and Paul. Let me also acknowledge Jacob Reider who has also been working very diligently on helping put together this process and Doug and I will summarize where we're at. You'll probably appreciate, we actually now have two subcommittees working on the quality measures front one is the Quality Measures Workgroup which is underneath the auspices here of this policy committee and then under the auspices of the Standards Committee is another Quality Workgroup that Doug will characterize here in a minute. So, we'll summarize where both groups are at this stage in the beginning of 2012 and I actually take your attention back to Paul's second slide this morning on the 2012 work plan where he showed that arrow diagram and suggested the 2015 objectives as being Meaningful Use criteria around outcomes, measurement and improvement, which would include next-generation quality measures, clinical decision support and population management, and so that inspirational direction that we've all embraced is really where both of these Workgroups have their eyes pointed right now and we're trying to use 2012 as a building year towards facilitating Stage 3 where those kind of functionalities are possible.

Actually, I think there is one extra slide in this deck, so I'll skip slide 2 and go right to slide 3. I think they are largely the same. On Stage 2 quality measurement development this year, obviously the Stage 2 quality measures will be characterized to some degree in the NPRM that comes out this month, but there is some work underway which will be I think referenced and we'll have a chance to see evolve during the next 6 months or so. There are a number of contracts that have been let between ONC and CMS, and outside measurement developers, and reviewers, and they're doing several things for the next few months to try to put in place a few measures we can use in Stage 2, which get asked some of the goals we've all talked about to build out the measurement dashboard.

So, there'll be some improvements, a look at retooling the 113 measures that NQF had passed along earlier to make sure their specifications are well defined and they are tested and ready to go, some additional work on hospital measures, additional work on behavioral health measures, and then some initial work on de novo, we're calling them, measures, some brand new measures which would address those compass points we've all talked about around care coordination, patient engagement, patient safety, efficiency and so on. And I'll come back to those de novo measures in a minute.

Also, beginning to look towards Stage 3 there is some work being done on annual wellness visits and risk assessments being done in consequence of the annual wellness visit, and I think in general a shift towards more outcome measures where we can. So, that's all underway. Hopefully, some of that work will pass muster and be used for use in Stage 2, but a lot of it really is pointing towards Stage 3.

The second thing that our committee will be looking at this year of course is when the NPRM is released this month, we will take our chance to review it and provide any comments we feel appropriate to the public comment process, so that will probably take quite a bit of time I'm guessing in February/March for the committee's work. So, let me pause there and ask Doug to talk a little bit about the Standards Committee Clinical Quality Workgroup.

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

Sure, thank you. Yeah and I would like to also acknowledge Jacob and Jim Walker who has been instrumental as leading that particular group. I think this is a good example of one of the challenges that we have in which it is going to take an interlocking of the HIT Policy Committee and the Standards Committee to really solve this problem and I think this is an example, I think going forward about how we can do that.

Within the Clinical Quality Workgroup there is really sort of three things that we've asked them to help us understand. The first is when we think about quality measures, they have a beginning and an end, and a maintenance period. There is sort of a lifecycle that occurs and it involves not only things like who sets the priorities and what are the kinds of quality measures that we need to do, but things like how do we understand the vocabularies and the value sets that define the quality measures? Who manages and maintains the syntax in which quality measures are evaluated? How do we tell whether or not a quality measure is ready to be promulgated and how does it align with some of the other activities? And so, one of the things that we'd like to do is to get a sense for that lifecycle, who does what/when in the process of developing, using and maintaining quality measures over time. As vocabularies change, how do we make sure that they stay aligned with the quality measures? So, that's the first thing.

The second thing is to see if there are things that are missing. Are some of the building blocks not there that if the HIT policy says we have a quality measure that we really think is critically important to this country, we need to make sure that we have the right tools and the right building blocks to support that and it may mean that we need to define, again vocabularies around that or that we need to change the syntax that we use to represent e-Measures. But, this particular committee is going to take a look at that and see if there are pieces that are missing that would be necessary to support the policy objectives that we have around quality measures.

