HIT Policy Committee
Final Transcript
September 3, 2014

Presentation

Attendance (See Below)

Operator
All lines bridged with the public.

Michelle Consolazio, MPA – Federal Advisory Committee 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 60th public meeting of the Health IT Policy Committee. This is a public meeting and there will be time for public comment before lunch and after lunch. As a reminder to those speaking, please state your name before speaking as the meeting is being transcribed and recorded. For those of you who are tweeting the hash tag is #HITPC for today's meeting. And we are going to do roll by going around the room and we'll start with Deven.

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP
Deven McGraw.

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
Neal Patterson.

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

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

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

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

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

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

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

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

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And Christine Bechtel is walking in. Is there anyone else on the phone?

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
The grand entrance.

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

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
This is David Lansky.

Paul Egerman – Businessman/Software Entrepreneur
It's Paul Egerman on the phone.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Okay and with that I'll turn it to you, Karen.

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Well, good morning everybody and happy week after Labor Day. Thanks everybody for being here and being on the phone. We have a really full agenda that Paul is going to tell you about today. So, we're going to try not to take a lot of time in introduction.

We will have some information from CMS during Beth's presentation today about the flexibility rule that came out on Friday. I know a lot of folks may have…want some more information there and some questions that they might want to ask. So we will have some opportunity during that presentation and in light of that ONC is not going to do any data presentation this week again. So we have plenty of time for dialogue with you all about the presentations from the JASON Task Force and the Governance Task Force in advance of what is going to be a very exciting joint meeting in October between Standards and Policy to talk about interoperability for the day. That will be our chance to unveil what we're calling Version 0.5 of the interoperability roadmap something we have been working on since the release of the vision paper in June and doing that in partnership with some subject matter experts, our federal partners some of whom just walked in and really learning to build upon what is already working in the community.

We'll be presenting that roadmap within those five building blocks and getting the information follow-up from the JASON folks, from the Task Force's that have been addressing that and Policy and Standards and also from the Governance Task Force.

That will be the Policy and Standard Committee's opportunity to listen, to provide feedback, to chew on where we're going with that public/private interoperability roadmap so that we can do some intensive writing, feed what we learn from the processes from that day, from our wiki, which is by the way still open as a public venue for people to give feedback on the interoperability roadmap.

If you just go to the healthit.gov website you'll find the link to the wiki page and we really encourage people to weigh in, anyone or any organization is welcome to that's going to close on the 21st of September this month in advance of our October presentation to the Policy and Standards Committees.

And just as a reminder in that work we are then going to do some integration of what we have learned and heard to the end of…in the winter of 2015 publishing for public comment and interoperability roadmap. So, there is going to be plenty of opportunity for this group and for the public to weigh in on what's the best path forward for this country so that we can have interoperability in the short run but also develop a pathway that meets our needs in the long run, something that is flexible and durable, and sustainable, and really as inclusive as possible with all the potential future trading partners.

And so I just want to make sure I am previewing it for the group and I'm going to get to say it later, but I really want to thank people like Micky and David, and Carol, and others who have been working really hard on seeing that we have the foundation laid in these last few weeks. I know it's been very intense to try to keep up with the pace but the country is waiting and we really, I think, we have an open window and an opportunity to see that we can get this interoperability piece right.

So, that's my framing and it's just really a reminder to this group that we're coming together with Standards in October. We have a full day to chew on a lot of things that is an intermediate stop along the way towards the interoperability roadmap which will be coming out for public comment in January and a chance for this FACA to weigh in again in the spring. Thank you.

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

Good, thank you, Karen. So, I really don't have a whole lot to add to what she just laid out in terms of the timeline for our FACA meeting but I'll talk a little bit about this meeting.

So, this meeting is informational and discussional for three major topics, one is the flexibility rules it's more of an overview of the rule and a chance for us to ask some questions for clarification. And the other two Karen mentioned one is the first presentation from the JASON and the Governance Subgroups that are going to be presented formally in October's joint meeting. And as Karen outlined that's one of the steps along the way in a very open and public process by which ONC is trying to help move interoperability along.

