

HIT Policy Committee Transcript April 8, 2014

Attendance

Members present:

- Madhulika Agarwal
- Christine Bechtel
- Neil Calman
- Karen DeSalvo
- Paul Egerman
- Judith Faulkner
- Charles Kennedy
- David Kotz
- David Lansky
- Devin Mann
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Joshua Sharfstein
- Alicia Staley
- Robert Tagalicod
- Paul Tang

Members absent:

- David Bates
- Patrick Conway
- Arthur Davidson
- Scott Gottlieb
- Thomas Greig
- Gayle Harrell
- Aury Nagy

Presentation

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is the 59th meeting of the Health IT Policy Committee. This is a public meeting and there will be time for public comment at the end of the call, a reminder to anyone leaving public comment that it will be limited to 3 minutes. Also as a reminder to everyone who will be speaking, if you could please state your name before speaking, it would be appreciated because this meeting is being transcribed and recorded. For those of you on Twitter, the hashtag for today's meeting is #HITPC. And with that, I will now take roll. Karen DeSalvo?

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

Present.

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

Good morning, Karen. Paul Tang?

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

Here.

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

Hi, Paul. Art Davidson? Alicia Staley?

Alicia C. Staley, MBA, MSIS – Patient Advocate; Co-Chair – Tufts Medical Center Patient & Family Advisory Council

Here.

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

Hi, Alicia. Aury Nagy? Charles Kennedy?

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

Here.

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

Hi, Charles. Christine Bechtel?

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

Good morning.

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

Hi, Christine. David Kotz?

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

I'm here.

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

Hi, David. David Lansky?

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

Here.

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

Hi, David. David Bates? Deven McGraw?

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

Here.

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

Hi, Deven. Devin Mann? Gayle Harrell? Josh Sharfstein?

Joshua Sharfstein, MD – Secretary, Department of Health & Mental Hygiene – State of Maryland

I'm here.

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

Hi, Josh. Judy Faulkner?

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Here.

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

Hi, Judy. Madh Agarwal? I know that she's on. Marc Probst?

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

Here.

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

Hi Ne – hi, Marc. Neil Calman?

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

Here.

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

Patrick Conway? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hey, Paul. Rob Tagalicod?

Robert Tagalicod – Director, Office of eHealth Standards & Services – Centers for Medicare & Medicaid Services

Present.

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

Hi, Rob. Scott Gottlieb? Thomas Greig? Troy Seagondollar?

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

Here.

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

Hi, Troy.

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

Hi.

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

And with that, I will turn it to you Karen.

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

Thank you, Michelle. Good morning everybody and thank you for taking time out of your busy schedules to join us for our 58th meeting of the Policy Committee; we have a good agenda today, I think. We're going to get some important updates from various groups and have a chance to talk about some bigger picture issues – focus on –

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

Just as a reminder to everyone, if you could please mute your line if you aren't speaking, it would be appreciated.

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

– about some of the focus, strategically and perhaps some structure to follow for the Policy Committee. And I just wanted to thank Michelle and everybody for putting together the recommendations for MU3 and let you know as you do, that we're going to be moving forward with some listening sessions. I believe those are in May, but hopefully Michelle and Paul can give us some specifics, as well as the other ways that we have of getting information about recommendations for MU. And you'll see in Jen's presentation, that I asked her to share a bit about where we're going to be getting feedback on MU2, so the committee can start to get a sense of where the quantitative and qualitative information will be coming in that will help all of us stay informed as we move forward on the NPRM for MU3 –

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

Karen, I'm not sure if you – you got low all of a sudden.

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

Did I, okay? I'm sitting still, so anyway, it was just to say thanks for the MU3 recommendations and that we have more to come in terms of getting information. And with that, I'm going to turn it over to Paul.

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

Good morning. Thank you, Karen. So I'll just go over the agenda for today. We're going to start out with the Privacy & Security Tiger Team talking to us about personal representatives. As you know, that's something that's enabled in HIPAA and how we're translating that into the electronic world. We'll then have an update from listening sessions from the Information Exchange Workgroup. They've had a couple of listening sessions dealing with both the transition of care document, the summary of care document electronically exchanging from one organization to another as well as view, download and transmit functions patients and caregivers.

Beth and Jen are going to update us on infor – on the data from CMS and ONC. And as Karen pointed out, we don't have a whole lot of attestation right now, but they expect experience to be coming in around the summer and fall, and so that will obviously input into the rulemaking or the proposed rulemaking activities of ONC and CMS, as they prepare for their NPRM.

Karen's going to then update on us on her agenda and thoughts about work that she'd like the HIT Policy Committee to be conducting and giving advice to HHS and some restructuring of the workgroups or proposed restructuring for discussion.

And then Charles Kennedy and Grace Terrell are going to talk about their work in the Accountable Care Workgroup. They have some recommendations related to the advanced care model. And then we'll conclude, as we always do, with some public comment. Any questions about the agenda? And thank you for putting up with this in a virtual format, we're trying to save some travel time, but it does require a little extra logistics and paying attention on the phone.

You had before the meeting, distribution of the minutes or the summary from the last time. And entertain a motion to approve those.

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

So moved. This is Deven.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

Second, Neil.

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

I'll second. Charles Kennedy.

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

Any edits or corrections? I submitted a few to Michelle ahead of time. Okay. All in favor?

Multiple speakers

Aye.

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

Any opposed or abstain? Okay, well thank you very much. So we'll begin with Deven McGraw and Micky Tripathi talking about their work on the Privacy & Security Tiger Team with respect to personal representatives.

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

Great. Thank you very –

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

I think Paul, sorry. Paul, before we do that, could – Jodi wanted to make a quick comment about FDASIA.

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

Sure, please.

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

Sorry.

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

Hi all, good morning, this is Jodi Daniel. I just wanted to let folks on the Policy Committee know, if you haven't seen the news already, that we, in collaboration with FDA and FCC, have released a FDASIA Health IT report that is a draft report for comment with a proposed framework for a risk-based, regulatory approach for health IT. It is out for public comment for 90 days, so we really encourage folks to review it, give us some feedback; we've asked some specific questions in it. Just a couple of quick highlights to let folks know what's in there. And I will come back in May and do a full briefing on it when we're – when we have a little more time on the agenda, if folks are interested.

But basically what we did is take a lot of the feedback we receive from the Policy Committee as well as from public comment and divide health IT functionality into three buckets, administrative functionality, health management health IT functionality and medical device functionality and talked about each of those three separately. So we focused on functionality as opposed to the platform or the title that folks sort of use for different kinds of products. So we didn't talk about EHRs, but much of the EHR functionality would fall within the health management bucket, that center bucket.

So what FDA said was that they would continue to have active regulatory oversight in the medical device functionality, which are the things that they typically regulate today. And that would be true, regardless of the platform on which that functionality resides. They talked about administrative functionality being sort of out of scope and not something that either – any of the three agencies will be paying any increased attention to. And the report really focused a lot on that middle bucket, the health management health IT functionality, which would include most of the functionality that ONC has included in our certification program, as well as some other functionality as well.

So we – I encourage you all to look at the report. We do talk a lot about – we talk about not adding additional regulatory requirements, but really working in a public/private collaborative way on things like best practices and standards and conformance testing, quality management principles as well as a learning healthcare system. So I encourage folks to look at it, give us your feedback. I'm happy to come back in May, give a fuller update, and walk through the report, if folks would be so interested. And also let folks know that in May, we will be holding a public meeting to get more feedback in a more formal way. So that's all I've got for now and I could take a question, if anybody has it, but otherwise, we'll turn it back over to Paul.

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

And Jodi, this is Paul. Do you want to mention anything about the proposed HIT – ?

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

And the Safety Center, I'm so sorry. So part of that learning health system piece, we have proposed a health IT – the creation of a Health IT Safety Center. We would do that in collaboration with other federal partners, most notably AHRQ. And we look at as a public/private collaborative process and a center that would serve as a trusted convener for three things, for education, engagement and improving evidence so that we actually understand any potential risks that health IT may cause, as well as opportunities for leveraging health IT to improve patient safety overall.

So that's proposed in there. That is actually the area that ONC is most interested in getting feedback on, because it's something we're actively thinking about and working on sort of behind the scenes right now. But we will be looking for feedback both in that public meeting as well as through comments. And we'll be starting to make progress on that over the summer, not waiting for a final report to come out, but weighing in the input that we get.

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

Any other comments or questions?

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

Paul, this is Karen DeSalvo, I just wanted to underscore what Jodi said, which is, we would very much appreciate if people have feedback in a written formal fashion. And then also that Safety Center was included in the budget – in the President's budget, so it is something that we are seriously looking into, thinking about, I believe is a necessary next step.

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

That's fabulous. Jodi, would welcome a more detailed report in May, especially on the HIT Safety Center, since that is something both the IOM recommended and this Committee weighed in on – just explained, there's budget for it. So, hearing more about how you – how the public/private entity would be established, etcetera, would be wonderful.

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

Great, happy to do that.

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

Okay. If there are no other questions, we'll proceed on with the Privacy & Security Tiger Team presentation. Deven and Micky?

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

Okay, great. Thank you, Paul, can you hear me okay?

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

We can.

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

Oh, terrific. All right, so I'm going to be on deck to present the material from the Tiger Team, taking the lead on that. Micky will take the lead on the Information Exchange presentation that follows on the agenda. Next slide, please. This lists the members of the Tiger Team, we've grown a little bit since the last time you saw this list, with a couple of new members, thanking them very much for the work that they've done on the topic that we're presenting today. Next slide.

So just to give you a bit of a roadmap for the presentation this morning, what we examined over the past several months was the issue of providing access to a patient's family members or friends or a legal representatives, to patient information through the view, download and transmit capability. We already have a number of rules within HIPAA about how friends and family and personal representatives can have access to patient level information. What we did was examine what those regulations meant for the view, download and transmit environment and whether there would need to be additional policies or whether we would have best practice recommendations. And as you'll see from the presentation, we don't see a need for additional policies per se, but we do think that this is an area where there could be some best practice recommendations and that's what we're presenting on today. Next slide.

So just to give you a little background on the regulatory requirements that already exist, for a personal representative if you have someone who's legally authorized to act on behalf of an individual, this is a personal representative. And then essentially stand in the shoes of the individual with respect to the capability to access patient level information under HIPAA. This is not someone who's casually designated to be a personal representative, but in fact has gone through some form of legal process, usually defined under state law to be determined to be that person's personal representative. Next slide.

The privacy rule also permits, although it doesn't require, a covered entity like a doctor or a hospital to share personal – protected health information, which is identifiable health information, with family members or other persons who are involved in the individual's healthcare or involved in payment for care. And the information that's permitted to be disclosed in this circumstance is information that's directly relevant to their involvement with the individual's care. Individuals actually have the right to object to these kinds of disclosures and if they have objected, then the information can't be disclosed to family or friends. But note that in the case of emergency or some other circumstances, the covered entities are allowed to make reasonable inferences and act in the best interest of the individual with respect to disclosures to friends or family. This is, as you'll see in a minute, this is a little less important for view, download and transmit. But it's important to sort of set out there that HIPAA, contrary to a lot of – there has always permitted information to be shared with friends and family members, information that's relevant to either care of payment for care, except in circumstances where the individual has objected to that. Next slide.

And the last legal area that we want to cover – I think I skipped a slide, but that's okay – the third way that patients – that family members and friends can get access to information is by the express authorization of the patient himself or herself. And we know that, based on anecdotal information and certainly from the experience on the Tiger Team, the patients are going to have an interest in having friends and family members have access to their protected health information through view, download and transmit. And by law, patients can expressly authorize the sharing of their health information with others.

So, notwithstanding these provisions that permit a doctor to have a conversation with a family member about a patient's condition, when you're talking about view, download and transmit, the most applicable provision for friends and family access is likely going to be the one where the patients expressly asked or authorized for a friend or family member to have access. But of course, there is the issue of the people who have legal authority to act on behalf of the patient. And there may be considerations under which they should be given direct access to view, download and transmit because they stand in the shoes of the patient. But we'll talk in a bit about sort of best practices for physicians and hospitals to manage this. Next slide.

So here are the issues that essentially need to get resolved before someone else is granted access to a patient's view, download and transmit. And the first issue is the person actually authorized to access this information, either because the patient has expressly asked that they be granted access or because they've got this legal status, personal representation designation. Then, of course, you've got the traditional identity and authentication of the individual, are they who they say they are? And these are all issues that we have covered previously in recommended best practices for identity proofing and authenticating patients themselves to view, download and transmit. And one of the reasons why we think best practices are relevant here is not only because we already have a lot of policy in this area. But because education for patients and providers on rights and responsibilities and even some limitations for this capability is going to be key to making this all work and best practices certainly plays an important role in that. Next slide.

I want to say for a minute before – I want to pause for a moment before we go through the rest of these slides and make very clear that we are talking in this presentation about adult patients. The Tiger Team is going to handle issues related to minors and access to data, access to a minor's data by parents and others in a completely separate setting. We're likely going to have a hearing on this, depending on approval of work plans that the Tiger Team had submitted earlier in the year, but we have a great interest in the issues around minors. They are very different and therefore these recommendations are limited to when adult patients either have a personal representative or are seeking to have access to the view, download and transmit accounts by friends and family members.

So having said that, we're going to move on with the presentation that's on the slide, which is to – and here we're acknowledging that today, it is likely that patients are accomplishing access to view, download and transmit by sharing their username and password. And it's hard to control what patients will do and even if we create systems to make it easy for friends and family to be designated in their own accounts, we will probably still have a little of this sharing of usernames and passwords. But we really think this is not desirable. For one reason, you have a lot less capability to determine who has taken action in view, download and transmit, because essentially everyone's using the same account for all actions taken in the portal. And it's probably important to educate patients on why this is not advisable.

But we also think that it's helpful to sort of combat this practice, by making a process for granting credentials to authorized friends and family and personal representatives sufficiently easy to discourage this shared access. And yet we've also got to balance the need to assure that in fact, the friends or family member is authorized to have access to the account and also has been appropriately credentialed. Next slide, please.

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

Okay, I don't know whether my computer is stuck, if you all have it, where we should be is on the recommendations – well, let's see, I think mine –

W

Online, correct?

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

Yes, so if you have it, I'll go on. So what we're doing is urging ONC, this is our recommendation that we ask you to consider. We're urging ONC to develop and disseminate the following best practices for assuring that access to adult patient view, download and transmit can be extended to friends and family authorized by the patient and, where appropriate, legal personal representatives. Next slide.

So with respect to the issue of authorization, is the friend or family member actually authorized to get into the account? Clearly, the easiest case is when the patient makes the request for this access, him or herself, and this can be done in person or remotely; for example, over the phone or through the portal if that functionality has been provided by the vendor, via e-mail. There are sort of multiple ways for the patient to be able to make this request. Providers should document the request and having some capability to electronically store, that documentation would certainly be helpful.

You can use what's called out-of-band notification to confirm that the patient has made the request. And this is essentially using another mechanism to communicate with the patient to confirm that request, other than the mechanism that the patient used. And this is particularly important when the patient request for this access has been made remotely or perhaps through a piece of software, for example, that's purporting to act on the patient's behalf. Next slide.

The harder case, of course, is when the request for access comes from the friend or the family member. And in this circumstance, the access – the authorization to access a record really has to be confirmed with the patient, such as through these out-of-band confirmation modes that we just talked about. If you've got an incapacitated patient, remember again that HIPAA does permit the sharing of treatment related information with friends or family. But it is really limited only to information that's relevant to the treatment of the patient at the time.

So if you've got a portal that's been in existence for a while and it has a lot of previous encounter data that's no longer relevant, it might not be as permissible for you to just grant the access through the portal for an incapacitated patient. Because in that case, you can't really get the patient's concern and you're having to rely on this sort of friends and family permitted sharing that we talked about earlier. If you've got a lot of older information in the portal, this is a case where the provider needs to consider whether providing direct access into the portal for relevant treatment information is really the most appropriate vehicle for keeping the family members informed about the patient's condition. Next slide.

So with respect to personal representatives, here's where we've got to manage the issues of the state law and who qualifies as a personal representative and who doesn't is really a state law matter. So there isn't sort of a way to kind of make national policy on this. But providers should already have processes in place for granting access to patient health information to personal representatives. And essentially what they need to do is figure out how to adapt the processes to view, download and transmit and considering whether the information that's made available in the view, download and transmit account is the information that would otherwise be accessible by that personal representative consistent with state law. And as was the case in the previous example, being able to store documentation of personal representative status would certainly be helpful, to be able to store this electronically. Next slide.

So now, we get to the issue of identity proofing and authentication. So let's say you passed the stage and you know that you have a person who is authorized, either by law or by patient request, to be able to access the view, download and transmit account. And now you have to essentially identity proof them and authenticate them for credentials into the account, just like you would do for a patient to provide them with credentials into the account. Certainly, the patient can be a source of credentials and directly authorizing this kind of access. For example, if the portal actually provides functionalities for the patient to be able to designate certain persons and to name them and identify them, who would have access or essentially can separately provide contact information. In all of our previous best practices, which we have on the backup slides, which the Tiger Team developed and the Health IT Policy Committee approved, with respect to identity proofing and authentication of patients, are also going to apply here.

Note though that providers and hospitals are going to need to develop a process and a capability to be able to cut off the access if there's been a change in patient preferences or a change in the personal representative legal status. If you're not a personal representative anymore, that your credentials to access that account are going to need to be cut off, unless you have sort of the patient sort of reauthorizing that person's ability to access the information. Next slide, please.