And then the third thing is to give us a sense for the readiness for some of those things and that means we may have very good quality measures but our electronic health records may have trouble gathering that data. It may not be data that is easily accessible or easily coded. So we need to make sure that when we take a look at high quality e-Measures, high-quality quality measures that they need to be simple, they need to be unambiguous, they need to be able to be implemented in real systems, they have to be aligned with our data collection capabilities. And so we believe that in the HIT Standards Committee there are a lot of those sort of technical details that we need to make sure that we work out to be supportive of the work that is going on in the HIT Policy Committee as well.

David Lansky – Pacific Business Group on Health – President & CEO

So, going onto the next slide, Stage 3 quality measurement opportunities, so, we've all talked in this group and Paul has presented to this committee last month some of the issues around the models we think we need to measure quality and take action to improve quality in the hopefully emerging environment. So, one of the things that Paul teed up last month is measurement platforms, how do we have a better technology environment to receive new quality measures, generate the data and transmit that data, so our committee will take some time this year discussing what that might look like and how we would see going forward.

The second item that is labeled community-wide quality dashboards, by that we really mean not necessarily the entire community but you think of any multi-stakeholder aggregation, it could be an HIE, an ACO, a Beacon Community, but a broad community level aggregation of quality information and sharing of that information so that people aren't seeing just their own patient encounters but they're seeing patient level information aggregated across a community on the quality measures that are important to manage. Similarly community-wide decision support, how do we create quality dashboards so everyone can see and take action on? And then as we talked quite some bit today, how do we see that data back to the consumer so the patients have quality information available to them? So, really looking at Stage 3 as an almost distribution platform for the quality information that becomes available and how do we support that?

On the next slide, quality measurement opportunities in Stage 3, we have the interconnections between the various agendas that we're all working on, how to create more plug and play so that clinical decision support, if we want that to be generalizable, we've put very small placeholders in the Meaningful Use Program so far around clinical decision support. So we think now that more quality data will be available and this potential of a platform becomes available we'll have some conversation about how to enable clinical decision support to go hand in hand with quality measurement.

Secondly alignment with outcomes research and comparative effectiveness research as another stakeholder who could be using the data coming out of its quality measures from the community. As we talked all morning, how do we make sure the quality measurement agenda aligns better with the payment and health reform agenda of the ACOs and other payers. So, we'll have some of that conversation in the quality measure environment in our Workgroup this year.

And then lastly, coming back to our compass points, the de novo measurement work, as you recall the Tiger Team has recommended various measure concepts in each of these six areas and some of them have seemed riper than others so they have gone out for contractual work under the auspices of ONC and CMS. So, just specifically what's underway right now, under patient and family engagement is a broad category, there's some initial work done on how to measure functional status following orthopedic surgery for example, under patient safety there is some work underway to measure adverse drug events, under care coordination to develop a measure on closing the referral loop that we have all advocated here. As we just talked about, improving and modernizing blood pressure control is under the population and public health category, as is the wellness visit and wellness follow-up measures.

So, we have half a dozen or so promising measures that are under development and we're hoping that certainly for Stage 3 they'll be available and with some luck maybe pieces of them or a version of them could be available in Stage 2. So, that's underway I think that gives you a flavor for what we have on tap for the next few months and welcoming any questions or suggestions.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Gayle?

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

Yeah, I do have a question. On the development of the quality measures, and you say ONC has it contracted it out to do this; I assume these are with organizations that routinely do the same kind of quality measurements and development. Do they have the expertise to put it in the E-setting? Because most quality measurement organizations are really specialty specific who deal with certain diagnoses, they don't come out of our HIT Standards Committee, you know, and are we making sure that we have the expertise because it's a totally different approach to it.

David Lansky – Pacific Business Group on Health – President & CEO

I'll make a comment after you do, go ahead?

Josh Seidman – Office of the National Coordinator

The answer is, yes, so absolutely the people who are contractors working on this, both the contractors themselves and in many cases their subcontractors have been actually the leaders in developing e-Specifications.