So we'll have a chance to hear what the JASON and Governance Subgroups have been talking about so far so that this group can weigh in and provide some more questions and feedback as they prepare their final presentation for the October meeting that…and Karen also mentioned the timeline of they're coming out with their plan to be posted for comment in December and working up towards the February final strategic plan.

So with that let me ask, if there are any other additions to the agenda? And you all had a distribution of the minutes and any additions or edits there? We got a few on the way in. If not I'll entertain a motion to approve the minutes please?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
So moved.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Seconds? Yes. Second?

M
Second.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And all in favor?

Multiple
Aye.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Any opposed or abstained? Thank you very much. So we're going to open up with a data review this time just from CMS because of the posting of the final rule for flexibility last Friday so both Beth Myers and Elise Anthony are going to present to us.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Beth Myers isn't here yet.

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
So we might need to shuffle the agenda.
Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay.

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

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Should we review the FACA timeline?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yeah, let's go to the FACA timeline…

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
And maybe she'll be here, if not we'll go to David and Micky.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, so, Michelle you want to go over that please?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Sure. So, or Karen do you want to?

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Do we have the slide that we can put up?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
It's in the packet.

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Okay, perfect, thank you. I can start. So we wanted to share with you all something we shared with the Standards Committee a couple of weeks ago which just is a visual description of what I have laid out but this also includes the added complexity of our renewed Federal HIT Strategic Plan just so you all can get a sense as you're reforming not reforming but re-forming the Workgroups and thinking of your work plans that we will be asking for some feedback on some specific areas within ONC in the federal government in addition to what you all generate.
So, just walking everybody through this, the JASON Task Force started in June. They are looking at the JASON Report that came out essentially in the spring from AHRQ it's a set of recommendations about the technology and some privacy and security framework for interoperability and is meant to feed into an overall roadmap that we are developing in partnership with others.

The Governance Subgroup got to work in July they've had several meetings and will present today where they are along the pathway of their findings and recommendations and then in October, on October 15th we'll have a joint meeting of the Policy and Standards Committees here in Washington. Both of those Subgroups will report out on their recommendations and, as I mentioned, that will be also the time that the ONC team will report out where we are with the roadmap more specificity within the five building blocks that we have already outlined and have a chance for you all to weigh in and think through the integration of the information from the two Workgroups with the overall roadmap.

Now I'll tell you that we've obviously been working on that as we go, it won't be the first time that these pieces are touching each other. There has been an awful lot of crosswalk so we hope what we're all seeing starts to look increasingly familiar.

We have been simultaneously or concurrently working in a broader area so interoperability being a deep dive initial set of work that is a priority for so many and that we didn't not want to wait before we went a lot deeper into, but we have, as you all are aware, been refreshing the Federal HIT Strategic Plan. This is one of the ONC responsibilities outlined in the HITECH Act.

It is good timing for a host of reasons we could talk about, but this plan, which you'll have an opportunity to see a draft of in December, is really designed to look at Health IT beyond EHRs and health beyond healthcare, and if I could, policy levers beyond MU, which I know we're going to talk about a bit today in the JASON Report.

So, this is a changing of the horizon and the vista for us and we're really looking forward to hearing some feedback from the FACAs on where that plan is going for the federal government so that we can have that out for public comment and have that finalized sometime in February and have something the country and the federal government can work from going forward.

Within that…within the Federal HIT Strategic Plan we are seeing that interoperability is one of those strategic priority areas so we're going to continue that work in interoperability again concurrently with refreshing the strategic plan knowing that the interoperability work will fold back into the strategic plan eventually, though let me underscore, what we're developing in partnership with others for this roadmap is meant to be a public/private partnership.

This is not meant to be what ONC or the federal government will do towards interoperability. It is designed to be something we will do in partnership with the private sector so it's slightly different in that frame then the Federal HIT Strategic Plan.

So, just on this slide then we really wanted to make sure that the FACAs had an opportunity to see more clearly and graphically in the months that come up until next summer what we're thinking through we're going to really want some feedback on as we reset the priorities on your behalf and then in partnership with you all for interoperability. Do you want to add anything Paul?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
No.