So, scope of view, download and transmit access is an important consideration. And what we heard in our review of this was that you could have a view, download and transmit account that might offer more than just all or nothing access to proxy, both with respect to the data content and the functions that can be performed. This is really something that the vendors are considering and offering to patients, but there's no sort of uniform one-size fits all in this respect. And so therefore, it becomes really important when you're educating patients about when they open view, download and transmit accounts. And when they consider making this access available to others that the patient understands what the options are that are available, so that they can make informed decisions about the scope of proxy access that can be granted to friends or family. And certainly also if it is an all or nothing deal, patients need to know that so that the choices they're making about who else can access this account, are informed. Next slide.

And with respect to personal representatives, again, this is a state law manner where state – what personal representatives have the capability to access may be – there may be parameters on that or limitations that are set by state law. And so you have to consider whether the type of – the scope of access is provided through view, download and transmit essentially matches what that personal representative would be able to access before that view, download and transmit capability can be granted to the personal representative. Again, keeping in mind that while personal representatives stand in the shoes of the patients with respect to their right to access information under the HIPAA, doesn't necessarily mean that they automatically have access to view, download and transmit. That might need to be a separate consideration based on relevant state law and what the personal representative would otherwise have access to and if that matches, essentially what's available in the portal. Next slide.

So in terms of these best practices, as usual, when we come up with a recommendation on best practices, we urge ONC to disseminate them to providers to enable them to be able to establish and to turn off, where appropriate, proxy access to these accounts that are consistent with law and patient means. So we have fewer instances of patients just sharing their usernames and passwords as a mechanism for providing this access. And then having providers educating patients on the risks and benefits of view, download and transmit, which is completely consistent with prior recommendations that we've made on this point, should also include the risks and benefits of proxy access, so that all are informed. Next slide. I think we might be at the end here. Yes, and we are.

Interesting that this says backup accounting of disclosures recommendations. Clearly, we are big on recycling slides here. We are saying nothing today about accounting of disclosures because we've said all of that already. But we are at the end of the presentation. It's one of best practices for assuring proper authority as well as identity and credentialing for friends and family access to view, download and transmit, as well as, where appropriate, access of legal personal representatives. I'll pause and see if Micky has anything that he wants to add to this, and then we can open it up for questions.

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

No, I don't Deven, thanks; I think you did a terrific job.

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

Okay, great; all right we're ready for questions.

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

Okay, thank you Deven and Micky. And so just to reemphasize Deven's last point, they are asking for recommendations and as Deven mentioned, there's no new policies that are being recommended, but mainly that of a best practices. And I'll certainly highlight something that she did say multiple times, but it's probably something that's not – it's not emphasized in the public and it's this all or nothing access. So not only is all or nothing – when you grant typically in today's system, not only is proxy granted all or nothing in the past, but an important concept that I don't think people understand is, it's is all or nothing going forward as well, until you discontinue that. So, it is something I think is under appreciated both by the patient, the proxy access and the provider that's offering the service. So just something to highlight.

Other comments and questions please.

Paul Egerman – Businessman/Software Entrepreneur

Yeah, this is Paul. I have a couple of questions. Paul Egerman.

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

And by the way, let me point out, on the web, there in the upper left-hand corner there's a hand raise sort of icon. If you just press that, then we'll know that you're in the queue. Thank you. Go ahead, Paul.

Paul Egerman – Businessman/Software Entrepreneur

Yes, thank you Deven, as usual, an informative and very helpful presentation. You talked about – a couple of questions. You talked about personal representatives and what would happen if the patient's disabled, but doesn't the patient's advance directive play some role in that? I mean, wouldn't that give you some process for determining what to do?

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

Well, I think that's a good point Paul. Again, since HIPAA does permit friends and family to be able to have information about a patient's treatment and – unless the patient has objected and when that patient's incapacitated the provider is directed to act in the best interest of the patient. If you've got an advance directive that indicates a desire to share friends – names of friends or family or that designates a friend or a family member as someone who would make decisions. I think you've got, at least for HIPAAs permission to share with friends and family, I think you've got all the evidence you would need, even in the circumstance where the default understanding is the patient likely would want this, absent a known objection or some indication that the provider thinks it wouldn't be good for the patient. For personal representatives though, it's not clear to me whether designation in an advance directive is sufficient to give you that legal status and that's probably a matter of state law.

Paul Egerman – Businessman/Software Entrepreneur

And that may be, but it just seems to me in a statement about the best practices, there ought to be some reference to the advance directive, perhaps as a guideline or assistance, because sometimes these family situations are very complicated.

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

Yeah.

Paul Egerman – Businessman/Software Entrepreneur

And that could help considerably if the patient is disabled. The other question that I have is, picking up on what Paul Tang said about all or nothing. I think he was referring to all or nothing in terms of access to the all of the data. But VDT functions also includes, as the name suggests, download and transmit. It also includes things like renewing prescriptions and entering data is being discussed. And I'm curious if you felt there was any need to have any best practice discussions on those things. For example, you have a – you might be creating a situation where a friend of the patient is able to renew prescriptions, and is that possibly something that you might want to restrict? And especially might you want to restrict access after the patient dies, perhaps not wanting the friend to renew the patient's prescription after they die.

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

Right, very good point Paul, so we did discuss this in the Tiger Team and essentially what we concluded, and we tried to make that clear on the slides, but maybe it wasn't, was that there are going to be some different levels of functionality with – and within a view, download and transmit portal. And vendors may, in fact, provide different capabilities based on roles, like the ability to order a prescription or book an appointment or to provide – or to make a transmit functionality, for example. Because we didn't want to be directive in terms of what proxies should or shouldn't be able to do. Essentially, what we said was, you need to educate the patient about what is possible in your portal and what the options are for what a proxy, a friend or a family member can or cannot do so that the patient can act according to whatever choices they're provided. They may not be provided with very much, depending on the functionality, but that this all has to be part of the education. But we didn't discuss the one about patients dying and turning off the prescription capability, that's an interesting point that someone didn't specifically raise.

Paul Egerman – Businessman/Software Entrepreneur

And actually, my final question is, you were talking a lot about PHI and the VDT function also includes information about the family history, and are there any privacy issues about giving the family data to, for example, a friend of the patient.

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

Right. Well, interesting point, if the patient recorded family history, it's considered under HIPAA to be PHI of that patient, even though it has implications for another person's health. It may – it probably makes sense that that be part of the education of patients, that when you provide proxy access to a friend or a family member, what they're going to see is all of this information that's in your portal, including anything that you have reported on family history. Which means if you said that Aunt Gertrude had heart disease, and give her proxy access and she doesn't, you're going to potentially create a family situation, but we didn't think that we needed overarching policy to broker that, just an awareness on the part of the patient.

Paul Egerman – Businessman/Software Entrepreneur

Thank you.

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

This is Micky. I would just add, but I thought Paul, I thought those were excellent points.

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

They're great questions.

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

I think that's why – and that's why we focused on the need for this education piece, because the law clearly is somewhat permissive with respect to this. And – but as a practical matter, there are obviously very sensitive issues here that have real practical implication for how people may want this to be made available to friends, family and personal representatives, which we thought was most appropriate to focus on the education side.

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

Yeah, and you know, I agree. This is Deven, again, that Paul, since these are best practices, I think we can add this dialogue to the transmittal letter as sort of part of the things that people thought of that might be helpful to communicate to providers.

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

Are there any other – I don't see any hands raised, anybody else want to ask –

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

Troy Seagondollar has his hand raised.

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

Oh, it's not on mine, okay.

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

Thank you, I appreciate it. Great work, I really appreciate what you've got into this. And I want to dovetail off a couple of things that Paul said. I'm really curious about this whole all or nothing process. It doesn't seem like we've really dug into this deep enough to make this robust. And there are a lot of examples in other applications where I as the administrator of that account, if I'm the patient, that I can actually send a permission or an invite to some family member to say, okay you will have editable access, you'll have view only access and these are the components that you'll be able to see.

So I'm curious, I mean, when we use these real soft words like "may," I – it's always difficult for me to think that someone may go ahead and spend the extra money to make this available. I think it really should be more of a "shall," that they shall make this part of their functionality, part of their process. That way we give the patients and their family members the decision, their choice as to which layer of this, what level they're going to allow their family members to view, to edit, to either download or transmit. And all these – I can see it as simple as making it check boxes, where I as the administrator, whether I'm a personal proxy to my family member, can go I there and say, yes, I would like to have the sister or the brother have view access. But I will be the administrator; I'm the only one that can edit on behalf of my mother or my father.

And I speak of this in personal terms because I do have experience with this. My mother-in-law, who has deteriorating Alzheimer's, there are seven children in my wife's family. Well every one of them has a different piece of her healthcare; one manages her appointments, the other one manages her medications, the other ones would like to know just exactly what happened in an appointment. So they would like to have different layers of capabilities in managing her health and making sure that the care is being coordinated in an appropriate manner. On top of that, she lives in an Alzheimer retirement home and so they too would need access to view, not so much edit, but to view what the nature of the appointment was, any kind of prescription that she's on. So again, I emphasize the fact that it's not just a matter of all or nothing, it needs to be layers of that and we need to say that this will be part of this functionality, it will be part of this process.

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

So, this is Deven. In response to that, we did on the Tiger Team have a discussion about whether we wanted to take the step of requiring as part of certification that there be some granularity to friends and family access that would include both with respect to what data could be viewed, but also what functionality could be performed within the portal. And the team decided that this was not an issue where they would recommend a sort of one-size-fits-all approach to certification, probably for a range of reasons.

One being the view I think of a number of people of the Tiger Team that certification should be limited to those functionalities necessary for interoperability. Another rationale is whether there are sufficiently mature standards, or even whether this is a candidate for sort of more of a strict approach. And generally the Tiger Team felt like, while certainly granularity is a desirable endpoint, it is best done by vendors through market demand not through certification. But whatever pathway a vendor decides to go with respect to that granularity, that the patient has to be – it has to be very clear to the patient and to the friends and family and to providers, what the capabilities are so that whatever choices are available can be informed ones.

That I can tell you was the context of our discussion, not that we didn't think that the granularity was desirable, but that we didn't think that it was appropriate for asking for a must, which is essentially certification – a certification recommendation. And we thought that the education of what did exist based on what the vendor was likely to provide based on market demand, was the important recommendation to make from a best practices standpoint.

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

And I think – this is Micky, I would add that what we heard from the vendors who were represented was that they were already on the path toward doing this –

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

Yeah.

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

– but each of them was doing it a little bit differently, and that just – that spoke less to the need for standardization and more to the complexity of the types of things that they thought were valuable to their customers in the market.

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

Yes, thank you, Micky. Good point.

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

Was there – from the point of view, did you have any public comment in regards to what access really meant and what was valuable and what was not?

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

Can I ask who's making the comment? I don't recognize the voice.

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

I'm sorry; it's Troy Seagondollar, again.

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

Oh Troy, thanks. So there is in the backup slide, a summary of all of the public comments that we received and yes, we did hear from people that this was important. But I think you got a response from both Micky and I that people thought, not ready for certification but the vendors are moving in this direction. It's just we're in different stages of this granularity and different stages with respect to what types of functions and, etcetera, so –

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

Okay, appreciate it.

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

Thank you. David Kotz has his hand raised.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

Yeah, hi, this is David Kotz, I'm on the Tiger Team and so I've been through all this before. Thanks Deven for a great presentation. It just occurred to me in listening to the conversation though, that we might want to make an explicit suggestion about revocation. So patients might grant this access to various friends and family, but it should also be very easy and quick when they want to revoke that for any reason.

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

Yeah, I thought we had that David?

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

I'm looking at the slides and I must be missing it, I'm sorry.

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

Okay, yeah, it's on – I'm unfortunately dealing just with the computer in front of me and not working –

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

Oh, here it is, I'm sorry. Slide 13, yup, okay. Yeah, I missed it, thanks.

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

Sure. It's that good of a point, David.

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

And this is Paul Tang. The all or nothing question that Paul Egerman raised and you put in your presentation, is a big one. One – an area that may not have been emphasized as much is the transmit function, so for people who are opening up that spigot to some other place, which could include a third party. That's also a forwar – wow, I guess it could be a backwards and forwards all or nothing and that may be something you want to address in your best practice education as well.

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

Yeah, that's a – it's a good point although as you'll see in the next presentation that Micky will lead, as of yet there's not a whole lot of demand for transmit.

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

Understand, but when they find out –

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

That doesn't mean we won't get there, right, exactly. No, I think that's a good point and we can add all of these points to the transmittal letter.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

So Paul, this is Neil, can I just ask a quick question?

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

Sure, go ahead Neil.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

We keep talking about the education piece, who's responsibility is it going to be to educate people about all of these subtleties and all of the information that people are going need to know to make informed decisions about this? Where's that education supposed to take place?

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

So we, as the Policy Committee already adopted a recommendation we made earlier, when we first talked about view, download and transmit access for patients and the risks and benefits. Unfortunately the provider who has the relationship with the patient and is offering them the portal and actually in Stage 2 gets rewarded for their use of it, is the one who is going to be looked to educate the patients on this. But we do have recommendations that ONC provide materials to providers to help them educate their patients about this.

I mean I get it, it's one more thing on the on the list of doctor responsibilities. But I'm not sure who else is in a better position to do this, given that the credentialing of accounts takes place in the doctor's office, or in the case of an institution, with hospital staff. And that's who patients are going to look to with questions.

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

And this is Micky, I –

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

Then who's – I mean –

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

– in most cases there are configuration options so just one EPIC portal or ECW portal doesn't look like the next ECW portal because the provider, as the customer, has the ability to configure it according to what they would like to make available. So that just speaks to the need for the provider to educate as well.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

I understand that, the piece about the educa – the providers educating the patients. But, even educating the providers around these kinds of subtleties, I mean, is this really what we're going to be doing in our medical education system now? We're going to be like teaching people about all of these laws and requirements and all of this st – I mean, I just think – I think what's going to end up happening, quite honestly, every time I hear this is that people just aren't going to get informed. I mean, they're just not going to get informed.

It's – I think when you, yes it's nice to say that, but when you rely upon that as a mechanism, what you're really saying is, you know, we really don't think people are going to get informed. Providers are just – they're teaching people about diabetic education, well no, we've hired diabetic educators to do that because we found out providers weren't really good at that. And we have providers using nurses to do a lot of education because they don't really have time in their office visit to do that.

So we have to figure out who in the workforce is really going to be trained to be able to provide this kind of information and make that something that's real and practical, if we really think it's going to be important for people to get this. Because relying on the providers to do this is really a nonstarter in my opinion.

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

I think when we – so, this is Deven, Neil and I don't disagree with you at all. I think when we – when we talk about educating providers, we probably ought to frame it in terms of not just providers, but material for the entire office staff, right. Because I think the expectation – we're not expecting physicians themselves to enroll patients and their proxies into portals, we fully expect that in most cases, that's a delegated responsibility that will be taken care of by either a nurse or front desk staff.

Neil S. Calman, MD – The Institute for Family Health – President and Co-founder

Right and my point is that, it's not within the educational scope of any profession right now to be doing the whole list of things that we've been talking about or sort of depending upon providers. So I just want to make the point that we need some – to the extent that some of this stuff is really critically important, we really need to figure out like – and provide some guidance I think, as to where in the process of workflow and the health care team, this stuff is going to happen. Or at least give some thought to it so that we can think about what's really going to happen in real life. That's really my main point. And I don't think we should be prescriptive about it, but I don't we have any solutions for this right now. We at least need to put that in as part of our dialogue.

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

And this is Paul Tang. I'll weigh in a little bit with Neil. I know that ONC and CMS have done great jobs at even YouTube videos to help providers understand their responsibilities in privacy and security, because it is hard in addressing the 500,000 providers. I guess along with Neil's point, there are 330 million Americans and this is a hard thing to teach the implications of making these decisions, lots of benefit as long as you watch out for your risks. And it may be worthwhile to – for ONC to think about the same kind of YouTube videos that perhaps we all link to on, what does it mean, what are the benefits of allowing proxy access? And what should you be considering, as you go forward and also considering whether you want to either limit or revoke at certain points of time.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul Egerman. I appreciate what you just said Dr. Tang, I appreciate what Dr. Calman also said. I'd say it's part of a broader issue. There's a lot of privacy policy that in theory, we're supposed to be educating patients on, but in practice, we just give them documents that nobody reads. And it's – I just say, it's a very good issue. I think that Neil said it right, in practice what really happens is, the patient simply is not educated and is not informed and –

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

Right, I think they have the feedback.

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

Yeah, that's really helpful. We can incorporate all of that into the transmittal letter.

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

Thank you. Any other final comments or questions? Okay, well thank you very much Deven and Micky and if you wouldn't mind incorporating some of these additionally raised comments in the transmittal letter, that would be very helpful, I think.

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

Yeah, so it's – again, it's recommendations for best practices and so all of the comments, I think, are relevant considerations for ONC and we can reflect them.

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

Then Michelle, do you want us to vote on this?

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

Yes please.

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

Okay. I'll entertain a motion to approve the recommendations, which is, as we pointed out, there are no policy recommendations; it's really best practices on primarily education.

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

So moved. It's Christine.

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

Thank you. Second?

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Second. It's Judy.

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

Okay, thank you. And any further discussion? Okay, all in favor?

Multiple speakers

Aye.

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

Any opposed? Or abstain? Thank you very much. Thank you Deven and...

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

Thank you.

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

And for the next show, we'll reverse the roles and Micky will be the Chair and Deven the Co-Chair as we move on to the Information Exchange Workgroup reports on their listening sessions.

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

Okay. Great, thanks. And I mean as all of you know from looking at the two of us, Deven and I are twins separated at birth, so we try to travel together in these. So, what we want to do today is just give the Policy Committee an update on listening sessions that we had. We're not asking for any recommendations or anything, it's really just this was really just to get feedback from the market on early experience with two of the Meaningful Use Stage 2 requirements related to health information exchange, namely the transition of care requirements and the view, download and transmit.