David Lansky – Pacific Business Group on Health – President & CEO

I actually listened in on one of the teams convened by one of the contractors on one of these measures and I have two take aways, one is to Josh point, they've done a very good job of recruiting outside experts to inform their thinking on both the content and the methodology e-Specification's question. But, I also came away with a concern that we, as a public advisory committee, will have to keep our eyes clearly on what we're trying to achieve because the history of work in most of these areas was based on a different area and a different set of tools and we'll have to continue to advocate for making sure that the outcomes and patient orientation we want is achieved.

Doug Fridsma, MD, PhD, FACMI – Office of the National Coordinator – Director Office of Standards & Interoperability

And with regard to the standards, one of the things that I think will be helpful to have the HIT Standards Committee work with the Policy Committee is as people develop e-Measures we don't want the people who write the test to take the test and then to grade the test and it's good to have criteria that says, this is what a good quality measure looks like. And so having a group in public be able to say here are the characteristics of what a good e-Measure looks like, not in terms of maybe the content, but in terms of the way in which it's represented and how it uses the electronic capabilities of the EHR, that's something I think that we can provide input to and I think that the HIT Standards Committee can help us make sure that there are criteria that says this is ready to be an e-Measure and it meets the specifications and the requirements that are reflective of a high quality measure.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

We have specific issues, when you talk about PQRI and how you can measure things and we don't want to put providers in a situation where they're having to hand count and to search records and whatever. We want to make sure this is totally done within the EHR and we've seen examples where that's not the case on some measures and things that have been out there in the past. We want to make things easier, not harder.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

On the phone? I don't know if Patrick is...

Patrick Conway – Centers for Medicare & Medicaid Services

No, I'm here Farzad. No, I mean, I think it's very consistent with the conversations that we've been having and not surprisingly from the group, I mean terrific work. I mean, as you know and was eluded to, I mean, I think one of our central challenges is always thinking about the alignment of measures, thinking about parsimonious sets whenever possible, thinking about single reporting mechanisms if impossible that qualify for multiple programs. I heard David earlier talk about sort of the data intermediary issue and then on the CQMs, I mean, just to say this, I think, and it comes out in the PowerPoint, is this, you know, making sure measures are tested, validated, you know, ready for use in programs which, you know, may mean, you know, for Stage 2 making sure that given that, you know, it may end up being a smaller set of measures and I think that's the sort of operational challenges that CMS and ONC are dealing with. I don't know if others in the room or Farzad or others, you in ONC want to add to that or clarify.

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

I would, you know, it's interesting we started off in this endeavor saying one of the key deliverables that people expect from us is that the Health IT landscape, the Nationwide Health Information Network and the Health IT that gets put in place, and it was actually in the legislation in HITECH that one of the three things they mentioned, EHR and Meaningful Use must include is quality measurements. And I think it's important to understand that in the context not only of quality measurement for the sake of reporting and accountability up, but also for the sake of quality improvement within the practice so that providers can

their own quality, you know,...talked at the innovation summit about how today instead of looking out the windshield we're seeing what, you know, the speedometer is showing us what other people did three months ago, you know, or three years ago.

So bringing that to the conversation, so making quality measurement be available at the point of care has been something that we focused on, but I think, and it's good to have these problems because it means we're trying. There has been more and more of an understanding of how inter-related this lifecycle of the quality measure is, that you can't just look at, say okay we have quality measures as they've been given to us and now we're just going to retool them and implement them within electronic health record systems. You immediately run into the immediate upstream problems. You immediately say, well this measure as currently designed, say for chart review, has all these small, rare exclusions and some of the seminal work that Dr. Tang, sitting to my right here did, if you take that approach to quality measure e-Specification the number of data elements you need just grows and grows, and grows, and grows exponentially and those data elements are not feasible for capture in routine clinical care. So, you end up in a situation, as Gayle is describing, where there is a lot of make work and a lot of, you know, documentation for the sake of documentation for something that will rarely be relevant.

But then if you want to go, you know, upstream from that, you say, well, you know, then we need either new types of quality measures that actually take advantage of the strength of electronic health records or we need to take a little bit of a different approach to quality measure definition and what it means for the quality measure, you know, do we really have to incorporate everyone of those exclusions? I know that some provider groups feel very strongly that, you know, I shouldn't be judged on a quality measure if all the exclusions haven't been put in place or maybe we can think of ways of having kind of manual overrides, as it were over the quality measure instead of expecting that all that information can be done in an automated way.