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Does that help?

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

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Do you have questions about that? Great, thank you all and…

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Do you want to go to the next one?

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
The next one is just I think more detail about the various Workgroups and when their work plans and recommendations…when we're anticipating that they'll come in and I don't know if it's on this slide but there is a subtlety to this work where the JASON and the Governance Subgroups are going to merge into the new Interoperability Workgroup for this committee but for a variety of reasons we started this Task Force one being that it was the JASON as joint with Standards, we really felt like we needed the talent from both of those groups, but, so this provides some more specificity it's in your packet, it will give you some sense of when some of the Workgroups or some of the draft proposals will come in for us to review and look at and then in some cases takes votes on.

Now I'll just say this again, this isn't all of the work of the FACAs we just wanted to make certain that people understood how the interoperability and the Federal HIT Strategic Plan were going to fit into the coming months. All right, thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, the two pages of plans are not all of the work of the FACA?

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Yes, that's correct.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Thanks, Karen. Okay, so we want…do we need to switch around…okay, why don't we move to an update from the JASON Task Force then first and then we'll get into the CMS piece. And this work was led by Micky Tripathi and David McCallie. As Karen mentioned, this is a joint policy and…why don't we go…since they're seated if it's okay if Beth is still available for afterwards? Okay, good, thanks. This is a joint effort by both HIT Policy and HIT Standards Committee. Go ahead Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Okay, great, good morning and thank you for the opportunity for us to present our preliminary findings and thoughts here. I'm Mickey Tripathi and with me is David McCallie from the Standards Committee we're Co-Chairing the Task Force and what we would like to do today is share with you really just our, you know, sort of initial thoughts from the Workgroup or from the Task Force I guess we should call it regarding our assessment of the JASON Report and implications for interoperability going forward.

I should say at the outset that, you know, sort of in the spirit of this process where we are now is giving you a little bit of a preview of some of the raw findings. So, as you've probably noted in looking through the document, it's a very dense document with very small font, a lot of it is, you know, sort of sharing a lot of the thoughts in, you know, not a full brain dump mode but a lot of the thoughts that, you know, were sort of emerging and then, you know, our ability, to the extent that we can, to try to synthesize those into categories, but, you know, really the hope is to provide you with enough information that we can have a meaningful conversation and you can give us good directional feedback as we move to the HIT Standards Committee presentation and then our final recommendations.

So, don't worry you won't get a presentation like this for the final recommendations. What we do anticipate is that we'll be presenting it in a pros document with an accompanying PowerPoint to help for presentation. So, next slide, please.

Oh, it's me, okay, got it. So, what we'd like to do is just do a quick review of the charge, I'll walk through that a little bit on the members, process and timeline as well, a very brief description of the listening session that we had but most of the details…a lot of the details of that are in an appendix as I'll describe and then I'll describe a little bit of the assumptions and caveats and then actually I think I'm going to turn it over to David at that point to describe some of the assumptions and caveats, and then we will dive into the recommendation framework.

So, the charge is as follows and I think you've seen this a number of times because it came from this committee to discuss the implications of the JASON Report, assess the feasibility and impact of the report on HHS and broader HIT ecosystem, identify use cases and lessons, establish specific recommendations for integration in the strategic plan as well as the interoperability roadmap.

The one thing I would note is that we were also asked a little bit later to provide a high-level mapping of the PCAST 2010 report with the JASON Report which we haven't done here but we will do that as a part of the final recommendations just to give some sense of, you know, sort of the continuity.

In terms of the members, process and timeline this is the group who has been on sort of a forced march here going through this discussion. We've actually had, you know, tremendous participation and we have four more meetings as we'll describe. So, we've got, you know, a lot more ahead of us here but, you know, the good news is we've got a lot of representation and participation from the Policy Committee and the Standards Committee which does provide a very good joint perspective on this.

In terms of, you know, where we are, we're, you know, doing the draft recommendations with you today, the Standards Committee is next week, and then as I said, we have four full Task Force meetings scheduled to, you know, sort of take feedback from the Policy Committee and Standards Committee, our further thoughts and then, you know, head us on our way toward the final recommendations for October 15th.