So, please advance the slide. Next slide, please. So as I said, we want to review the findings from the listening sessions. Next slide, please. So what we wanted to do is determine if there are any gaps in vendor and provider readiness for the achievement of the Stage 2 ToC and VDT requirements. So we held two listening sessions, one focused on vendors and one focused on providers, to identify any of the readiness issues. We want to recognize that we're still very early in the attestation period and there's very limited field experience to date. But the idea was to gain whatever early insights we could into the initial experiences, to help to inform the Policy Committee in the overall process of any red flag kinds of issues that we might be seeing.

These were listening sessions and so we did the best that we could to reach out to providers and vendors who were already well underway to trying to field these kinds of systems. Just as a reminder to everyone, it is early in the process for the Meaningful Use Stage 2 for eligible hospitals. Their attestation period began October 1, 2013. For ambulatory providers it was January 1 of this year and we held these listening sessions a month ago, so, it is still very, very early in the cycle for both. Next slide, please.

So these were the two sessions that we had. We had the vendor ToC panel, so in each session, we had a ToC panel and a VDT panel, just to get a little bit of differentiation in focus there. And you can see the list of vendors that we had in both of these. I want to thank both for this panel and the provider panel, those who participated in these panels. I want to thank both for this panel and the provider panel, those who participated in these panels. And I'm always amazed in all of our working groups, how responsive people are and how candid and thoughtful they are in sort of addressing these issues and being willing to share their experiences and their recommendations and advice for the broader community.

Next slide, please. So the overview and the bottom line in this is that what we found is actually remarkable consistency in the vendor and provider panels. And they both identified main challenges to meeting the ToC and VDT requirements. First was –

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

Micky, we lost you?

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

Collaborative

Can you hear me?

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

Just when we got to the punch line.

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

Collaborative

Yup. Can you hear me now?

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

We can.

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

Oh yeah, there we go.

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

Collaborative

Oh, okay, sorry. So what we found was there are really two issues, one was related to ecosystem maturity and the other to workflow. So with respect to the first, it's having the technology in your hands is just one piece of being able to communicate, the other piece is about having the ecosystem or an infrastructure that can support coordination and trust with the other parties. And the healthcare ecosystem is really at a very, very early nascent stage in implementing both transition of care and VDT types of use cases, and a lot of these maturity issues and these early stage issues were what people were identifying,

The second was related to workflows within the care setting themselves. Again, implementing the technology for these types of things is one matter, but then actually doing the detailed training, workflow adjustments and really the education, which is, I think, a theme that we've seen now across these two presentations of the Tiger Team and this one. Where really sort of the key areas that really need to be focused on now.

One thing that didn't come through as a major issue was technology. So now I would sort of caveat that by just reminding everyone that there's extreme selection bias in this because we deliberately chose organizations that, providers in particular, who were already doing attestation cycle, who were already in their attestation cycle. So there was a lot of a selection bias there because they wouldn't be testing unless the technology was working for them to begin with. But we did that deliberately because we wanted to get the experience of people who were actually trying to do this and not those who were still thinking about it.

The other thing that we hear was that to a certain extent you might think some of these organizations, going back to the selection bias issue as being real lead adopters and in many cases, you could – with listening to them, you really got that sense. So one of the things that we asked them was, how lead do you think you are? How far ahead of the curve do you think you are? And they did express that they thought that they were sort of well ahead of the curve and some of these issues that they were raising could be significant challenges for the broad cohort and the bolus of providers who are going to be following them in the attestation periods. So, there are certainly some issues here that hopefully time and greater familiarity with the workflows and the ecosystem maturity in particular, will help resolve, but they felt that they were issues right now. So why don't we dive down into the specific panel findings. Next slide, please.

So with respect to transitions of care one of the things that we heard was that there was difficulty finding trading partners. So just as a reminder to everyone, you have get – to have 10% of your transitions of care summaries have to be sent to other entities and via the Direct standard. So you're aiming for that

10% and there are some unique challenges that some organization might find. First off was just how – are there sufficient trading partners who I can actually identify and have endpoints that I can send to? In some places like rural areas, for example, it may be that in order for you to reach your 10% or that the vast majority of your trading partners could be non-Meaningful Use providers. Which doesn't mean that they – I mean, they obviously count of transitions of care, but the issue is, that they don't have the funding, motivation, resources to have implemented electronic systems on their side. So it's very hard for me to send something to them – to someone electronically when they don't have the electronic system to be able to receive – to receive it.

And in particular, there are many places where you have integrated health systems where they're on the same EHR instance. So, in that case it may be that in order for them to hit their 10%, the vast majority of that 10% is going to be made up of long-term care providers. Who would fall specifically into that category of a significant part of the health care delivery system that didn't have the benefit of Meaningful Use incentives and resources, and so are having a difficult time adopting these technologies to make them appropriate recipients for this eligible providers and hospitals to meet their requirements? This wouldn't apply for the organizations who are able to do what people like to call the "selfie," which is you have two different EHR systems, even though you're an integrated delivery network. But for those who are on a single instance with their ambulatory and hospital for example, this presents a significant challenge to their meeting their 10%.

We did find that there are providers who are actively working with their referral partners to address this through outreach and education. But this was...what we heard was, some really sort of above and beyond what one might think of as the call of duty. Of people literally reaching out very, very aggressively to their referral partners, giving them – literally sending them letters saying, I need you to be a referral partner for me in order for me to meet my transitions of care requirement. Here is a step-by-step sort of cookbook for how you can create an account on this particular vendor's system that will allow you to have a portal type of endpoint for me to send things to you. So there were – we heard from one provider in particular from Illinois who spent a lot of time doing that in order for her to get to the point where she could have confidence that she was going to be able to get 10%.

In other cases, we heard of hospitals and other organizations who were literally purchasing Direct endpoints for non-Meaningful Use eligible trading partners. So for a long-term care facility, for example, a hospital might purchase webmail accounts or web portal accounts via some Direct provider, in order to ensure that the endpoint has a webmail account and that they have a Direct address that's known to the sending party, so they could be able to send things to them.

Identifying – figuring out, even figuring out whether the trading partner has a Direct address was also noted to be a challenge as well, let alone the issue of finding it once you've established that they do have a Direct address. So these are kinds of the maturation issues that we were seeing. It certainly recalled for me, and I think for other members of the workgroup, the early stages of email and Internet networks in general, when you think back to AOL, Prodigy, CompuServe and then how email started to slowly get adopted in the office settings. I know I was in the Defense Department at the time that we first started bringing email in and a lot of these issues sounded very, very familiar with the kind of experiences we had there from moving to paper-based processes to electronic. They're very real issues and it takes time for the system and for the ecosystem to catch up with where the individual demanders are wanting it to be. Next slide, please.

HISP-to-HISP interoperability was another challenge. So even to the extent that you have endpoints, endpoint users, if you have Direct addresses or are enabled with some type of capability to be able to send and receive according to the Direct standard, you still have the issue of lack of network interoperability between HISPs. So, if I'm on one HISP and the other provider is on a different HISP, if those HISPs have not established HISP-to-HISP interoperability, whether it be bilaterally or through DirectTrust or NATE or some other type of facilitating organization. And I literally did not have the ability to send something to them in order to meet my transitions of care requirement, even though I have a Direct capability and they have a direct capability. So again, that can be seen as sort of a maturation issue, but it's clearly an issue that seems to be sort of common across the market as we think about how the HISP market is developing. And the lags that we're seeing in terms of the different vendors getting their arms around what their approach is going to be to the HISP functionality. Whether they're going to have a HISP of their own, partner with an existing HISP or allow the provider customers to choose which HISP they belong to, and then deploying whatever capability they've decided to implement in the market.

The other challenge that we found in HISP-to-HISP is even if there is a relationship that's established, a network relationship, the lack of standards related to provider directories in particular leads to challenges of identifying the endpoint email addresses for the receiving party. So again, there are lots of manual processes that are taking place right now, as you would expect, to be able to accomplish that. But I think that as we think about scaling this in the future and being able to move above the 10% and hoping that this takes off, that sort of definitely presented itself as one of the challenges that people had identified in their being able to do this easily within their current systems.

We also heard just a lot of confusion over what might count as a valid transition of care, a valid transition of care for measurement. And we gave sort of a sample here of the kinds of questions that are coming up, there are many, many more. This doesn't speak specifically to the technology or the infrastructure, but it is sort of a barrier that was identified as part of the complexity of this, that could be a factor that prevents

people from moving forward as quickly or as easily as we would hope with this particular Meaningful Use requirement. So I think this is the last one on the transition of care, if you can advance to the next slide, please?

Oh, no, I guess there are a couple more here, sorry. Workflow retraining was raised as one of the most significant issues. One of the interesting things that we heard from one of the vendors was that in order – in terms of being able to enable a provider sort of easily and effectively do the transition of care workflow. What they found was that, one vendor in particular reported that it took them 1-2 weeks literally to get the system in place. To configure the technology and have it ready for the user use, but it could take something like 6-8 months for the provider to actually be able to use it, because of all of the workflow issues that were raised by the new technology and the need for training, redesign of workflow so that it could be effectively used.

And one of the interesting things that we heard was that even to the extent that they're able to get their arms around that, that's mostly on sending, so on the outbound. And that provider organizations are really just starting to think about what to do on the inbound side, what to do when you get an unsolicited C-CDA, let's say, from another organization. How that gets vetted – how that gets identified, vetted and then routed appropriately within your organization?

The ensuring implementation aligns with other program requirements was another issue with respect to workflow for organizations that are embarked on patient-centered medical home or accountable care. Those also have a variety of use cases and workflows in figuring out how this new capability is going to align with that, was another challenge. And so in general, trying to figure out how to integrate these documents into the existing care referral processes, to limit the sending of redundant data. Because that was another issue was that there's ongoing processes that go on today related to some of these other types of care models or parallel care models. And then trying to make sure that you're not as a matter of trying to fulfill your transition of care requirement, sending stuff that may already have been incorporated in things that you're already sending to that organization, outside of your Meaningful Use requirement, just as a part of continuity of care. So a lot of workflow issues, a lot of training issues that hopefully will shorten over time, but the current experience is that those are significant issues in terms of time it takes for providers to be able to use this.

The other sort of nuance on the workflow issue is the internal organization issues of, how do you manage this kind of inbound traffic in particular, when it comes into your care setting? So, some vendors and/or some providers are working to have a centralized inbox, so let's say your HIM Department sort of mimic the workflow that happens today, let's say with faxes or with paper that comes into a care setting. Have it go to the HIM Department, have them open it up and then validate what it is and then appropriately route it within the organization. Some organizations and vendors are mimicking the process, whereas others are trying to enable a little bit more nuanced or granular types of addressing that would allow things to go directly to an individual provider, let's say, who was identified within an organization as a recipient.

Again, those aren't – there's not a right or wrong there, but it's just sort of the issues related to these being new processes and having to rethink perhaps, how you're doing things in order to accommodate the new ways that information may be flowing into the organization. And making sure that you're not dropping the ball on anything, which obviously is a huge safety and quality issue. Next slide, please.

In terms of the view, download, transmit, what we found was, and Deven alluded to this in the previous presentation, view and download seem to be relatively well understood and implemented by providers and vendors. And it was really transmit that was sort of the one requirement that they thought – that both the vendors and the providers found could pose the greatest challenge. What they did find was that it's not – it's sort of a showstopper because overall, as Deven had alluded to, there isn't a whole lot of demand for that right now and a provider could meet their VDT requirements by – through view or download, this is a view or download or transmit from the provider attestation perspective. So the fact that patients aren't yet demanding this and the fact that all the ecosystems that we just – ecosystem issues that I just discussed and the workflow issues that I just discussed that were related to the ToC would also be issues here. It hasn't presented itself as a barrier because there are other options, unlike in the TOC 10% requirement that is the only way that you can do it.

Next slide. So, HISP-to-HISP interoperability, again that's the same carryover issue – same issue here. It also presents another sort of unique angle in this in that if a patient wanted to be able to send something or transmit something to another provider, so again, there are all sorts of use cases that one can imagine through the greater patient engagement and greater patient control over their information. One possibility is that they could download their information or through the provider application, be able to directly transmit it to someone else, but the same HISP issues apply. But in this case, the patient is now further sort of back from understanding the network working compatibility issues that might exist there in the market, which is just sort of a huge area for confusion and frustration, as you think about that. So if a patient wanted to be able to send something to another provider, to a specialist let's say, how would he or she even know that that other provider is on another HISP? Even if they could find out whether that other provider is Direct enabled and what their Direct address might be. So, the same issues about being able to discover provider Direct addresses and provider directory interoperability and access, sort of present themselves here, except this time as an issue for patients.

So, this issue of trust across these networks is sort of a big issue that came up in both. I think it is working itself out through some facilitating organizations like NATE and DirectTrust and through lots of bilateral arrangements. But there is certainly a lot of confusion in the market right now and a lot of opportunity for people to get frustrated and to see these are short-term barriers to their being able to move forward. Next slide, please.

One of the things that – on the good side, one of the things that both the providers and the vendors noted was the use of the C-CDA as a single content standard seemed to be very, very helpful as we think about enabling standardization and easing the implementation of VDT. There are certainly technical issues that I think all of us are aware of as you think about the different variations of C-CDA and what gets incorporated and the existing optionality that is still there. And whether that is the most meaningful for a patient, rather than for a provider. But all those issues aside, there was the sense that using that as a single content standard was a good step forward.

The panels shared that provider outreach is perhaps the single best way to get patients to use the portal. And we'd heard that way back when the Information Exchange Workgroup was considering the Meaningful Use Stage 2 requirements and considering this particular requirement. And one of the things that we had heard from a number of vendors was that the best way to get patients to use the portal is for the providers to use the portal. And now that people are starting to implement that, they're reporting, in fact, that that's what their finding as well.

There was, as I said – as we said, there was limited discussion of workflow issues related to the transmit because transmit really isn't something that any patients have really demanded, or very, very few. I think – I don't know if any of the providers had reported that any patient had yet demanded transmit as a function. Deven, maybe you can correct me if I'm wrong, but I don't remember any of them reporting that yet. So, the real issues were about training and workflow and educating and engaging patients. So, I think that's the last slide – and, yes. And let me now conclude and first off ask Deven if she has anything else to add?

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

No Micky, you did a great job on that. I don't have anything to add. Thanks.

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

Okay. Great. Thank you.

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

All right, thank you. And Paul Egerman has questions.

Paul Egerman – Businessman/Software Entrepreneur

Yes. I actually, a few comments. And first Micky, thank you for that presentation and thank you Micky and Deven for doing the listening sessions. I participated in one of the two listening sessions, I read the transcript for the other one and I would encourage the other Policy Committee members to read the transcripts, they're very helpful.

On the issue of the transmit function, what I heard during the hearing session was that zero patients have used it, absolutely no patients have used it. And the other thing that was said is, if a patient did use it and did transmit their record to a physician, the physician probably wouldn't know what to do with it, based on how it works. And on the transitions of care document, I did hear one other thing that was not included in Micky's presentation, at least I didn't quite hear, which was that there were questions about the overall utility of the transition of care document as is currently specified in Stage 2.

And there were statements from some people that, to the extent physicians meet the transition of care 10%, it'll be like a check the box thing, it will not be something that will be changing behavior. So there were some fairly pessimistic statements. And there was also a statement saying there are so many problems with the Direct protocol that somebody had, at one point predicted that ONC would allow the transitions of care document to occur without the Direct protocol. And those comments are all interesting because I looked at the 2015 certification NPRM and in that NPRM, the transmit function is sort of like respecified and there is – the Direct protocol is detached from the transition of care document. And there seems to be a suggestion that maybe you can use other ways to transmit the documents,

But I would also simply say that these issues are creating a huge amount of concern and frustration. And also some anger on the part of developers, people are unhappy because they worked hard on doing things, like the transmit function in VDT and nobody is using it.

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

Collaborative

Thanks, Paul. On the first point, I agree with you, that definitely came out. I think we just touched on it in the point about the concern about redundancy with ongoing kinds of activities like the patient-centered medical home and accountable care. But, you're absolutely right, that did come through and there was certainly one person who had – at least one, who was expressing a lot of frustration with the protocol itself.

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

Thank you. Anyone else have a question or comment? Okay. Well thank you to both Micky and Deven for both of these presentations, they were both very informative, well organized and helped educate us.

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

Collaborative

Right, thank you.

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

Okay, the next presentation is from our colleagues at CMS and ONC, so Beth Myers and Jennifer King with updates both on the data side and some of the analysis. So it looks like Beth is going first.

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

So we have done our closure of our attestation for 2013. It ended March 31, so I'm going to go through the normal items that we usually go through, but I also have some early data from the attestation for 2013 to share with you. Before we even get there, I do want to put out a caveat that this is estimated data, we have not run all of the crosschecks with all of the various systems. We have not received the Medicaid report outs from all of the states, so these are just the very beginning, very raw gross data pushed out of the system. But I did want to share it with you because there are a couple of developments that I think are important and interesting. Next slide, please.

So our basic registration and payment data, these are accurate through February. The February reports are also posted online, so you can find this the information on our website. Next slide, please. I just want to highlight that we have over 300,000 eligible professionals who are registered for the Medicaid or Medicare program. We have over 151,000 who are registered in their various states for the Medicaid program. And we have 4711 hospitals registered for the program as of the end of February 2014. Next slide, please.

The total payout for Medicare, so far, is \$13.7 billion. Next slide. And the total for Medicaid, I want to highlight here and I apologize, this is a little bit smaller than I intended the text to be. The payout for Medicaid so far is 2.7 for eligible professional and 4.9 for eligible hospitals, that's 2.7 billion and 4.9 billion, but more importantly I want to highlight that we have again seen an uptick in the number of Medicaid eligible professionals who have demonstrated Meaningful Use successfully, we are at 34,288. And then there are 114,872 who have demonstrated – or who have attested for AIU adopt, implement or upgrade. Next slide, please.