So, you know, the problem is not one that we in the Health IT community can solve. We really need to engage the measure developers; we need to engage the groups that work on setting priorities for measure, who work on the measure concepts and the measure gaps. And we also need to link it downstream to the ability to not just look at quality measures but actually improve them by linking them to decision support, making it computable on that side and registry functions and so forth. So this is just fascinating to me how through this Health IT window it just opens up, it's like a core biopsy through so much of what is right and not right with healthcare. And the good news on this topic, I'll just say is that there has not been a better time or a better opportunity for us to get this right. And, I think it extends both to the readiness in the private sector, but also frankly to the incredible collaboration that we have within the federal government and I am so glad Patrick has joined our Policy Committee because he is going to be an essential part of that.

Gayle Harrell – Consumer Representative/Florida – Florida State Legislator

I'd like to tag onto exactly what you said, Farzad, because as we're moving into payment change and payment reform, linked to quality measures, how this is setup and how this is done is a make or break situation. So it's extremely important that we get this right.

Paul Tang – Palo Alto Medical Foundation

Good, thank you very much, David and Doug. And I think if there is no other business, we're ready for public comment.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Operator would you open up the please?

Caitlin Collins – Altarum Institute

Yes, if you are on the phone and would like to make a public comment, please press *1 at this time. 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.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And while we're waiting, if there are people in the room who would like to make a comment please come forward and be prepared to make brief remarks and introduce yourself please. Operator is there anyone on line?

Caitlin Collins – Altarum Institute

We have no one on the phone yet.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

We'll go ahead and start with those in the room. Introduce yourself.

Jason Dubois – American Clinical Laboratory Association

Hi, I'm Jason Dubois; I'm with the American Clinical Laboratory Association. I have a prepared statement here. I'll be short. Dr. Mostashari, members of the committee thank you for the opportunity to make a statement today. ACLA is an association representing independent clinical laboratories throughout the country including local, regional and national laboratories. I'm reminded of your conversation last week about ineligible professionals and we're obviously one of those. My comments today address an issue laboratories will face once Meaningful Use Stage 2 implementations are to begin. To be clear we're not against the implementation of Meaningful Use, in fact we're trying to facilitate it and I think the comments of both Claudia and Doug today helped reflect that fact. Our issue is one of timing. Once hospitals and eligible professionals begin trying to qualify for Meaningful Use Stage 2 laboratories will need to work with these providers on achieving that end. Simultaneously laboratories will also be working with other providers to qualify for Meaningful Use Stage 1. With a hard deadline for providers to meet there will be an ensuing bottleneck of providers looking to qualify for Stage 2. The onus on laboratories to meet both of these obligations simultaneously will strain their limited resources.

Today, we're asking, you Dr. Mostashari and the committee to consider ways to ameliorate the situation. One suggestion we have is to allow providers to qualify for Meaningful Use Stage 2 on a rolling basis. Another suggestion to help address the bottleneck issue would be to clarify that a provider only needs to qualify for Meaningful Use with only one laboratory and not all that they connect with.

And finally, on kind of a broader, slightly different topic, that is worth mentioning in light of the issues we're raising today over Meaningful Use implementation we feel there is a greater need for coordination on the myriad of regulatory initiatives being implemented. All providers including labs face a burden of meeting the requirements these mandates demand, among them Meaningful Use, the conversion to ICD-10, and 5010 to name a few. What would be truly helpful in a roll perhaps best filled by the Policy Committee would be a series of priority recommendations and sequencing, although I do know that you are limited by what the statute demands in a number of these areas, but doing so would allow all providers to more efficiently and effectively implement these directives in a way that would likely help addressed the burden on all providers. That's it.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Is there anyone else in the room? Operator is there anyone on the line?

Caitlin Collins – Altarum Institute

We do not have any comments at this time.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. Farzad?

Farzad Mostashari – Health and Human Services – Office of the National Coordinator for Health Information Technology

Well, that adjourns this month's meeting of the HIT Policy Committee. Thank you all.