So we did have two days of listening sessions which, you know, was…as with almost all the listening sessions with the FACAs end up being incredibly informative, you know, always, you know, sort of, you know, pleasantly surprised at the very high level of participation we get, the amazing amount of candor and this was no exception.

We had two listening sessions. The panels focused on exchange service providers, research, standards, consumer facing ecosystems, vendor APIs, App providers in the best way that we could to try to represent the spectrum of interest here, you know, again that's always, you know, a difficult process when you have to jam that into two days.

So, you know, we did the best that we could. There are certain stakeholders who didn't get represented but, you know, again we tried as best we could to get, you know, as broad and deep as we could in terms of the representation.

The…here's the list of the participants who did participate in the two days. We're not going to share…we're not going to try to synthesize those findings for this we've basically taken those findings and inputs and incorporated them in our thoughts for the recommendations, but we have for your benefit provided in the appendix our detailed summary and synthesis of the listening session for any of you who have, you know, thoughts or want to understand a little bit more about what we learned there.

So, let's jump in now to, you know, to our initial thoughts on the JASON Report. I'm going to turn it over to David here.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Okay. Thank you. Micky and I were discussing this planning our presentation this morning and I was reminded of a famous quote from I think it was Mark Twain, maybe Winston Churchill, depends on who you consult, that we would have made this shorter if we'd had more time to work on it, we would have written a shorter letter.

So I apologize that there are a lot of words in these slides they reflect the complexity of the subject matter and we'll do our best to highlight the things that I think are the nidus of the discussion going forward and reduce it to a little bit more manageable chunk of data for the next presentation.

But we wanted to start with a summary here on this one slide that is what we thought the core of the report itself said. So this is not our conclusion this is a summary of the actual JASON Report under the assumption that maybe not all of you have actually carefully read the report, it's well worth reading, but in case you haven't the gist of the report is captured here I think.

So, the report concluded that Stages 1 and 2 have not achieved meaningful interoperability "in any practical sense." Now I'll remind you that the report was written before Stage 2 attestations were under way so you can think of it as pretty early in the Meaningful Use process and the JASONs point to a lack of architecture supporting standardized APIs as well as technology and business practice, structural impediments to achieving interoperability.

They recommend as a remedy to this focusing on what they refer to as a unifying software architecture to migrate the data from these legacy systems to a new centrally orchestrated architecture to better serve clinical care, research and patient uses.

Clinical care, research and patient uses are three themes that you'll see running throughout their report and in our recommendations we've tried to carve those into separate sections in our report to you this morning.

And then perhaps a key finding is the architecture that they recommend would be based on the use of what they refer to as public APIs for access to clinical documents and discrete data from EHRs coupled with the enablement of increased consumer control of how their data is used. So this is their charge in a sense, their report, there is a lot of other content in the report but this is what we pulled out that we thought were the key drivers.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Great, thanks, David and so one more slide before, next slide, please, before we dive into the recommendations, the preliminary recommendations is we did want to put down just some assumptions and caveats just so, you know, we can be clear and have some clarity about certain things that we've assumed, certain constraints that we've found in, you know, as we've gone through the initial assessment here.

The first thing is just about the JASON process itself. So, although I think we would all agree that the report is really incredibly well-written and concise it covers a lot of ground in relatively few pages considering how much ground it's covering, there are a lot of issues that can be interpreted in different ways and, you know, the JASON process itself does not allow us to go back to the authors and have, you know, a little bit of back and forth on certain questions that we have, so our only point there is that we've tried to reasonably infer or, you know, extrapolate or interpolate, however you want to think about that, you know, things that aren't quite clear to us and we certainly may have misinterpreted some of those things. So, we're just sort of, you know, apologizing in advance if that's the case and we'll, you know, certainly clarify if we get feedback to suggest that we've misinterpreted something that's in there.

The second is that the recommendations…on the JASON recommendations themselves if you go through and look at the report itself they have a set of findings and then a set of discrete recommendations. We did note as we've, you know, read through this many, many times now that the report actually covers more ground then it identified in the recommendations.