So, I want to point out on here that we are up to 224,000 Medicare eligible professionals who have been paid. We are up to 114,000 Medicaid professionals who have been paid, and we are at 4515 hospitals who have been paid through the EHR Incentive Programs to date, for a total of just over 355,000 providers. Next slide, please. Our total payout in monetary terms so far is \$21.6 billion for all of the various versions of the program. Next slide.

I just want to highlight the percentages. So we have 94% of eligible hospitals have at this point registered for the Medicare and Medicaid EHR Incentive Programs. Next slide. And we have topped over 90%, this is – February is the first month that we went from 89% to over 90% of eligible hospitals who have been paid through the Medicare and Medicaid EHR Incentive Programs. Next slide.

Our registered eligible professionals, we're at 56% who have registered for the Medicare program, 28% who have registered for Medicaid. So we are currently at just 15% who have not registered for either program. Next slide, please. And paid eligible professionals, we are up to 41.7% who have been paid through the Medicare program, 21% who have been paid through Medicaid program and just over 2% who have been paid through an MAO. Next slide.

So this is where we have some estimates that have come out of the 2013 attestation period. As you know, it closed on March 31, I mentioned that previously. These are very raw, so you'll see that they have been rounded and I would like everyone to keep in mind that these numbers will shift as we crosscheck data and move forward and get more information about what the net totals actually are. Next slide, please.

So we had approximately 63,000 first-year attesters come in for 2013. And this is all eligible professionals for the Medicare program. As I mentioned, we have not received all of the report-outs from the Medicaid programs. We will get that data moving forward and incorporate it. We had approximately 114,000 who came in for their second year of the program and we had approximately 47,000, just under that actually I think it's about 46,000 something, who came in for their third year of the program, those are returning early adopters. For a total of about 224,000 eligible professional who have attested to Meaningful Use for the Medicare program for 2013. Next slide, please.

So this is the important data that I wanted to – all to get to, because I know this is the sort of top question that we've received over the past year and that we're concerned about going forward. And this is the number of participants who attested in a year and then did not return. So I want to point out before we dive into this data, that the numbers that you see here are not the numbers that we talk about when we generally talk about this. These are the growth numbers, so these numbers do not – have not accounted for anyone who switched from Medicare to Medicaid. They also do not account for anyone who retired or any eligible professionals whose eligibility status may have changed, whether it's because they are hospital-based or something that would affect their eligibility status.

So the number that you see for did not re-attest in 2012, from our early adopters in the 2011 cohort, that 14,000 or 25%, that is a growth number. When we refer to these over the past year, we had actually cleaned up that data and it came down to about 17%, but for the purposes of comparing it to the growth data for 2012-2013, we're reverting back to this number that has not been cleaned or had the non-returners who couldn't return removed. So this is just a bit of a flowchart to show you who went in which direction in 2012 and then – I want to point out that we had 8000 providers who had attested in 2011 who did not attest in 2012, but came back into the program in 2013. And that is an important number to note. If we can go to the next slide, please.

So just to break it down again, last year at the – immediately after the close of attestation, so again, before we cross-referenced it with Medicaid to see if anyone had switched programs, before we cross-referenced it with anyone who may have retired or had their eligibility status change, we had 14,000 Medicare meaningful users who had attested successfully in 2011, who did not return in 2012. And at that time, before we did the cross-referencing, that gross number represented about 25% of those early adopters.

In 2013, again just using the gross data, 57% of those providers returned to re-attest, so that is incredibly encouraging. When we account for Medicaid and – for Medicaid switchers and for those who have retired we anticipate seeing the number go up, probably well over 70%. So in total, 85% of Medicare early adopters have successfully attested for 2011, 2012 and 2013, so that's incredibly encouraging as well. Next slide, please.

For our 2012 cohort, again these are brand new users in 2012 who attested to Meaningful Use for their first time in 2012 and then either re-attested or didn't come back in 2013. Again, these are gross numbers, they have not been adjusted for anyone who switched programs, retired or whose eligibility status changed. So at gross numbers, we're looking at 17,887. Next slide, please.

So 114,000 providers who did successfully attest in 2012 as their first year and returned to attest in 2013, which is 86% of the 2012 new meaningful user cohort, so that actually brings just in gross numbers. Before we've adjusted for those who couldn't have returned to the program because their eligibility or that they're no longer practicing or they've switched programs, is a reduction to 14%. So that is really good news number that only 14% of our cohort from 2012, for whatever reason did not come back and re-attest after their first reporting year. And again, we expect to see that number go down as we adjust for those could not have returned to the program at all. Next slide, please.

So just a couple of program trends to highlight, at this point we are over 90% of all edible hospitals who have received an EHR incentive payment for either Meaningful Use or Adopt, Implement, Upgrade. We stand at more than 65% of Medicare and Medicaid eligible professionals have made a financial commitment to implementing an EHR in their practice. And we have over 355,000 Medicare and Medicaid eligible professionals who have received an EHR incentive payment. And that wraps up what I have for you today. So if we have any questions and we can go to the next slide. Thank you.

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

Thanks Beth, very encouraging. So if I look at the top – the bottom line numbers, you're saying 85% of the early adopters, that is from 2011 cohort, attested all three year – attested successfully all three years. And that from the 2012 cohort, 86% re-attested in 2013. So I think that does answer some of the questions that have come up in committee and looks favorable. And both of those are gross – what you called gross numbers and haven't been adjusted yet.

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

Correct.

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

Comments or questions from the committee?

Paul Egerman – Businessman/Software Entrepreneur

Its Paul Egerman, I have a question.

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

Um hmm, go ahead, Paul.

Paul Egerman – Businessman/Software Entrepreneur

So, I have a question on your slide number 6, Beth. I'm wondering if you could – we could return to slide number 6. Terrific. So, I just didn't understand this column that says unique providers paid 2014 program year. Does that – especially I'm curious about the one that's for eligible hospitals that shows the number 5. Does that represent Stage 2?

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

No it doesn't necessarily represent Stage 2, they could be attesting to Stage 1 in 2014.

Paul Egerman – Businessman/Software Entrepreneur

Well how many people, as of February, how many hospitals have attested to Stage 2?

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

I'll have to double check, I think we had a couple who were in progress in February. A number of them were – just from anecdotal evidence that we've had, waiting to make sure that got everything right and double checking quarters before they did finish their attestation. But we did have a few in progress, I'll have to double check to get the final numbers on that.

Paul Egerman – Businessman/Software Entrepreneur

So that's – the summary is five months into the year, right?

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

And so Paul Tang, you said we're off to an encourage – this is encouraging information. Do you think Stage 2 is off to an encouraging start?

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

We have no way of knowing that,

Paul Egerman – Businessman/Software Entrepreneur

You have no way of knowing.

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

Right.

Paul Egerman – Businessman/Software Entrepreneur

I'm understanding that even now, half way through the year, less than 20 hospitals have attested?

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

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Do you know if that's correct?

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

True, but also – so I just want to point out that it's about the 2014 software as well and we have all had discussions about there being concerns about the availability of the software. And that's the biggest thing we heard, in terms of anecdotal discussions of hospitals. We know that a number of them have started reporting periods on April 1, so we have to wait and see how it's going in terms of getting the software and being ready for Stage 2. So we're still waiting.

Paul Egerman – Businessman/Software Entrepreneur

Okay. So then it's off to a slow start, but it's really the fault of the vendors.

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

I'm not putting fault on vendors necessarily, it's the software's availability and availability to implement, it does take time. And we did discuss this at the last meeting that it takes time to get through certification and it takes time to implement. And we're very aware of those and we're keeping an eye on it.

Paul Egerman – Businessman/Software Entrepreneur

Okay, thank you.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

This is Judy, and I just wanted to comment that it is hard on many vendors. But it also – the healthcare organizations repeatedly say that a huge amount of their time is being spent on implementing these criteria.

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

Okay, anything further, before we go on to ONC? Okay, Jennifer, can you provide an update from ONC? Thanks, Beth.

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

Thank you.

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

Okay, great. So today on the ONC side, we wanted to sort of compliment the presentation we just heard from CMS, to really provide sort of a recap of what we've learned about progress so far in the Meaningful Use Program. And then provide a draft snapshot of quantitative data that will be coming available in the near term to continue evaluating progress towards Stage 1, progress towards Stage 2 and to help inform recommendations and future proposed rulemaking. So there's a lot we've been learning so far and a lot we'll be able to learn in the near-term, both about whether providers across the healthcare system have been able to achieve Meaningful Use and whether Meaningful Use is having a positive impact on healthcare delivery and healthcare outcomes. If we can go ahead to the next slide.

So just to quickly recap the things that many of you have heard before, but just what we already know about the Stage 1 Meaningful Use experience. First the key question of whether providers have been able to achieve Meaningful Use? On the next slide we can see that the vast majority of eligible providers have attested to the Stage 1 so far. So especially on the hospital side, and also over half of professionals – eligible professionals have attested to Stage 1 Meaningful Use.

On the next slide, we've also asked the question whether or not providers who have attested have been able to really succeed in terms of meeting the objectives that have been set forth in the program or whether they've struggled to meet the thresholds that were in place in Stage 1? And as we've seen before, over the past several months, most attesting providers have far exceeded the minimum requirements for Stage 1 objectives, both on the hospital side and then on the next slide, on the professional side.

And then on the next slide, we've also been monitoring whether or not all kinds of providers are able to equally make progress towards Meaningful Use. And we have seen some slight differences by provider type. So on the hospital side we've seen that critical access hospitals and small urban hospitals have been a little bit less likely to attest to Stage 1 Meaningful Use, when you compare them to small rural hospitals, medium sized hospitals and large hospitals that have had higher rates of attestation. And on the professional side, on the next slide, we have seen some differences in terms of physician specialty and characteristics along those lines in terms of attestation to Meaningful Use. But along the lines of other characteristics, like rural/urban location, we haven't seen many differences in the rate of attestation; so some moderate differences emerging, but nothing too major in terms of disparities at this point.

We also – not included in the slides here today, but the other key question of whether or not this widespread adoption of Meaningful Use has been translating into improvements in healthcare delivery and outcomes. We've presented data in the past several months to the Committee that has shown early evidence that there is a positive association between Meaningful Use objectives and healthcare outcomes. We've seen a recent systematic literature review that found that the majority of studies that have been published in past years have found positive association between Meaningful Use objectives and functionalities and healthcare safety, quality and efficiency outcomes. And we've also seen data from some physician surveys that show physicians are reporting that when they use the Meaningful Use certified EHRs, they are reporting that their EHR use has led to clinical benefits in their practice.

So we have a decent bit of good data on the Stage 1 and really the burning question is whether or not we'll continue to see these same patterns in 2014, as people continue to attest to Stage 1 and move into Stage 2 as we just discussed? So we have a lot of qualitative information about early provider experience with Stage 2, heard a lot of good information along those lines this morning, and that's really useful to help us understand what's happening on the ground. But there's also a strong demand for quantitative data and the experience that we're having. So today we wanted to provide a draft snapshot of what data is going to become available in the near-term to help us continue evaluating Stage 1 and Stage 2 progress, and inform those future recommendations.

So if we can go on to the next slide. And the next one. Just wanted to first point out, sort of going back to the question that we just discussed in the – during Beth's presentation, that we really do expect most 2014 attestations to be occurring towards the end of the year, in the third and fourth quarters. And this is consistent with the attestation patterns that we've seen in the 2011 through 2013, where providers have typically waited until the later quarters of the year to submit their attestations. And we expect to see the same pattern, if not to an even greater degree, in 2014.

But with that in mind, while we're eagerly awaiting these data, the next slide shows a snapshot of sort of the full range of data that we planning to draw on to continue monitoring progress. So both including the EHR incentive data, but also some additional data sources that will help get more information about Stage 2 progress in the near-term. So really there are sort of four main categories of analyses that we are planning on conducting and presenting to the committee over the next several months. So first there, there are several sources of survey data that will allow us to continue to monitor provider adoption of functionalities necessary for Stage 2 and potential Stage 3 objectives. So data both on the hospital and the physician side that will allow us to get sort of a national level sense of the extent to which providers are adopting these functionalities across the country.

Then, of course, the actual attestation data from Stage 2, which will allow us to look at how providers are moving into Stage 2 and how they're performing on the Stage 2 objectives. And like I mentioned, we'll probably be seeing some early data from the early attestors after quarter 2 of 2014, but we'll be getting the bulk of the data in quarter 3 and quarter 4, so probably around the summer and fall timeframe. There are also projects going on that the Committee is aware of, that are funded by the Agency for Healthcare Research and Quality, so specifically targeted to evaluate some of the proposed Stage 3 objectives and identify ways that they might be enhanced in the policy process or how they can be best implemented and practiced to achieve their results.

So there are 12 quantitative and qualitative research projects that are ongoing and the final reports for those will be out in June of 2014. I believe the Committee has received some preliminary information from the projects to inform your recommendations as well. But final results will be coming out shortly and those will be available to the Committee and the public soon.

And then finally data that we are expecting to have ready in the short-term as well to allow us to continue to assess physician's perceptions around the extent to which Meaningful Use functionalities and objectives are improving the quality of care in their practices. So some of the data that we presented recently was collected in 2011 and we'll have updated data from that survey collected in 2013 over the next couple of months. That we'll be able to present as well, to allow us to understand whether or not those positive trends that we saw a couple of years ago have continued and as get closer to Stage 2 and Stage 3.

So, stay tuned for more information across all of these data sources. I think altogether they'll help us paint sort of a comprehensive picture of what's happening on the ground in terms of Stage 2 readiness and leading into Stage 3 and allow us to build off of what we already know from experience for Stage 1. So, happy to take any questions or comments?

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

Great. Thank you, Jennifer and that's encouraging to see the kind of data that's going to be flowing in. We knew we didn't have that while we made our recommendations, but know that we have further – we have more time after your proposal to comment with some of this data available.

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

Exactly.

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

So Marc Probst has a comment or question.

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

Just a comment, and as a primary thorn in your side relative to this topic, thank you, this is really good to see. And I don't know if it's encouraging yet, because we don't have enough data around Stage 2, but I really appreciate you putting this together and this was a helpful presentation.

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

Excellent. Great.

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

Thank you. Any other comments or questions? Okay thank you both to Beth and to Jennifer, I mean these updates really give us a – keep our finger on the pulse of what's going on and we understand and we're anxiously awaiting Stage 2, but like before, we sort of come in closer to the due date. So thank you for these updates. Okay, our next – now Karen, are you – wait a minute, let's see here, Karen are you online with us now? I know –

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

I am.

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

Okay, great. You're on for the workgroup – the work plan.

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

Great. Thank you, Paul and thank you everybody for a chance to put forward some suggested adjustments to form and function of the work. As we discussed in prior health Policy Committee meetings, this seems like a good time for us to make some form and function adjustments to the Policy Committee and the workgroups and as we have discussed, there are a few reasons. First as our funding and grant work ends for the ONC, we are pivoting internally and working to readjust to our smaller budget and perhaps over time, changes in our structure of our agency, the actual form and function inside of the ONC. And so we need to be very thoughtful about what are the core expectations from the American people about what we should focus on and do and of course to the workload of our staff, which is our most important asset internally.

Secondly, there is an expectation from Congress that we update the Federal HIT Strategic Plan and the timing of this is wonderful, because it is a good pivot at this 10-year mark of the ONC, for us to think about the 2016-2018 or 2020 plan. And we'll be beginning that and are counting on, as is expected in the law, that you all give us some feedback and some guidance on that and help us to implement it. This also goes in concert with the VA-DoD work that we're involved in and such an important time for us to work with them on interoperability and other standards base.

The third reason that we think this is a good time is the sector is really growing, but without the – as we have described it, the nervous system of the healthcare infrastructure being – continuing to be more vital and robust and sustainable. We're not going to really be able to fulfill the promise for improving care, lowering cost and improving, the three-part aim.

The fourth reason of emphasis is really that as we've had success for ARRA and the Meaningful Use Programs, we've had these new challenges, new opportunities, ongoing issues, so we have rapid adoption, which pushes issues around user usability. We have new opportunities to capture data and put them to work for payment and care delivery. We have ongoing challenges, issues, important things around consumer engagement and health disparities reduction, so we have lots that we have learned but we still have the opportunity for new discussion.

So what I'm going to walk through here is a slide deck that is a high-level – that sets some expectations around some high-level policy issues, based upon what we've had in feedback from you all from prior Policy Committee meetings. And some other conversations that we think might be relevant for us to address in the next decade for ONC and HIT. And we also propose some revisions to, not just the names, but the scope of the workgroups and thinking about how we may adjust those so that we're more forward thinking. And I really appreciate your thoughts and feedback today, we're looking to begin this transition in May, with a couple of the workgroups and continuing through the summer, so, the sooner we can get these thoughts on paper and get this finalized, the sooner we can get moving forward for the team.

So with that, I'm going to finally turn to the slides and if you can go to the next slide. This is just a reminder to all of us about the creation of this FACA in the Recovery Act of 2009. And the scope, which is that we are – you're to advise the National Coordinator on a policy framework for the development and adoption of a nationwide HIT infrastructure that permits electronic exchange and use of health information as is consistent with the Federal HIT Strategic Plan. And that includes recommendations on the area in which standards, implementation specification and certification criteria are needed, the order of priority for this development, harmonization, recognition of such standards, specifications and certification criteria for those areas under section 302. So this is the overall charge of the FACA. Next slide, please.

And as a reminder, as – the Federal HIT Strategic Plan that we've been working under was from 2011-2015, it's available on the website, but here are the five overarching areas of it. To achieve adoption and information exchange through Meaningful Use of HIT, to improve care, improve population health and reduce care cost through the use of HIT. Inspire confidence and trust in HIT, empower individual's with health IT to improve their health and the healthcare system, and then achieve rapid learning and technological advancement. Next slide, please.

A word before I move into the committee about priorities within ONC, because I mentioned them at the outset, but I want to repeat and be clear that these are the things that we thinking about every day. We are in a process of evolving from our ARRA structure, one that is more focused on grant making of those funds to one that is engaged still in standards and interoperability framework and policy – privacy and security, amongst the other policy issues that we have to address. That this is a part of our pivot and meaning that going forward we are more of a policy and a coordinator function, which many have called for, and I think is part of the original expectation of the agency.

We are renewing the Federal HIT Strategic Plan, developing a national consensus agenda, which we very much need guidance on from the HIT Policy Committee and others as we go forward. We'll be discussing that at future Policy Committee meetings. We are setting as a very high priority, Health Information Exchange use and infrastructure. The continuation of Meaningful Use as a program, but also more broadly as meaningful using HIT in spheres outside of the Meaningful Use Program, so for behavioral health providers, as an example, long-term post-acute care providers is another. And finally focusing heavily on the advancing HIT tools to support the three-part aim. Next slide, please. 15008

Based upon conversations that we have had in the Policy Committee and what has bubbled up through workgroups, we see that these might be proposed global quality issues for the Policy Committee in the next few years. They include work that we're already engaged in but I think some evolution of the thinking is there are some lessons learned in the environment of IT, but also healthcare. So supporting advanced care models that help reform broadly, completing adoption across care spectrum outside of Meaningful Use eligible providers, so that we can connect care all across the continuum for patients. Use policy levers to support HI – health information exchange and use, support consumer engagement and disparities reduction, improving regulatory processes, particularly the certification process and move towards a clinical quality measure platform that is significantly more agile and efficient as one of the many means of improving payment reform programs in the healthcare environment. Next slide.

So what we are proposing is a structure that – of the workgroups to get some of those policy questions addressed, to evolve into having an HIT Strategic Planning Workgroup, an Advanced Care Model and Meaningful Use Group, HIT Implementation, Usability and Safety focused area, Interoperability and Health Information Exchange and then continue with Privacy and Security and Consumer Engagement. They're vertical on this slide simply to reflect the idea that this is a major conversation, as frankly many of these are, so we'd appreciate some feedback on how all of these workgroups interact. As I mentioned at the outset, really important that we enhance not just the form, but also the communication of all these workgroups within the Policy Committee. And then with standards and with ONC, so that we are reducing redundancy and the potential for reactive work but really are being as strategic and forward thinking as possible, because that is the goal of these groups is to really help inform the process. Next slide, please.

So just to walk-through some of the scope potential for these workgroups, so Strategic Planning could have in its work creating the learning health system, so the big picture of a long-term strategy around a really enhanced data infrastructure and sharing that allows us to improve health and healthcare in an iterative fashion. Fostering and embracing innovation, the Federal HIT Strategic Plan feedback and then working on dovetailing that with the private sector to have a national consensus agenda on HIT. And then, of course, evaluation and milestone tracking for the Policy Committee and the workgroups to assure that we're staying on track and being as responsible as possible in getting our work done that we promised to get done. Next slide.

Advanced Health Models and Meaningful Use, this group would focus on management tools around care coordination, decision-support, focusing on population management. Some of the work that's been happening in the ACO Workgroup, for example, and thinking also about how we enhance care delivery outside of that specific model, within other areas of delivery and payment reform and looking at outcome measurement tools. Quality measurement including patient reported outcomes and the proper platforms for like e-Quality measurements to reduce burden on providers and in the practice setting, so that we can gather information without adding unnecessary burden. And then, thinking about improving access and quality as a way to reduce disparities. Next slide. On the prior slide I didn't mention this specifically, but obviously the Meaningful Use work goes into that workgroup's scope.

Health IT Implementation, Usability and Safety, this is an area where I think there's been emerging knowledge. And a set of questions raised as we point out in the FDASIA report, for example, that there's an opportunity to really understand HIT usability and safety and enhance the learnings from that, thinking about the best, most appropriate way to report and to analyze data and to be able to feed that back to make improvements. This also would be an area of product certification work, thinking that this is a regulatory tool that can support and allow for better usability and implementation across the healthcare continuum, including outside of existing providers, the certification work, for example, that's already happening in thinking through behavioral health and LTPAC.

And then finally implementation learnings from the field along the lines, for example, of the latest hearing about ToC and VDT. To learn from folks on the frontlines and make sure we're hearing what's working and what's not, so that we can do everything that we can to make sure that again HIT is enabling and supporting care and health and not interfering. Next slide, please.

Interoperability and Health Information Exchange, involves obviously the – sorting out the best use case for HIE so that we can think through the best form of governance and supportive regulatory and business environments and the technical and policy standards that are relevant. There are some very important policy issues in this space that have been raised by this Committee and would be extremely helpful for ONC to have feedback on patient matching, being one area, provider directories another. But there are a host of really important challenges, but I think opportunities in this area if we can get it right. Next slide.

Privacy and security would continue to have its own stream of work through expectations from the Policy Committee. But also be available, as – to other workgroup, which – privacy and security. Next slide, please.

Consumer Workgroup also continuing in its efforts not only around engaging patients with meaningful voice and votes, thinking about how care plans are shared with patients, not just care plans but all of their health data across the care continuum. How we can improve efforts around disparities reduction with the tools of HIT. And then this very interesting area that's emerging of mHealth, remote monitoring that consumerism around quantified self, to make certain that we are creating the appropriate portals for patients not only to see the health information but to be meaningful contributors to the electronic health record and to the information exchange. Next slide.

This is a proposed transition, many of the workgroups we have in place have work ongoing and plans in place, so we don't want to disrupt all that. We would just propose to start to evolve. This means that we don't stop the good work that's happening, but it allows us to begin to ramp up any new strategic work and this also gives us some time, I think, to hear from you all about of course what you believe about the policy issues and the structure of the workgroups. But of course, what you have an interest in terms of evolving the composition of the workgroup, the leadership and membership. Everybody is still welcome, I want to be clear about that. We cannot do this work alone and we so appreciate all the thoughtfulness from the stakeholders and participants in these workgroups and so we want that to continue. We're just trying to evolve this into something that is more forward thinking in terms of language and the work ahead as well as –

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

I know Karen's line has been going in and out, she's calling in from France. So we may have lost her just at the end there, it's probably good timing because we made it through almost the entire presentation. Just to confirm, Karen, did we lose you? Okay, I think that we did lose her, so Paul –

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

So, yeah, we'll –

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

– do you have any other comments?

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

No, I don't, so I'm glad she got through her presentation. This is sort of talking about her priorities and agenda for this coming year and the advice and help she needs from this Policy Committee. And as soon as she gets back, we'll hear from her again. But as she expressed, this is –

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

I'm back.

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

Okay, great, I was just summarizing, we're – you're live.

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

It was almost perfect timing, actually, next slide I think we are finished with – actually, so we could be – yup, we're good. Perfect. So I'd love to get some feedback and thoughts from everyone about what we're proposing both in the big frame and then with the work. We can do that now or if you feel more comfortable, you can certainly send me something in writing, I'd appreciate that also. This is open for discussion. Thank you.

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

Thanks, Karen. So entertain comments and questions from the members. We don't have any raised hands at the moment, maybe people are still digesting it. Christine?

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

Yeah, I just think – this is Christine Bechtel, I just had a quick question. So as you're thinking about the scope, I appreciate a lot the forward thinking nature of this and I think it does a good job of reflecting where the market is probably going. When I think about the scope, my question is, the bullets that are listed, are they sort of, this is what your scope is limited to or is it including but not limited to? And the reason I ask is that as I about advanced care models, I could imagine that new issues will emerge under the category of health management tools that won't be limited to the traditional tools that we've perhaps always thought about. And I think about things like care plans or some of the functionality related to information exchange that may be more of a health management tool than sort of the business case and interoperability and all that stuff. So I'm just wondering if this is sort of included but not limited to, or how that is being thought about?

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

I would say included but not limited to insomuch as that we wanted to just put some ideas in writing about the kinds of things these committees either are, because they fold in other work already engaged in or thinking about in the future. And the area of consumers is one of the most complicated, I think, because it's a part of the market – the healthcare market that's moving very quickly and some of it is consumer based in the sense of purchasing products. Some of it is about privacy and security expectations. It really spans, frankly, every single one of the workgroups, which is one of the reasons we had tried to show it in that way, Christine. But specifically about scope, for each of these areas this is meant to be a strawman and if we think there's a better way to describe it and/or things that are definitely missing now, then please let us know so we can include it. But yes, going forward the world is changing and we need to be able to keep up with that so I wouldn't want to limit us based on something we knew in 2014.

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

And I agree with you about how you structure privacy, security and consumer groups as well and hope that the Consumer Empowerment Workgroup at least can be more of a touch point and a bridge to some of the other groups in their own work. As I think about consumer voices, I am wondering if you've given thought to how you'll construct the membership for these workgroups. Because I think we've – it would be terrific to have consumers on every workgroup, but I know that that's not always an easy task – willing and able to – but have you given thought to the process for constructing the membership of the groups?

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

We've had some very general thoughts about it and part of our limitation is the number of folks that we have we can get engaged. So let me be more specific, as we were thinking about this, it's clear that much of this is very matrix and as much is possible. Whether in technical areas like privacy and security or broader areas like HIE, it seems to me valuable to spread the talent and the skills and experience across the workgroups and not cluster. For example, all the HIE and interoperability folks into one workgroup, but to make certain that there is a chance for that voice to be heard across the board; the same would be true for consumers. So as people are thinking about where they are currently engaged in workgroups and the topics, and they may have an interest and a willingness to participate in a different workgroup, even though they consider themselves consumer, because that would be very helpful.

I don't want to push people in a direction, but if I knew that there were consumers, for example, interested in the strategic planning element, that would be incredib – that would be helpful because that voice needs to be heard in all of the workgroups. And again, I think it's the same for all of the talent we have. This is one of our challenges inside of ONC is moving ourselves from being somewhat siloes because of the kind of work we were doing in grants, and the evolution of the agency into a much more matrix organization, where we have the chance to learn from and grow from all of the experience and talents in the different areas. So it would be the same kind of structure I'd like to see in the Policy Committee. Getting there is a lot harder, so – but that also means I'm counting on people who are already volunteering to make known what their interest might be as this evolves.

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

And this is Jodi Daniel, if I may add a couple of more points to that. One, we do have an open process for folks for nominations for participation in workgroups through our website. So I encourage folks to – who are listening, who are interested in participating to provide the information and complete the nomination process. And Christine, if there are folks, particularly in the consumer space, and we don't usually get as many folks nominating themselves in that space as we would like, I would encourage you to encourage them to apply. I think it would be great, as Karen has said, to add some more consumer voices across the different workgroups. It's something that we talked about internally and we would continue to use that nomination process to bring more folks in, and we'd be happy to talk to you off-line more about that.

Also to the extent, to your point about better coordination across the workgroups and having the consumer group more connected with the work of the other workgroups, besides just adding representation. We'd be open to any suggestions you have, Christine, on how best we can do that. Sometimes we've done that by having a member from one workgroup participating in those other workgroups. It's a little bit harder if we're trying to have somebody on all four of the other workgroups or all five. But if you have any suggestions on how we can do that, or if we can try to bring the Chairs together on a periodic basis, is something we've done in the past, we can consider that as well.

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

Thanks and I'd be happy to work with you guys to identify some additional consumers. I do wonder if it's – everybody has time constraint limits for sure and so while it might be ideal to have everybody who's on one workgroup actually be serving on another and to mix them up so that each workgroup has a tieback to all of the others, I think that becomes extraordinarily time-consuming if you're not careful. But I wonder if it's worth thinking about an approach where if I'm sitting on the HIE Workgroup, I'm being asked to also be a touch point back to let's say the Consumer Group or the Meaningful Use Advanced Care Model Group. And I get some sort of monthly or quarterly summary of the work that that group is doing, so that perhaps I don't have to sit in on every one of their other meetings. But I'm really charged with taking some responsibility for thinking about, gee, does this issue touch that line of work and how is it connected and should we do more to connect the two groups together.

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

Um hmm.

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

So everybody has a hat for another workgroup, but they all – they don't have to necessarily serve on that workgroup, as long as they're attentive to the general work that's going on.

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

I –

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

I'll just – it's Paul Tang, okay, go ahead.

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

No, go ahead, Paul – I was just going to say, I certainly appreciate that and didn't necessarily think that folks would sit on two workgroups, because of the time consumption issue that you mentioned. But to think about instead of everyone with an interest in consumer engagement sitting on one workgroup, for them to say instead of that, I'm going to sit on another team, so that I can be sure to be a touch point and share that voice. But we can think about the best way to structure that.

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

And, this is Paul Tang. I was just going to mention there are times certainly that I can't participate on all the workgroups and what I'll do is listen to the podcasts, as they actually are recorded and you get a lot of the nuance by listening in. I know it takes time a little time, but it's another way. David Lansky has his hand raised.

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

Thanks, Paul. Karen, thanks I like the structure of the committees on the approach that you're taking, so I'm generally very supportive. I think what's not in here, maybe it doesn't need to be yet, but I'm wondering how it is brought in. And we started today's call with your informal discussion about the public health framework and looking more broadly at health improvement, and I know obviously the Triple Aim remains a good framework for talking about that. So what I'm – I'm wondering about a couple of things.

One is sort of valuation or metrics and how we know that over the next 5-year period, or whatever timeframe, we have a set of national goals and the mechanism for monitoring our progress toward national goals and sort of where that function, if you like, sits. Is it in the strategic planning function or is it somewhere else, obviously it cuts across everything. And to the extent we want to, as you said, matrix everybody together into some common direction. I think having a set of objectives that we're all tracking against, and essentially done that with the adoption issues in Meaningful Use, but now we're beginning to get past that point. And in some sense the goals are going to be more difficult to articulate and direct everybody's attention to them.

And one of the reasons I'm interested in that, figuring out where that sits and how – what the processes is my own sense, and it goes to Christine's point I think of, where we can best capture I'll call it customer requirements. Customer is broadly interpreted, who are the users or our health system and the information flows that come from it. And where do we capture the changing requirements that payers and purchasers and consumers and patients and providers are all articulating now. So that our – I guess what I'm worrying about is that there's a risk that we'll be sort of inside out planning instead of outside in planning. We may have – there's a risk of having so much legacy and continuity driving what we do in the composition of the committees and the inputs we receive and the goals we set, rather than having a strong mechanism for bringing the outside communities into our process. So that's, I think consistent with Christine's point, but may be a little broader.

And I guess my other concern about it is, how do we balance building on infrastructure that we've successfully stimulated, which is largely EHR-oriented. And not being wedded to it, and having a pathway to go, so 5 or 7 years from now, we've really opened up the infrastructure to many of other platforms and modalities of information gathering and sharing. And some of the pieces of that like the patient-reported outcomes, are nested in here somewhere, but I'm worried they could be kind of a small atoms instead of – pathways toward driving a real rethinking of the whole environment. So that's a lot, but I think the main question is, where do we sit goal setting and then evaluation and then getting outside customer views into the process?

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

Karen, did you have – I can add here as well. Its Paul Tang. David, I think that's an extraordinarily important point and I think that also your assessment of where we are is a good one in the sense of there's been a tremendous progress. We just heard the CMS and ONC update in terms of what progress have we made with one major part, but not the only part of our charge both ONC and HHS and the HIT Policy Committee is to get these systems up and running and adopted and meaningfully used. This actually is a nice step back point, you've made this comment before, too. Now that we're finished wrapping up in at least 2014, our comments and advice on Stage 3, I think we'll be looking a lot towards the, are we getting the value out of it that we need that directly inputs into the strategic planning process that Karen outlined. And you'll see the evaluation and milestone tracking it purely addresses your point of making sure that the outcomes, from the perspective of all the stakeholders, is not just, for example providers or patients, but all the stakeholders and can we develop milestones and tracking of how we're doing against that.

So I think your com – it's very well timed in the sense of, this is sort of a stepping back. We have a new National Coordinator, we're looking at beyond Meaningful Use the formal program, you already see the voluntary certification of other providers in this space. How do we really work on the Triple Aim and have HIT support that and enable that. So I think it's a very valid and timely comment –

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

I completely agree and the – I would see, David, the goals and metrics being part of the strategic planning element that will come out in the Federal HIT Strategic Plan. And as we look to weave that with the outside, as you say, to make certain that the national agenda that we would set for ourselves, for the public and the private sector, would have a set of very clear goals, knowing though that those will evolve as new techni –

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

Hopefully Altarum can cut that one out. So, is Karen still here?

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

I'm here, I'm struggling I guess, with my phone. I don't know what you heard, but I think that's great. I think the metrics and goals are in the strategic planning piece. And the evolution from the Federal HIT Strategic Plan, which will add those to a national agenda that we would develop with the Policy Committee and others outside is really important. I don't know exactly where to nest public health, it's really important to me, as you all know and if there's some thoughts about how to do that well, would be welcomed. Nor is, I think, we have a well nested the idea of big data and how to handle that, would welcome some thoughts on those items.

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

Hey Karen, its Christine; before go to the public health and big data, just to close the loop on David Lansky's comment, which I think is right. I think as a second step, it would be helpful once there is a national agenda with some clear goals for the workgroups themselves to create and do some planning around how they will align to those goals and which goals they can contribute towards and set some milestones for their work as well. So that will help prevent scope creep and I think ensure alignment in a stronger way.

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

That's a great suggestion. And just for timing for everybody, it probably will take us until, well our goal is by July to have the Federal HIT Strategic Plan draft done and then be able to move it out for some...for public comment with the expectation that by the end of calendar year we have it completed. So that gives us a lot of months to work out many of the details. But I'm trying to have something this summer for the federal side, just because of the pressures that the VA and DoD and others needing to make some earlier decisions about interoperability, for example.