For example, they have some pretty strong views about consumer access and the abilities for consumers to access data that's not listed in any of the recommendations that's just, you know, one thing for example. So, we just note that we're actually covering more ground than is listed in the detailed recommendations because we think those are important and they're important findings for JASON and for interoperability for the country at large.

The third thing is just to note about the timing of the JASON Report and this was really just a limitation that they had is that there has been a long time lag since the JASON Report was conducted, you know, the investigation was conducted in early 2013 much has changed in the industry in the last 18 months, you know, in particular market deployment of direct enabled functions and the beginning of Meaningful Use attestations using C-CDAs.
So, they were constrained by the fact that, you know, Meaningful Use Stage 2 actually hadn't started by the time they wrapped up their investigation and started writing, it literally hadn't started, it was six months before the attestation period began for hospitals. So that's a limitation I think we all need to appreciate that in the context of what they're saying and recommending.

In terms of the scope they are explicitly focused on high-level technical architecture considerations and they do, again, explicitly note that there are lots of other challenges to interoperability, you know, and they do a great job of listing those but then they say those aren't, you know, in the scope of the report. And as we'll discuss in the recommendations some of those things legal policy, federation jurisdiction, business model are key barriers and issues related to how far we're able to go in interoperability and again they note those this isn't to say they didn't note those it just wasn't the focus of their report.

Two technical issues in terms of our consideration of some of the specific discussions in there, one is our consideration of the security issues. They do talk somewhat about encryption of data in transactions and if you look at the diagram that they have that crypto layer that they have on the bottom is suggestive of, you know, sort of a very large importance of security which obviously, you know, I think all of us would agree that it is very important, in our reading of the report they weren't suggesting anything different than is really relatively common industry practice today as we think about encryption.

So that's why we've, you know, essentially not focused on that in our assessment. Now again, you know, if there is input from the Policy or Standards Committee that we should do that, you know, that's fair enough but our initial assessment is that, you know, they're not saying anything different so it didn't warrant our, you know, digging into it anymore.

The other point they have a lot about the, you know, patient identification as being a barrier. They themselves noted in the JASON Report it came up over and over again in the listening session and indeed it has come up in the, now I think this is the 60th meeting I heard, of the Policy Committee and I think in probably every one of those 60 meetings it's come up as an issue. There aren't clear pathways to solving that and ONC has, you know, certainly had a number of initiatives to try to move us forward on that. We note again that it is a key barrier but we didn't really feel like there was a whole lot that they didn't suggest anything to change that or move that. So, we haven't focused on anything to change or move that either.

And then finally just, you know, the normal caveat that these are our preliminary recommendations we haven't had a lot of time, we're all volunteers so please be kind to us, no, so again, just in that spirit, you know, we're really throwing out a whole bunch here that we hope can, you know, help you be able to provide us with some guidance. So why don't we dive into the recommendation framework…and Paul, I don't know do we want to just go through the whole thing?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Why don't we go through it and then…

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Okay. So, what we've done is we've divided up our assessment into seven categories it doesn't align perfectly with their recommendation categories but as we've thought about it again, you know, we had the…we were originally going to do it, you know, using the ONC building Blocks from the vision, but that didn't quite, you know, fully map to exactly what they were saying. We were going to address item by item their recommendations but again we found that the report covers more than their recommendations do, so we ended up deciding we'd have to come up with our own taxonomy and framework here.

So, what we've done is divide it up in these categories, you know, the benefit of this is I think it's, you know, somewhat intuitive in terms of things that we tend to talk about in the policy and the technical area. The downside of it is that these aren't mutually exclusive so you're going to see a little bit of repetitiveness unfortunately I think in part, to David's point, that we haven't had enough time to synthesize through it.

So, I apologize in advance that, you know, sometimes you may feel like you're seeing a recommendation over and over again, some of its intentional because we feel like it's really important so we're going to tell you five times, but, you know, it's also because we just haven't had time synthesize it.