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

David Lansky, were we responsive to your comments?

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

Yeah, thank you. Yes, thanks.

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

Anyone else want to make a comment or question? Okay, Karen, any further thoughts? We're a little ahead of schedule.

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

Great, none right now, but I – if folks have some thoughts and feedback and want to give it offline, I can be e-mailed and/or send things through Michelle. And we would appreciate that. We'll send back out to the committee something with the hopes of finalizing the restructure, so we can get evolving in May. Thanks, everybody so much.

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

Thank you. Okay are Charles Kennedy and Grace Terrell on the line?

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

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

This is Grace, I just got on.

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

Okay, great. Okay, we're ready for the update from the Accountable Care Workgroup, please.

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

Very good. If we could go to the next slide, please. One more. So in creating this workgroup, this workgroup was a little bit different than many of the other workgroups because Accountable Care is a new phenomenon within healthcare. There is substantial uncertainty as to how to generate success within accountable care. And so on putting together this workgroup, we took the perspective of a bit broader purview than just what might appear in Meaningful Use recommendations. Because it was – we thought it was most important to generate value from these recommendations and in order to do that, we really needed to take a bit of a broader perspective around what we were looking at, what the needs are of accountable care for success. And then how to translate that into a set of recommendations. So when you go through the recommendations, they may be a bit broader than what you might purposely see or expect to see within Meaningful Use, but that was a conscious decision that was strongly supported by all the members of the workgroup that you see listed here. Next slide.

What I'd like to do is to just make a few framing comments, before we get into the specific recommendations, so that we can have a perspective of why they came out the way they did and how they align with accountable care success. And so, as we define accountable care, what everyone really speaks of is the notion of moving from volume to value, but what does that really mean? And what are the technical or HIT and technical implications beyond HIT for success in a value-based care system? And this slide is really meant to offer you a summary of how we kind of thought about the transition from fee-for-service or volume-based care, to fee-for-value or ACO-based care.

The first notion is that of quality improvement tied to performance-based reimbursement. And what we observed I think both in the testimony we had, as well as multiple workgroup sections is that part of the foundation of accountable care is tying the interventions of hospitals, physicians, health coaches, etcetera, to the health and wellness and disease management of a specific population. And so there's a specific tie around quality-based or evidence-based interventions that we know promote wellness, promote disease – or retard disease advancement and the resulting reimbursement they you receive. And this is generally done through some kind of a gain-share or risk-share type of arrangement, such that if you do a better job keeping people healthy and keeping people out of the hospital, you will get to share in the savings in some way.

The second principle relates to cost and efficiency, not so much in the MSSP program, but in many of the private payer programs, we see an incentive in a variety of ways to lower cost within the delivery system and have those lower costs be reflected in financial gain to the delivery system. And so a focus on improving the cost structure and improving the efficiency with which care is delivered is another component of accountable care, as we defined it and I think as broadly defined.

Third is, I talked about the realigned financial incentives, but also not just in how you get paid. But also we're seeing many of the more advanced accountable care organizations actually diversify their revenue stream, getting into things like becoming a health plan themselves as a provider-based health plan. With the logic being, I've gone as far as to take on population-based management, how much of a leap is it further to actually be an independent health plan or a true integrated delivery system. And then finally aligning – the other implication of aligned incentives is to provide care in the most appropriate setting, so again with the notion of efficiency in mind. Next slide.

When you sum up all of the kind of components of what I walked through in the first slide, I think this is a very important opportunity. Because as we have worked over the past several years in the Accountable Care Workgroup trying to deploy technology that achieves the Triple Aim, we've been retarded in many ways by the very payment system that supports our healthcare infrastructure. And so accountable care really represents an opportunity to have both the financial incentive as well as the underlying technology align in a common direction associated with Triple Aim.

Under population management, this is perhaps an extension of what a physicians or delivery system accountability might be and I'll just personalize it. When I was in practice, when I managed a diabetic patient, I did my levelheaded best to manage that diabetic patient as best that I possibly could. However, I was not focused nor in any way thinking of diabetic patients that might be out in my community, who weren't seeking care, whose hemoglobin A1cs were highly elevated, whose glucoses were out of control because they weren't before me, either in my office or in an inpatient setting.

One of the foundational aspects of accountable care is this notion of being accountable for a population. And therefore having to ask questions that are more preventative in nature, and you see a sample of those listed before, that are more an assessment of how are you using the emergency room or the healthcare delivery system and is that appropriate? In other words, do we see people who are using the emergency room perhaps as their primary care office and with negative implications for cost for the accountable care organization. And in fact, is there something we can do through technology, through incentive, through education to be able to deal with that. So you see a sample of some of the questions that are particularly important in accountable care, may or may not be as important or as much of a focus for a physician or provider in a fee-for-service type of environment. Next slide.

And so the workgroup rationale, again, kind of to close the framing component, was to really say let's look at this from the pol – at a policy level. But through the lens of the provider and the business and clinical requirements necessary to help them make both the transition to accountable care, as well as sustaining themselves in this new way of operating as a delivery system. We did focus our attention on the HIT infrastructure and we did create a series of priorities that we think in many circumstances are things that already being worked on, be they interoperability or others. But we identified these lists with a particular focus on what are the requirements of accountable care and how do we think about this? How do we think about technology, interoperability and all the things we focused on for so long? But specifically through that accountable care perspective. Next slide.

And so what we're doing today was we're bringing forward what I'll call a preview of our recommendations. Again because we took a little bit of a broader perspective perhaps than some of the other accountable care workgroups, we thought we'd bring these recommendations forward. We're not asking for any formal approval or anything like that, but this is really a preview of where the work is headed and to give the committee a chance to kind of shape our direction and how we move forward. Next slide. Grace, I'll turn it over to you.

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

And hello to everybody. Could you confirm for me that you are on slide number 7 at this point, Charles? I don't have any visual in front of me.

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

Oh, I'm sorry, yes, we're on the draft recommendation areas, the six areas and slide 7, yes.

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

Okay, so I've got a paper form of it, so I'll say next slide periodically and hopefully keep us on track with this. So basically our draft recommendation areas are in six separate sort of categories. The first is in HIT adoption and infrastructure. The second in access to administrative and encounter data, the exchanging data across the healthcare community was the third with data portability for accountable care the fourth and clinician use of data and information to improve care the fifth. And streamlining the administration of value based programs the sixth. What you'll see in our draft recommendations that Charles and I are going to sort of tag team back and forth and comment on shortly are that this is the way we felt that was most useful to categorize things so that we could talk about it in a cogent way.

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

If you could go to the next slide –

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

We did?

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

Pardon? Okay –

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

I'm sorry, I just lost power here so I'm going to have to also work from a separate deck, my apologies but we'll both have to say next slide.

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

Okay. So right now I am on the one that – the slide that says Workgroup Activities, it is slide 8 on my draft and it says Workgroup Activities. So basically to talk about the work that we've done as a group starting in April of 2013, we really started by jointly looking at the CMS ONC RFI and literature on HIT and accountable care and had a fairly extensive review of that. We then spent a fair amount of time at the committee level looking at a comprehensive HIT framework for accountable care white paper that CCHIT had basically just published, that came out right around the time that this committee work was beginning. And we used that to basically allow us to start thinking through the sort of approaches from a process and functional standpoint on how HIT technology could be basically process mapped back to the actual needs for providing accountable care.

As you all know, we held a public hearing in December where we had representatives from across the different entities participating in accountable care, including physician providers, health system providers, community organizations as well as vendors. And after that, we basically synthesized the input from all of these different conversations, literature searches and public input to basically come up with our draft recommendations. If you'll go to the next slide, which should be labeled Criteria for Considering Recommendations.

What you will see is a diagram of the way we then decided to think about how we might come forth with rational recommendations. And we came up with four principles in that it seemed to us that any HHS policy and programs had to basically be in a sweet spot that would as much as possible do four things. One is, it had to be clinically important. There had to be a business imperative to do that. It needed to be able to be driven effectively by regulation, there are a lot of things out there in the world that we need, but it doesn't necessarily arise out a regulation. And finally, we felt it needed to be unlikely to arise from current market forces alone. There was certainly a strong amount of discussion on the part of the workgroup that if there were aspects of accountable care information technology enablement infrastructure that was going to come out of the market itself, there was not necessarily a need to regulate that, if it was going to be a standalone solution.

So most of our discussion was really centered on, as we came up with various things to assess, were all these four aspects for consideration relevant to any particular recommendation that came up. If you'll go to the next slide, which is labeled slide 10, you'll see that these are – we're now going to go into, by category, the recommendations. And then if you'll go to the next slide, which I have listed as slide 11, it will be under the first category, the HIT Adoption and Infrastructure.

And so there are basically several points that we'd like to make related to the strengthening the recommendations around the adoption of HIT, eliciting additional detail around planning for applicants, expanding the advance payment model and providing additional shared savings. And they are as follows. We think that broader – that providers broadly recognize the importance of health information technology for accountable care, but we need to continue to point to the importance of aligning our HIT infrastructure with these models. And quite often, a lot of what we heard was that there was a – not necessarily a mechanism in place right now to do that.

At the same time, we felt that the – it was quite clear from all the folks that we talked, to both publicly and in literature search, that the amount of initial investment, over \$2 million according to survey data from the National Association of ACOs, continues to outstrip the current savings providers can expect from value-based programs. And so therefore it really is important to understand how this is going to impact the move to the market to more accountable care and HIT enablement infrastructures. It was felt that more that could be done to invest in providers taking on these models, especially smaller providers that are at risk of being left out of the transition to value-based care. We had some dialogue from rural ACOs that were physician provider-based and this was clearly a challenge to those.

So under the first bullet point of strengthening requirements around the adoption of HIT for participants in more robust accountable care models, such as potentially two-sided risk models under Medicare Shared Savings. It really was part of our dialogue that it's going to be – we need to recognize that it's going to be very difficult to providers to succeed under more robust two-sided models without the right HIT infrastructure. But, we need to also be sensitive to not raising the bar of entry for providers joining one-sided ACO models.

As part of future requirements for Medicare Shared Savings and other accountable care programs where providers are taking on risk under two two-sided models, we're proposing that CMS consider providers demonstrate a base level of adoption of EHR technology among the primary care providers, in order to qualify for the program. It was felt to be probably not the wisest to even think about two-sided risk models without a certain basic level, at least among primary care. And it was noted that the primary – that the Pioneer ACOs had succeeded in meeting a 50% threshold requirement, suggesting that more sophisticated organizations participated in two-sided risk models will be able to meet these requirements.

Under B, elicit additional details around HIT infrastructure planning for applicants to accountable care programs, we think that HHS and applicants to accountable care programs would benefit from simply articulating a more explicit HIT strategy as part of their applications. So the applications that we would want to know about how these participants see their glide path for basic EHR functionality and care coordination to the more advanced superstructure needed to succeed within more robust risk models. This glide path concept references back to the CCHIT document, which certainly talked about a transitional stage to get us to where we needed to be ultimately when it came to HIT functionality within the context of ACO enablement.

Under expand the advance payment model within the Medicare Shared Savings Program, we feel that ACO investments today are far outpacing the shared savings they can receive under these programs and threatens to make successful participation challenging for organizations without lots of capital to invest. We heard this during this hearing, I can tell you from my personal experience as a provider who has all of our contracts in shared savings model across the board, both commercially, with Medicare Advantage and with Medicare Shared Savings. The upfront investment that we put in this is an enormous cash flow strain on us while we're waiting for all the stuff that we're developing, both at the care model stage as well as the information integration stage to bear fruit. So personally I understand that, but it was something that was said and iterated throughout the hearings by many, many different providers.

The advance payment model has been a great success for current participants and CMS should certainly make sure that that model is available to a wider swath of organizations in the future. For example, my organization is not for – is a for-profit, large multispecialty group so it's not – it does not have access to a lot of grants that some of the not-for-profits or large health systems might have from a capital standpoint. And it's above the 50-position threshold that allowed us to participate in advance savings, so our personal experience which illustrates this point, is that it required a significant amount of investment on the part of us as physician providers to go down this road.

Under D we need to provide additional shared savings incentives to ACOs that include partners who are not eligible for EHR incentives. ACOs have a strong interest around investing in entities such as of LTPAC facilities so that the long-term care facilities that are not eligible for Meaningful Use incentives and others that are currently lagging in providing HIT. But certainly will be part of the whole value-based reimbursement solution if we're really to get the cost of care down and the quality up, there needs to be some thought, we think, placed on how some incentives could be put in place for more than just health systems and physician groups. And we do recommend that CMS consider policy changes in the future rulemakings under which ACOs could qualify for additional shared savings for partnering with these providers and then using these funds for additional investment to HIT adoption by these providers.

With that, I'm going to turn back over to Charles and the next slide for him to go into some detail with data and comments about the second bullet point, which is number two, Access to Administrative and Encounter Data.

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

Thank you, Grace. Again, on Slide 12, I apologize, the number of times of lost power in California I can count on one hand, and it happened to be this moment. So, we will work through this as best we can. In terms of Access to Administrative and Encounter Data, again Meaningful Use has not made that the focus of activity and with good reason. Claim data has neither the granularity nor the timeliness to be used in clinical settings on a routine basis. That said, claim data has proven to play an important role in the development and facilitation of ACOs. And so both in our testimony as well as in survey data of ACOs that we reviewed, claim data really in many ways was critical in the eyes of existing ACOs.

Part of the reason for that is the ACO introduces a new business requirement, which is the notion of managing patient leakage. Some may call it patient keepage, but when you look at the wallet-share or the spend that patients have in any one particular facility, what you will find is that maybe a facility that thinks it's providing the majority of the care for a particular patient, may in fact be only providing 20 or 30% of the total dollars spend. And if you're going to be successful in managing the total cost of care of that population, you must be aware and cognizant of where the members who are attributed to you are receiving their total care.

The notion of an all-payer claims database comes out of that realization. One of the best ways to provide these analyses is by looking at the claim data and seeing where the people are getting their care. That is a pretty straightforward analysis to do with claim data. However, with the variety of market share that each payer may or may not have any particular geography, it's particularly difficult to try and get all of those individual downloads in a standardized way for use of the ACO as they try to be successful in a gain-share or risk-share type of agreement. So both our panel, as well as our team members on multiple phone calls felt that the inclusion or the development of state level all-payer claim databases would be a meaningful enhancement to the likelihood of success of the ACO model.

Secondly, another important theme is behavioral health information. Clinical, but also claims data as well, with an appropriate nod to the sensitivity of that information, but it was felt too critical to make the ACO model successful, because behavioral health is strongly associated with chronic disease. And chronic disease being responsible for 70 cents on the dollar or more, depending on the population. Behavioral health can play a very, very important role in helping the physician manage the overall health and therefore cost of a particular patient associated with ACOs. Risk factors, such as stress and other behavioral health issues are related to adverse health behavior and have a direct connection with, as we all know, the drivers of costs, obesity, smoking, alcohol use, etcetera. So it was felt that the inclusion of that information is critical for ACOs success.

A third area in the Administrative and Encounter Data section was, believe it or not, eligibility and benefit determination. Although there are a variety of capabilities to make eligibility and benefit information available, the survey information, as well as the testimony we received, indicated that data issues were the number one complaint of ACO participants. And these issues could be the timeliness of the data, the cleanliness of the data, the amount of time it takes to get set up to be able to use the data. And so both eligibility and benefit determination data, as well as the claim data itself, it isn't just specifically linked to eligibility and benefit, it's that as a component of a larger challenge, is something that our ACO team members felt was an area that needed additional progress.

Some of the other components include the emergent complexity of ACO – of administering ACOs, meaning that in a commercial setting, ACOs are helping to drive the development of narrow networks. Narrow networks by definition are more complex to administer because you have multiple tiers or multiple concentric circles and that information is not always available to providers as they manage within an ACO construct.

A scalable model for delivering timely electronic patient event notification was also felt to be very important. When your patient gets admitted to the hospital or is in the emergency room seeking care, electronic notification, be it from an ADT system or other means, is absolutely critical for ACOs to be able to intervene. Many of them have developed care management programs using nurse extenders, health coaches etcetera, who are specifically tasked with reaching out to patients and trying to avoid those emergency department visits and hospitalizations. And so, the ability to kind of have that information in real time was another component felt to be required for administrative and – in the Administrative and Encounter Data bucket.

And then finally, as delivery systems have advanced their thinking around population health management, there's an evolving understanding that the population health mechanisms may extend into the social – do extend into the social determinants of health care and even public health types of interventions. And so, ensuring that we have progress on the standardization to both to capture, as well as the sharing, of social determinants of health are also felt to be a greater importance in accountable care model than perhaps in some of our traditional fee-for-service approaches to healthcare. Grace, back to you.

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

Thank you, Charles. So I believe that our next slide is labeled on my slide 13, which is Exchanging Data Across the Healthcare Community or Neighborhood. And there were four subsets of this, which were, setting expectations that hospitals and health systems participate in federal accountable care models must participate in health information exchange activities. Specifying within hospital survey and certification standards that institutions must electronically transfer discharge summaries to treating providers in a timely manner. Increasing public transparency around hospitals and health system performance on measures related to health information exchange. And issuing additional guidance around sharing information protected under 42 CFR Part 2 across participants in the accountable care organization.

So, the general context of this, that was – sort of explains this focus, was that particularly at the public hearing, we heard from multiple different stakeholders across the organization that there was still a great concern about data being siloed in major institutions in many communities in their market, which was making it difficult to deliver effective care to patients. As the ACOs are trying to coordinate care across providers for an attributed population, it was becoming clear that these challenges are being experienced very acutely within the context of trying to innovate how to provide accountable care, particularly when they when not exchanging information with local hospitals.

So in addition to ensuring that information can be exchanged through greater interoperability, there needed to be a stronger approach to assume that the right incentives were in place to get providers to take the next step and to share their data. So within that context, it was really felt that setting the expectations for health systems in the federal accountable care models that health information exchange is really necessary and expected. We believe that CMS should consider mechanisms that would ensure that at a minimum at least, organizations that are participating in public value-based payment models are sharing data to the extent that's technically feasible for them to do so. And within the context of hospital certification standards, it was felt that CMS should also look at more robust levers for encouraging data sharing, such as conditions of participation for Medicare. So this was a very, very strong sentiment in our committee and at the public hearing.

In future rulemaking, CMS could add to the current survey and certification guidance around hospital discharge processes by requiring hospitals to demonstrate if they can electronically transmit discharge summary to the treating provider, regardless of whether that provider is affiliated with that particular institution, as it needs to be very patient-centric care.

Within the context of public transparency around health information exchange, we had a considerable amount of discussion about besides regulatory options, HHS should consider ways to increase the visibility around participating in health information exchange. And, for example, institutions could be required to report on transitions of care measures through the Hospital Compare website, so that consumers could see how they're doing on exchanging patient data.

Within the context of additional guidance around sharing of information that's protected, ACOs have reported erroneous interpretations of privacy policies for protected information that is continuing to hinder the sharing of protected information, even when sharing is permitted in accordance with privacy protection. So this seems to be part of what seems to at this point giving traction to a lot of the continued siloed behaviors on the part of a lot of healthcare providers. SAMHSA could build on valuable close guidance to further reduce confusion in this field by developing guidance focused specifically on the ACO setting, which we believe could give some clarity to the issues.

Some examples of where the guidance could help would be, how ACO entities that include substance abuse facilities might establish QSOAs across participants with an administrative relationship, to permit sharing of clinically relevant information. Or the conditions under which primary care provide conducting SBRIT services are considered Part 2 providers. So, there was a considerable amount of passion around this issue as the feeling is that some of the protected information in some of the older regulations seems to be creating an environment where holistic whole person care is somewhat not occurring as a result of the inability to have appropriate information for accountable care. Charles, I believe you're the next section, Data Portability.

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

Yes, Grace. Thank you. This would be Slide 14, I believe on my version, Data Portability for Accountable Care. And let me just take the first two recommendations, what do we really mean by that greater specificity in federal interoperability and strengthen data portability? Both at our public hearing, as well as the information we received from the team members, there's a very clear realization of the particular importance of structured data and in fact the term, semantic interoperability, even came up. Because from the ACO perspective, in the business perspective what these clinicians and ACO leaders are interested in is support and further automation of what they do to advance value-based care.

And so being able to receive a CCD is good in helpful, but there was strong hunger for the information coming across to be in a discrete and structured form that could be semantically interpreted by a system. And it might be an EMR, it might not be an EMR, that they could use to identify simple things such as my patient is seeing two specialists who are in the same specialty, for the same problem to more complicated analytics around what clinical intervention might be appropriate from a value-based perspective for a particular patient. So the hunger for semantic interoperability and structured data exchange couldn't have been stronger.

In terms of C, future certification criteria, there was some pretty strong frustration expressed by several of the members in the public testimony section. Not so much that HIEs at the end of that they couldn't meet their needs, but rather more the performance of their vendors in meeting the needs of an accountable care system. And what I mean by that is, when you take an accountable care payment, there usually is some form of risk, it may be upside only risk or two-sided risk, but there's some form of risk associated with participating in an accountable care arrangement. That puts a real focus and an underline around the speed of deployment, the responsiveness and the capability of your vendor to adhere to nationally recognized standards. And I think there was some requests for a – not so much a certification or you could call it certification, but it was almost like an accreditation.

We understand that software has certain functions and that it's been certified, but what is the performance and the level of support in the vendor in helping a delivery system execute around a value-based contract when different things are more important like responsiveness, speed to achieve interoperability, willingness to do it without or with perhaps expensive upgrade. So we got a fair amount of feedback for a desire to either kind of expand certification criteria so it might include some of these other functions, as well as the notion of responsiveness and performance.

And then finally, the last area on this, the desire to extend the physician-patient relationship beyond the 15 minute office visit to more of a continual relationship where data is received from the patient in the home or wherever the patient might be. And the ability for our HIT solution to be able to react and help support the patient so they can stay in the home for longer period of time, so they can avoid admissions, etcetera. Grace, back to you for slide 15.

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

All right. So the next area of concentration from our part was on Clinical Use of Data and Information to Improve Care, with the concept being that to help clinicians conduct true population health management we need to think about how clinicians use information to deliver effective synchronous and asynchronous care, both during and outside of traditional encounters. And there was quite a lot of thoughtful discussion about this among the various members of the committee and really got into some quite nuanced discussions over time really about what is actually needed. When and how this might impact from a rational standpoint, the types of recommendations we would make to you all.

Providers in accountable care arrangements have a special interest in tools such as shared care plans that can help coordinate across team members and the patient and offer a dynamic, longitudinal view of care. We heard this throughout, especially in the strong community-based models that were encompassing diverse types of providers across the community. It was refreshing to me personally to hear the real focus for the first time in a lot of discussions not so much on the episodic care which those of us who provide care tend to get focused on exclusively. And realize the broader implications of starting to think about asynchronous information that may help us actually do population health management rather than just episodic care.

So within that context, we had several recommendations. The first was to create a taskforce to accelerate the development and adoption of standards-based electronic shared care plans across that federal programs. We felt that shared electronic care plans promise to be a hugely important tool for allowing care teams and patients to coordinate care. The standards for care plans are maturing, but we need to understand the critical policy factors that can accelerate adoption of these tools and practice and understand, for example, who curates the care plan, where it resides and who can change the care plan. And furthermore, HHS has an opportunity to leverage care plan requirements in various programs to encourage the use of electronic shared care plans. The HIT PC should create a taskforce to look more deeply into how we can create a roadmap to ensure that policy across HHS is working towards adoption of electronic shared care plans. I think there was a lot of focus on the need to do this as well as a lot of feeling that we need to understand very carefully how it ought to be done in a way that was practical and functional as opposed to just iterative of additional paperwork and information that sometimes is not very useful.

So from within that context, the feeling was that there needed to be pilots to be developed to test different shared care plan models because we did not think that at this point there were effective models in the marketplace that we could with any sort of reliance, feel that we're ready for regulation at that stage yet. Besides this taskforce, we need to look at some real-world experience with care plan models that work to compliment and expand on examples already in the field, prior to putting something in final reg stage. HHS could accelerate programs around care plans by funding additional pilots within different innovation models that currently exist, for example CMMI, the AHRQ and the HRSA type of structures that exist.

We felt that improving the impact of clinical decision support tools by measuring effectiveness is extremely important. And that it's at an early stage right now that needs some support that regulatory policy may help. Clinical decision support is a key capability for ACOs that want to ensure providers are considering and adhering to evidence-based guidelines. However, we heard that there is a high amount of degree of variability and effectiveness of current CDS support tools today, in terms of how it's presented and used. So research is needed to determine how to increase CDS adoption in the clinical workflows in a practical and useful way.

Increasing the sensitivity and specificity of CDS algorithm tools by encouraging standards that will support the incorporation of comprehensive data from multiple resources, we felt is a recommendation that is very essential to making sure we get it right. Furthermore, a key use case for ACOs around CDS is the ability of external data to be integrated with the data in the EHR so that it can trigger a specific and sensitive algorithm-driven CDS alert. More work is needed on how to get this done from a functional standpoint in order to make sure that we're doing it correctly at this point.

So there are – an additional need we think, for a lot of innovation that can be supported by HHSs work around pilots as it relates to care plans, around pilots as it relates to clinical decision support. And the more we have that will allow innovation in the market, the closer we think that it will come to actually achieving what we heard across all the stakeholders that were providers, that there was a real crucial need to have this, but in a way that's functional and easy and not too complex. And actually provides additional resource without providing complexity to the point that we're not able to provide care efficiently. Charles, I'm turning it back over to you for subsection six.

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

Okay, thank you, Grace. Slide 16, Streamlining the Administration of Value-based Program, these areas of recommendation here – let me just provide a little bit of context around point A, aligning quality measures. Well that's kind of a mom and apple pie statement, but there's a little bit more depth behind that. Part of the feedback we received from the open panel was that when you use accountable care models, quality no longer becomes a measurement process that becomes – that can be thought of almost separate from the care process. In other words, generating the quality measures and reporting them can be done separately and distinctly from the actual delivery of care itself.

And in fact, many of the delivery systems who testified said that they largely do it in that way, perhaps as a check on quality and in more of a retrospective fashion. However, in an accountable care model there's a very strong desire to align the quality measures at the point of care and in real time so that quality can be further embedded within the actual process of care, as the care is occurring. And so in order for that to happen, although there's been substantial work and substantial progress in aligning the quality measures, the workgroup felt that there was additional progress that needed to be made specifically with select private payers.

A second area that became important was the notion of further work around how to appropriately integrate claims and clinical data. There are some insights that are provided by the claim data, care that might be provided outside of a particular ACO where maybe connectivity or health information exchange is not in place, but you will get claim data from that visit or whatever care is provided. How should the specific use cases of claims data be aligned and integrated with the robust clinical data necessary to manage the patient, not just from an episodic care perspective but also from a financial and efficiency perspective. And so the workgroup felt we needed a lot more work around how to ensure that claims data is appropriately used in clinical settings with a deep understanding of both its benefits, as well as its substantial limitation.

Attribution. Attribution is absolutely critical for success within an ACO but the methodology changes between private payers and HHS, the MSSP Program and Pioneer Program, etcetera. A desire to standardize those attribution methodologies was felt to be helpful that would further refine the simplicity and ease of getting accountable care organizations up and running, as well as we understanding in rules as to how to manage these patients in a consistent way, regardless of payer type.

Standards for administrative procedures to reduce variation in provisions of care, I think that one's pretty self-explanatory. But let me just conclude on the regulatory review point. There was a discussion on one of the calls where although regulatory review might sound fairly far afield from Meaningful Use. In order to make an ACO successful there can be regulatory I guess collisions, I might call them; in other words many of the ACO participants we talked to, a part of their overall strategy to transform into accountable care is the use of Medicare Advantage. Because the economics of Medicare Advantage can align very nicely with MSSP or private payer gain-share, risk-share initiative and certain actions in certain markets by the federal government caused private payers to withdraw from those markets, which made the progress to accountable care more difficult. Because one of the most important levers Medicare Advantage as an economic driver was no longer available.

And so the notion was – that’s just one example, but the notion was there are a confluence of regulatory activities, some synergistic, some in conflict and again this is probably beyond our specific purview. But we thought we would put it in record and reflect the fact that the regulatory burden on providers was felt by our participants to be challenging in order to make accountable care work. So that’s our last slide. Let me just conclude by saying our goal here was to go again a little farther field than we might typically go, but we felt that was very important because of the infancy of accountable care as a provider model. The uncertainty associated with how to make it successful and – but a universal acceptance that HIT technology overall are critical to making the models a success. So with that, Paul, I think we would be done with our formal presentation, would take any questions people might have.

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

Well thank you very much. I think this was a very comprehensive view of looking at these advanced models of health and care. And actually I couldn’t help but think of all the ways that sort of the – both the priorities and the workgroup proposed structure that Karen outlined fit in with this. In other words, you could see how a lot of these measures were crosscutting, the notion of combining the advance health model with the Meaningful Use and not really necessarily limited to the Meaningful Use Program, but meaningful using HIT, just as you described, to support these new models. It just makes a whole lot of sense and good timing. Thank you. Judy Faulkner has her hand raised.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Okay, I have one question for Grace and one for Charles. The question for Grace is the diagram that is on let’s see, screen nine. And I’m trying to figure out what are business imperatives that are unlikely to arise? I’m not understanding that and I was wondering if maybe Grace could give some examples of business imperatives. The things I was thinking of that if they are business imperative, but the one – the organization that wants to use it can’t afford to pay for it. So, it might take the EHR organization a huge amount of resources but the – but it’s a business imperative for the consumer, not – but it’s not enough to be paid for.

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

Sure, you’re sort of in the same sort of vein that we were thinking and talking about this. A lot of this came out of some of the discussion at the public hearing, from my recollection, where there was a fair amount of complaint that there were things that were needed in the market now by ACOs to provide good care. But it was not in, for example, the vendors interest to actually have products in the market that would allow that to occur. So there was a disconnect between those that might have capture over the technology within one context versus the ACOs that may feel that there’s a business imperative to having certain types of information. Versus the ability for there to be innovation because there’s a disconnect with the economics that are out there right now.

I think that you could think about it within the context of as an alternative example, within the context of the need for sharing of certain types of information across some of the silos. Yet a lot of the way that we’ve got it structured right now within the context of electronic health records for example, tend to be very much based on episodic care. Since there’s not that much funding yet in the system to allow a profit motive per se. As we discussed earlier when we were talking about the amount of investment that is having to be put into the system for what at this point at least is a fairly amount of – smaller amount of revenue that’s going to go back come back and it’s going to come back on the backside. There does not appear to be in the market specific solutions that are coming out of this.

So Charles, I don’t know if you want to add any the context to that, but that’s my recollection of just an example of where that occurs, a disconnection between vendors, the business and the ACOs.

Multiple speakers

(Indiscernible)

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

Yes, I think you're right, Grace. I would make two comments. There was – and again I in no way mean to impugn the vendor community, I am simply trying to reflect what was said. And what was said was there was a belief by many of the physicians, or several of the physicians on the panel, that once a vendor has your business, it is not in their financial interest to promote things like data portability, interoperability because there was a sense on the customer base that that was counter to the economic incentive. Again, just reflecting what was said, so that was kind of the nature of that part of the discussion.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

So it does sound like one of the challenges is assuming that the vendors need to be solvent, how assuming there is a business imperative for the user, but there is not a business incentive for the vendor. How do you create a business incentive, other than, this is government regulation even if it costs you millions of dollars, you have to do it? So it seems to me that that problem is a major one to solve.

The second one that I had for you, Charles, is on Slide 14 C, I think you passed over that one. I thought that was a particularly interesting section on your slides about extending the use of the software for other parties to get access to it. And I think coming up is going to be, is at the C-CDA? Is it more than that? Is it allowing third parties to request the data set for individual patients? Is a third party sending a query? Is it third parties requesting a query or is it sending over information into another database? Very, very interesting multiple ways to do it, some unsafe, some unsafe and dangerous, some more safe, some more doable, some doable, but I thought that was an interesting paragraph that got skipped.

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

I'm sorry, which page did you say, Judy, 14?

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Yes, slide 14 C. Didn't you go from B to D? I thought you skipped C.

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

Uhh, develop future – to promote access – ah, yes. No, I mean I think I made a couple comments, but I think the basis of this component of the discussion was that as you say, an EHR is generally going to be thought of as the source of truth for understanding and describing the patient, the patient status, how they are being managed, etc. But that information is critically important in an ACO construct to some other tools, for instant a population health analytic tool that might not make full use of all the data in the EMR but might make use of some component of it.

And as you're indicating, there are a variety of ways that vendors in the marketplace are looking to pull data from Cerner, EPIC, Allscripts and all the rest. And that variability in how they're pulling information may result in analytics that are either accurate or very inaccurate. And so I think the notion of, if we're going to have an accountable care technology that supports population-based analytics, should we be thinking about some kind of standardized way of pulling that data out of an EMR, so that the analytics vendor has a rela – has a substrate to act upon that we collectively think is appropriate, actionable, safe and reliable.

Judy Faulkner, MS – Founder and Chief Executive Officer – EPIC Systems Corporation

Thank you.

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

Okay, thanks. Troy?

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

I had to take myself off mute, thank you very much. This is Troy Seagondollar. I really like the accountable care stuff and I think you've done a great job in looking at a lot of the recommendations. One of the things that I really need to comment on once again is looking at the care plan verbiage. I like the way that you have qualified this as being an interprofessional process and again I think one of the issues that we always have is, there seems to be this overwhelming thought that the plan of care or a care plan is not defined well. And my concern is that we're sending out a message that it's not defined well, when in actuality, it is.

I am a registered nurse and have been practicing for 26 years and it is the foundation of our education, it's a foundation of our practice. And plan of care is something we learn in our very first day when we walk into school. So I struggle with this, I think in terms of looking from a provider's point to view, yeah, I mean it might be not defined well. But from all of the other providers of care and – well, let me take that back, all of the other interprofessional team members, we have been utilizing plans of care for a very long time. And that's how we actually share information define mutually patient defined goals, look at the interventions beyond what are prescribed as medical interventions, but also and then the social issues, the psychological issues, any barriers that would limit their ability to achieve an optimal level of health and wellness.

We are looking at processes in sharing those across from the inpatient worlds to the ambulatory worlds. We do that in a certain context now with our nurse case managers. We have case managers that focus on diabetes, so we identify an issue, maybe in the ambulatory world and the inpatient world, we set up a plan of care that's shared between those case managers from the inpatient world to the ambulatory world, even home health utilizes our process. So I, again – I mean once again, I struggle with the fact that we keep saying that it's not defined well. I think it might be advantageous to this group to allow maybe some of our nursing experts in concert with some of the other members of interprofessional teams to do a presentation for the HITPC, as well as any other workgroups that are struggling with this definition of what a care plan is, to show what processes are in place and how they can through accountable care or through any other processes, give intangible benefits.

And I think that that might be another layer that we're having problems with. When we define the tangible things, we look at lot of the financial benefits of it, reimbursement levels, different things like that, is this something that can be part of the fee-for-performance or fee-for-service, which ever model their using. But there a lot of intangible benefits in proper care coordination. And the like I said, that's what we are educated to do, is to take all of the team members input and assure that the patient is being walked through the healthcare continuum to assure that we're achieving the goals that were set up both by the patient as well as the care teams. And I'm –

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

Maybe, I don't think that from my recollection of the part of the discussion that I was participating in as it relates to this, that there was any discussion per se about care plans not being important or valuable or crucial or something that is already part of the process. It seemed to me that most of the discussion was about the relationship of a care plan as it relates to different providers in different contexts and understanding it. So perhaps you're understanding it as it relates to how it would work in an integrated HIT accountable care world.