So we're going to go back and forward here in the presentation of the different categories. I'll start off with the current state of HIE, architecture, core clinical and financial systems which is EHR/PMS systems, APIs and we'll talk about consumer access and control of data, research and HIE and then finally accelerating interoperability which was a core part of some of the recommendations that they had.

So, I'll first start and what we've done in terms of the structure of this is…and this is similar to, you know, the structure that we've used with the Information Exchange Workgroup in the past which seems to have worked is start with some background to provide just a little bit of background to help feed the conversation, give you the, you know, the preliminary recommendation so you kind of know what it is, you know, what position, you know, we're taking and then have the discussion piece to provide some of the rationale of that. I know that may seem counterintuitive you may want to start with the rationale but I guess in the past we've found that it helps to focus to know exactly what it is we're saying and then gives you some context, you know, for the rationale. We're happy to flip that if that doesn't work.

So, in terms of the background here and this is on the current state of HIE, this isn't a recommendation on the JASON part it was really one of their findings or comes out of a number of their findings, but one thing that we just did note, you know, from this is that, you know, first off they find, you know, fairly strong finding that meaningful interoperability is virtually non-existent, you know, as written in the report. They conclude that it's hampered by lack of published APIs to enable automated data and document exchange across systems.

They note that there is very little patient access and as they, in their words, that there is no rational access between organizations for clinical care or research. Throughout the report you'll see in italics, I won't read all of these and I think David won't either, but you'll see in italics where we have pulled quotes directly out of the report just to, you know, sort of support some of the bullet points that have up here.

In terms of our preliminary recommendations the concern that we had as we looked at some of the findings is that we think that JASON didn't adequately characterize the progress that has been made in interoperability though we completely agree that there is considerable room for improvement as will be outlined in the recommendations that follow.

So, our recommendation here is that ONC should take into account the current state of interoperability as well as the current trajectory before incorporating JASON findings and any decisions on HIE plans, policies and programs going forward. So, it's really to say that we think that it's just not fully characterized in terms of the current context.

As noted earlier, sorry I forgot I have the…in terms of the, you know, sort of the discussion of that, as noted earlier the JASON findings were reached 18 months ago so they didn't have the experience of, you know, some of the market activity that we've seen. And in addition the trajectory we would argue has changed somewhat.

So, even though the current status may not be that different the trajectory has changed somewhat not only because of, you know, sort of what Meaningful Use Stage 2 has done, but also the growth of value-based purchasing, population health services, ACOs, consumer expectations about what they'd like to see from healthcare all of those are starting to, you know, sort of create greater demand for interoperability than I think was even the case 18 months ago.

The other thing that we would note in their finding is that they do express concern that Direct and C-CDAs, which, you know, were again defined in Meaningful Use Stage 2 not yet to the point of beginning implementation when they were looking at it and they expressed a lot of concern that those could become interoperability dead ends and looking at it now in hindsight it appears to us that this concern maybe just a little bit misplaced. Part of it is because, you know, structurally Meaningful Use, I think as all of you know, was intentionally staging interoperability over time to allow for market adjustment and new technologies and workflows. So, you know, a part of the concern they expressed, you know, is something that was baked in to the way Meaningful Use was intentionally staged to roll out.

They certainly correctly identified that interoperability does not yet enable standardized API mechanisms for accessing clinical documents and data and as we'll, you know, discuss later, you know, we sort of endorsed that call for moving aggressively towards that.

And we also agree that immediate attention should be focused on improving interoperability for both document-based and data-based exchange through standardized APIs and I think David will cover in greater detail what exactly that means.

And we also note, and this will come up again, that in addition to that these aren't just technical issues that we're going to need as an industry to figure out mechanisms for market coordination that doesn't exist today in a world where you have published open APIs for where clinical data is involved. Let me turn it over now to David to discuss our architecture recommendations.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
If there was any single part of the report that we wished we could have had the JASONs present in the room to interview them it would have been what did they mean by "architecture" so we had quite a bit of discussion about the meaning of the word "architecture" and the kind of architecture that they are proposing in the report.

The phrase they use a number of times as overarching software architecture you'll see that in quotes there on the third bullet point. We, to put it in our own words, have added the phrase or come up with our own phrase called centrally orchestrated nationwide architecture that's a placeholder concept that I'm sure we'll have some discussion about to capture the JASON's clear understanding that the architecture does need to apply to the breadth of the industry but isn't in fact a top-down mandated centralized architecture. So we've used this phrase centrally orchestrated.
They're clear to note in the report that it's not one-size-fits-all that there could be different kinds of implementations that could be consistent with the architecture. So, let me go to our recommendation because I think it will pull up some of these thoughts in more detail.

So, again, you'll see some of this echoed in subsequent parts of our presentation this morning so this is the first pass around this notion of the industry should accelerate a current path of loosely coupled architecture based on iteratively proven and standards-based APIs and data model standards that support both document and discrete data access.

If there is one key assertion that the JASON architecture points out to contrast it to what they thought was the state-of-the-art today it was the existence of standards-based what they call "public APIs" and it was the addition of the ability to fetch data at the discrete level instead of just at the document level.

So we are essentially endorsing that high-level assertion that we need a loosely couple architecture that supports both data access and document access, data level access and document access, and relies on standard data models for improved semantic interoperability.

ONC should help shape and accelerate this process by assisting with the convening of industry stakeholders to define these minimum components necessary to create a loosely coupled architecture.

ONC on the other hand should not attempt to define or impose a detailed architecture on the market. ONC should help accelerate this process by aligning federal infrastructure and other programs to assure a rapid deployment and adoption of these components once they are defined.

Now as you can imagine our discussion on this was intense and deep and our next slide, which I've got to move here forward, I'm not going to go through all of these points here, but quite a bit of discussion about what is an architecture for a country, what is a nationwide architecture?

We are clear that it's not monolithic it requires top-down orchestration but not top-down control. I used a phrase in our discussions that it's an architecture pattern rather than an architecture per se and in software engineering terms software patterns are just what the name implies, they are patterns that reflect an approach to solving a problem but they don't dictate the exact solution so we think the JASONs have put forth an architecture pattern which we'll go into in more detail in a few minutes.

We also noted that the direction that Meaningful Use has been moving in subsequent to the time the report was created is consistent with the direction that the JASONs have proposed with the exception that they've pushed further into this notion of public APIs and discrete data access. So, I think you'll see us come back to that point a number of times that that's the next step compared to the progress that we've made to date. I think…

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Go back.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
So, category three is on core clinical and financial systems which are essentially EHRs and other source systems. The JASON Report concludes the current EHRs and in some of their, you know, sort of strongest words about the current state of interoperability in the industry they conclude that current EHR and financial systems need to be replaced in order to meet the goals of the proposed software architecture and they have, you know, sort of a few quotes there explicitly stating that.

They focused only on documentation and storage of clinical notes and data in considering sort of EHR functions and they largely ignored other currently available EHR functions such as CPOE, CDS and workflow orchestration and so which I think led them to characterize EHR, current generation EHR and financial systems as still pipe legacy systems.

They also assume that the current structure of the market suffocates innovation and that has two dimensions, one is about being open to new entrepreneurial activity and the other is about whether existing players or existing vendors can innovate themselves and, you know, sort of on both counts they, you know, either strongly suggest or explicitly say that they believe that the current landscape and environment does not encourage either of those.

In terms of our specific recommendations and then we can to go into the rationale, you know, as I think David said, it's our recommendation, the preliminary recommendation that the industry itself should accelerate the parallel path of improving current document level and coding standards while introducing discrete data access APIs and associated data element standards in EHRs and perhaps we should just take a second here to define what those things mean at a very high level and it's dangerous for me to do that because I'm not technical, but I'll do it because I can do it in lay terms and David will correct me if I've got it wrong.

You know it is interesting to note that after, you know, much reading of the report it was in yesterday's Task Force meeting that we sort of had a little bit more of an "aha moment" of "oh, wait a minute that's what they're saying" and had, you know, a little bit more ability to parse that. So, I think that just speaks a little bit to the complexity of the task of, you know, taking what is concisely and well-written but has a lot of complex ideas in it.