In our organization we have care plans that are very much part of our outpatient ACO integrated efforts with our nurse care coordinators that are very much involved with the team around that. But what we do personally struggle with in our organization is the technology that relates that and integrates that with what's going on with our electronic health record in some of our population health management tools. So the idea of educating around the very valuable part of care seems to be a very rational approach. But most of what we were discussing at the committee level was the integration of that in a way that allowed it to be more functional within the technology tools that are out there right now that are not necessarily constructed to integrate that in with other aspects of care.

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

That is absolutely understandable, so we get back to the people process and technology aspects that I think we have the right people in place, there just has to be an understanding as to this is more than just the providers, it is interprofessional teams that coordinate and manage the care. And that lends itself into the process. Now the technology obviously, yeah, we do need to work on that and there are – I was at the American Nursing Informatics Association conference last weekend, actually a week and a half ago. Anyway, there are monumental strides being made in terms of technology and functionality in order to share that information across the numerous teams. And again, I mean it emulates much of the content and this C-CDA aspect and given the opportunity, again I believe that we can make monumental strides in improving healthcare through the ACO process. I think it's a great way to go. So thank you anyway.

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

Thank you. David Lansky please.

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

Thanks. I really congratulate you both, I think it's a fantastic assessment of some of the challenges and opportunities we have to help everyone migrate from that fee-for-service world to a more value oriented and accountable world, including, as you said Charles, a number of different products and structures not just ACOs per se. I think you've got really a great list of things we should be looking at and I know there's probably opportunity to consolidate it and make it actionable in various ways. But I really like it a lot.

I had a couple reactions from where I'm coming from, from the purchaser perspective. These movements towards accountable models and products is largely driven by payers and purchasers. It didn't emerge naturally out of the traditional, the previous payment system and everyone's sort of trying to figure out where it's going to go from here. But in that respect, I think it's cont – it'll evolve in ways we don't yet anticipate and in particular the quality measurement requirements and accountability requirements both for episodes and ACOs and similar models will keep evolving. And I think one of the challenges we have is to figure out how to go back into the EHR and the certification program and essentially update it to accommodate emerging requirements for information that cover the continuum and that reflect outcomes and continuity of care across the different sectors and silos.

So there are several points in here I think are great. I thought point 6 B was really to me one of the most important things in the whole report. Because I think the integrated – because these are sort of a payer-driven evolution of the health system, everyone is going to be very concerned about managing the costs and knowing that the opportunity to survive is I think – pointed early on, depends upon integrating the clinical management program with the cost program. And so it's not just claims that have to be pulled together, it's really real-time cost and resource use information, which traditionally we don't do a very good job of tying across the clinical and administrative systems. So I'd broaden 6 B a little bit to say not just about claims, but about cost and price data and maybe emphasize sort of the real-time nature of that in order to be successful, is where we want to get to.

On the quality measurement front, I think Judy's point is very good. Both points 2 E and 4 C kind of open the door to this issue of thinking about a data network rather than thinking about an EHR as the focus of our attention, even in the Policy Committee. And as we kind of broaden our lens and think about a data network and the interoperability across that network and a variety of notes, many, which were not, covered by the Meaningful Use Program I think it is very challenging. It's exciting and it gets to more patient centered view of the data flows.

From quality management point of view, I think we need a path to look back through our previous sort of patient requirements and ask, are we capturing the right data to reach platform, let's say EHRs, which will allow us to report on the successful outcomes of the entire treatment program. So it's not just sort of building another layer to build a longitudinal record on top of a bunch of EHRs. But it's also looking at the specific capabilities of those current EHRs, so that may be the data fields, the patient linkages, means that are aggregating social data with clinical data for both an episode and an accountable care organization type model.

So I guess I'd just mostly congratulate you on the strength of the overall approach and highlight those two or three elements as places we might do a little deeper digging to flesh out the implications of that for the work ahead. Thanks.

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

Hey David, this is Charles. I think that's really well said. We did not mention cost input data to the hospital or to the delivery system, but you're absolutely right. Managing those cost inputs are critical, their expense reduction and whether they need to necessarily be integrated in with an EMR or tool sets within the delivery system that I don't know and can't yet speak to. But I couldn't agree with you more, those are critical components and a good expansion of the recommendation.

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

Good, thank you. Paul Egerman, please.

Paul Egerman – Businessman/Software Entrepreneur

Great. Thank you. Its Paul Egerman and Charles and Grace, this is an amazing presentation, there's almost like too much information to absorb. I did, similar to – somewhat similar to David's comments, I did like Charles your comments about the quality reports in the fee-for-service world. In my opinion, most of our current quality reports are not quality reports, they're really penalty reports and they're penalty reports because they're simply used by payers as an excuse to not pay the provider for something, or as a reason to not pay the provider for something. And hopefully in the accountable care organization there might be really desire for quality reports, in which case they would be desiring not to make it a separate process, but somehow integrate it into the real-time and daily activities of what occurs.

And I, similar to Judy's comment, when I saw slide number 9 with the comments about unlikely to occur due to market forces, I had some questions. And I don't want to repeat the examples that you gave, those were helpful, but when I saw that sort of like I immediately looked to see who were the members of the workgroup, because my first thought was, I wonder what the EHR vendors must have thought about that slide and how they got any input into it. And I'm just kind of curious, because if I'm reading this – looking at this correctly, you have like two HIE vendors, but other than that there's no EHR vendors or for-profit technology vendors involved in your workgroup, is that right?

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

I believe that's correct, but there was a fair amount of representation at the hearing from vendors.

Paul Egerman – Businessman/Software Entrepreneur

I understand, but in the workgroup, the group that developed these recommendations, you do not have any EHR vendors, if I'm looking at this right. Maybe there's somebody I'm not recognizing.

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

No, we did have a vendor panel, I believe, at our testimony but we did not have an EMR vendor per se in the workgroup, you are correct. I will say that the public testimony, some of the physicians who were making those comments and the vendor did take exception to that and got into quite a of a bit of a back-and-forth. So I would say there are a variety and a diversity of opinions on that particular point, but we wanted to reflect what the delivery system perspective was.

Paul Egerman – Businessman/Software Entrepreneur

Thank you.

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

Next is Neil.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

Hi, thanks. We're going through the process of implementing our ACO, I can just say, this is the most comprehensive view of this situation and I just compliment you guys. I mean, it's really an ama – I copied all of these slides to bring to our first meeting – our next meeting, because it's really – it's incredible. There are two things that I want to emphasize, I think that are particularly important. One is the notification process, which you highlighted in one of the slides. I think this is just critical, I mean for people – for primary care providers, they have to know in real time where their patients are going and what's happening to them. And so I just highlight that as one of the things that I think is most critical.

And the second, which fits right into work that we've been doing for quite a while already is the need to really develop the standards around social determinants. Because the second thing the ACO immediately delves into it is getting out of sort of the medical model and into sort of looking at all of the social issues that people are dealing with. And I think those two things are critically important.

The one thing that I think I would – that may be a little bit of a negative in terms of one of the things you mentioned. I don't think I would put any further requirements on providers based upon their participation in ACOs. Because as you move out into the provider community, some of the people we need to recruit to be participants in our ACO, and I think this is especially going to be true when you sort of get into the world of Medicaid ACOs and others. There are already enough requirements on providers, so I would just say, maybe saying that they should be meaningful users might be one model. But I don't think I would sort of highlight, I think your first couple of slides, you had a few areas where you thought there should be perhaps some additional requirements on people taking risk. I don't think we should add any requirements into the providers.

The question I have is whether or not the discussion came up about the – there were number of bullets you had around combining clinical and claims information and also the availability of claims to be able to be seen. There are two issues that have come up around that in our discussions. One is around privacy. I mean, do we really think that when somebody comes to a providers office that in order for them to be in their ACO that they are basically giving the provider the right to know every single place they touched the healthcare system? Because I know that that's a privacy issue for a lot of patients, people feel like they should be able to go get a second opinion somewhere, go for a procedure that's not necessarily relevant to the other provider. And we've been talking a lot about sharing information, but that minute you make sort of all claims available, you find that somebody went to an abortion provider, you find that somebody went for substance abuse treatment. And they may be information that's important in terms of managing costs, but I think the cost shouldn't be like the ultimate driver here. We have to figure out ways that we can allow people, I think, to have some privacy in terms of the way they see care.

It's a little different than the pharmacy stuff. I mean there are already issues when people come in and you say, oh, well I see you went to this pharmacy and you got a medication filled by this other provider. I don't think people expect that automatically when they become a patient of yours and they're in an ACO that you're going to have access to every single thing that they do within the healthcare system. So it's just an issue I think that we need to discuss.

And on the claims side, similarly the payers don't want their rates revealed automatically to the providers. So they'd like us to know maybe what different – where your patients have gone, but not necessarily to reveal the rates that they've paid to different providers, because they consider some of that rate information proprietary. So I'm wondering if those discussions about sort of privacy around claims data came up in your discussions?

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

We talked about privacy in multiple contexts, including this one throughout the discussions. But I personally do not think that this is just about cost savings or managing cost. As a general internist who

sees my patients and is trying to do care that's the whole person, the information you don't have can have a lot of impact that's clinically relevant as well as been being related to cost. And certainly having the right to exclude information from providers is something that continues to be debated. But within the context of, for example you may go to a mental health provider and not know – not what that information revealed to your primary care provider, but a particular medication that you're on may have enormous impact on your health. And so it's a very complex topic that's not, in my opinion, just about the cost of care but about how do you have the right information relative to what's going to allow you to provide the most care.

It's interesting you talked about the payers not wanting to provide claims data. I am in the middle of this on a daily basis. The thing I love about the Medicare Shared Savings Program, there are many things that I certainly do not love is that I have absolutely, other than some privacy excluded behavioral health data, access to all claims. And if I'm going to be accountable for care, it's really important for me to know what care is being provided and under what circumstances. Many of the payers in commercial accountable care models are not wanting to provide adequate claims data. And that really puts those of us who are trying to provide high-quality care at a lower cost at a great disadvantage. Because if you – between the context of accountability as it relates to healthcare from a clinical side, you add ambiguity about wanting to provide care the right cost and at the right location.

But having no pricing information about that that's available to you and then at the same time being held responsible for those cost and taking financial risk to do it, it's really absolutely a nightmare. And one of the things that we're doing in our contracts right now is, to the extent that it's appropriate and possible and legal, we want go to full-risk contracts as soon as possible. Because with full-risk you get access to claims and can therefore manage in a world that's less ambiguous where you have partial information. There was discussion about this, I'm sort of rendering my own opinion, but there was a lot of respect around the issues of privacy. But there was a lot of pushback from a lot of the providers that were in the middle of this on our committees about the risk that you are putting us under with partial information that may harm not only us as we try to manage cost and quality but also the patients.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

I just want to make the point that it's a very paternalistic view and in some sense sort of flies in the face of patient engagement that basically says, we're not – we're basically taking the control over your information. And often times remember people aren't choosing to be in commercial HMOs – I mean in commercial ACOs, that their employer can be putting certain kinds of programs in place for them. And so basically I think that view that going to a provider now opens up your records and maybe not your EHR record, but the payment record is basically like the EHR record. It discloses pretty much everything about where you've been, maybe not about the diagnoses in all cases, but I think it needs to be subject to the same sort of privacy concerns that the EHR has been.

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

I couldn't agree – this is Charles. I couldn't agree more, but in many ways we're already there. When you think about ePrescribing, in fact in many circumstances if your using Surescripts as your intermediary, a lot of that data comes from claims, drug claims but claims nonetheless. And so we didn't spend a lot of time in this set of recommendations because we knew the extensive work that the privacy and security team has done, I would just say we agree there's an issue there. We would defer to the privacy and security team as to approaches to deal with that.

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

This is Paul Tang. I was wondering if Deven wants to make any comments on this?

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

Hi Paul, this is Michelle. I don't think Deven's on the line anymore.

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

Okay, thank you. And David Kotz.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

Yeah, thank you. This is David Kotz. I just wanted to follow-up on that with point 4 D, which is on the slide still. I think there are a lot of interesting, to me anyway, interesting privacy issues around this question of data from our remote monitoring devices. It's one thing for your provider to know all the places you've touched the healthcare system, but if you're wearing devices that are collecting information about you, your behavior in particular in daily life, then there are a lot more deeper privacy issues and I for one would like to engage with that topic. Thanks.

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

This might be something we want to ask the Privacy & Security Tiger Team whether it's something that they could take up. It is an interesting – it's a legitimate discussion.

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

I'm having a little hard time getting around I guess the boundaries that you all are concerned about. I think when we were talking about information from remote monitoring devices, certainly it needs to be

information that's pushed from the patient as opposed to pulled from the patient from a – involuntarily. But the ability to integrate remote monitoring devices on such things as for example, this morning a patient I saw was Coumadin management or daily weights for heart failure treatment could be a real freeing experience for patients that are currently right now tied to facilities that are quite expensive. So we didn't see this as being the sort of big brother behavior monitoring so much as we were seeing taking things that are already out there in the world today that are part of the way that we're already trying to provide care for patients. And integrating it into our other HIT to allow us to have more comprehensive information.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College

Oh, I – don't get me wrong, I absolutely agree. I think there's huge potential benefits from this kind of remote monitoring of all kinds. I just think that we want to think through the privacy issues that come up in some of it as well.

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

Yeah and this is Paul Tang. I think we were all assuming that you were speaking with the assumptions you had, Grace. I think this is like our VDT discussion we had earlier, there may be some education needed for all of us to understand whether there's a consent involved in terms of some of these things, like notifications was brought up. A lot of positive upside and does everybody understand what they're signing up for, the benefits and potentially the risks. And so I think it's in that bailiwick and so maybe – privacy and security can help us sort through.

Okay, I think I have – we've exhausted the hands up. Want to express again our appreciation for the workgroup's very comprehensive view and I'm glad that you took this sort of out of – what you thought was a little bit out of scope. But I think it was very helpful to look at the new model – an example of a new model of care and what are the data needs and how can it be more impactful on the delivery of high-quality care and improving outcomes. So you did an outstanding job of doing that. As I said, I think it'll feed into the work of our future workgroups by taking that perspective as we sort of step back and look at the whole situation – plan – policy. Anything else from anyone before we go to public – so thanks again, Charles and Grace.

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

Thank you.

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

Any other comments before we go to public comment? Okay, operator, could we open the lines please?

Public Comment

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-6006 and press *1. If you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no public comment at this time.

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

Okay. Well thank you. I want to thank all the presenters for very informative presentations and to the committee for a very productive and informative discussion. And these will go on to inform the development of the policy agenda for the rest of the year and the restructuring of the workgroups, as Karen described. So thanks everyone –

Rebecca Armendariz – Project Coordinator – Altarum Institute

Paul, we do have a public comment.

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

Okay.

Rebecca Armendariz – Project Coordinator – Altarum Institute

LaTonya, can you please put him through?

Operator

The line is open for –

Mari Savickis – Assistant Director, Medical Affairs – American Medical Association

Hello? Can you hear me?

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

We can hear you.

Mari Savickis – Assistant Director, Medical Affairs – American Medical Association

Okay great. This is Mari Savickis with the AMA. I thought maybe I had not gone through. Thanks very much for taking my comment. I have – actually I have a question, which I know that you probably aren't able to answer over the phone. But it's something that we've been wondering about which is, going back to the discussion from this morning concerning the HISPs. When a vendor is acting as a HISP and a doctor is sending information through their EHR, who may be acting as a HISP to another physician or healthcare provider, using another EHR who's acting as a HISP, are there fees associated with the movement of the data? We're trying to understand this issue better so any clarification that could be given by the Policy Committee in understanding this would be helpful. So just a comment and I'm happy to listen if anyone wants to give me an answer.

And then the second thing is more of a comment than the question. So the data that CMS presented this morning, we did a back of the envelope crunch here of numbers and while CMS has said that 65% of the eligible professions have attested to the Meaningful Use, that's at some point in time. According to the data presented, almost 45,000 eligible professionals have dropped out of the program and this doesn't include all of the data for the 2013. There's still, I thi – as I understand it, CMS is looking at the attestation numbers, which attestation closed for eligible professionals on March 31. So we've been told that the data in its complete form won't be available until later this summer maybe July. So right now that again, it looks like 20% , a fifth, 45,000 out of 224,000 is a fifth of eligible professionals under Medicare have dropped out. Thank you.

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

Thank you. Any other comments?

Rebecca Armendariz – Project Coordinator – Altarum Institute

We have no further comment at this time.

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

Thank you. Thanks everyone again and we will see you face-to-face in May. And just to note, there is a – there's a certification hearing that's being conducted on May 7, following our HIT Policy Committee on May 6.

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

Yeah, Karen had also mentioned there will be listening sessions in the Meaningful Use Workgroup and we are – we haven't finalized plans yet, but we are looking towards doing those on May 20 and May 27.

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

Great. Thank you. So lots going on. We continue to hold public sessions and continue to get feedback. Thank you very much and see you next time.

Neil S. Calman, MD – The Institute for Family Health – President and Cofounder

Sure

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

Thank you, Paul.

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

Bye bye.

Public Comment Received

1. Is there publicly available data with the numbers of EPs, by specialty, that are eligible for, and have both successfully and unsuccessfully attested to meaningful use under the Medicare EHR Incentive Program, and payment amounts, by specialty?
2. These slides about MU attestation are great, will they be available through the ONC emails in the near future?