So, the idea here is that you've got data models document level, data level which can exist within a source system, the C-CDA is a specific data model and what we want to be able to do and the Implementation Workgroup on the Standards Committee side has made recommendations about constraining that further and making that, you know, better able for interoperability right there are all sorts of issues with C-CDA as we know.

So, and then what we don't have right now is a standardized data model which is you want to be able to get data getting data, you know, information at a document level and information at an atomic data level. We don't have that.

The second thing is, if you have those the question is how do you access those from the outside, right, how could an external system be able to access those that's the idea of the API. So, you have two things going on, document model, data model and then how can the API either access a document like a structured, you know, referral summary or structured discharge summary or data like "I just want the last, you know, lab results." Right, so is that a fair description?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
It is. I will add one caveat or caution that the phrase data model means a bunch of different things and depending on who's listening it could be a scary thought that you're talking about the internal architecture of a system and we're not at all talking about that.

It might be better to call it a data element model or a clinical element model and what we're referring to is the information that gets moved around via these APIs. So you need a model for the way to move that information around but not necessarily to constrain the way any sending or receiving system actually data models it internal to their system.

So, we'll probably drop that phrase "data model" because it's a little bit of…in retrospect maybe not the right choice of words and maybe go to clinical element model or data element model, but the important notion is that if you have two systems talking to each other over a standardized API they have to agree on the shape and structure of the data that's moving back and forth between them otherwise you get a message that you don't know what it means.

So, we'll talk in the API section about how we think what are called profiles can be used to address that problem but when you see the word data model here think about the shape of the data on the wire moving back and forth between systems that's what needs to be standardized.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
All right, just what I said. So the second recommendation is that, you know, ONC should immediately seek guidance from the Standards Committee on two points and I'll explain this in a second, but one is on the maturity of development of standards to enable documents and data level APIs and the second is, you know, is actually to sort of flip the question.

So, the first one is asking to the extent that we want standards for…now C-CDA will be sort of a pathway toward the document level standard but we don't, as I said, yet have a data level standard or a standardized API as David will discuss FHIR seems like, you know, the leading candidate right now for something that could be adopted.

That said, you know, the first point is to ask the question of the standards, the possible standards that are out there, what's their state of maturity and, you know, what's the hope of being able to incorporate those in Meaningful Use Stage 3?

The second bullet point actually flips the question and says, rather than asking which standards are mature enough, we're asking, we're suggesting that the Standards Committee be asked how can we get foundational API requirements into the 2017 additional certification? Because I think that flips their question to ask what can we accomplish not what are the constraints, you know, that are going to stop us from getting there.

And, you know, we had a lot of Task Force, you know, sort of conversation about this and I think one point that will come up later is that, you know, there are long cycles on the approval process here that I think David is going to talk about in the APIs and this is one of the things that this is getting at is that when you have these kind of long cycles it's very hard to get any kind of new or emerging standards incorporated in certification so we're always behind the ball as it were and this came up in the PCAST Report where they made recommendations but said, you know, it's too late for Stage 2. Well, now here we are with JASON and saying, gee some of this stuff maybe too late for Stage 3, well, you know, it sort of begs the question of well, you know, when are we going to catch up and how can we use certification as a lever to be able to, you know, sort of get broader adoption of new and emerging standards in a way that's future-proof.

So, the last recommendation is related to the certification process and, you know, leveraging standards-based APIs as they're…as we're able to define them where possible to expand opportunities for modular certification and the reason we hit on that particular point is noting that modular certification has, you know, in our assessment, has done a lot to encourage entrepreneurial activity related to the EHR technology and so what we'd want to be able to do is say the standards-based APIs as we heard in our listening session could be, you know, a way to really open up that space to developers and designers going forward and so we want to be able to say when we have those let's do everything we can to make sure that they help to expand the notion of modular certification as a way of opening that up.

Oh, sorry, going the wrong way. So, you know, in terms of the rationale for that, you know, one thing is just that current EHR systems…this is going back to the critique that the JASON Report, you know, sort of criticism of current systems I think, you know, one thing to recognize is that current EHR systems are much more functionally sophisticated and technologically dynamic than JASON seems to give them credit for.

Now it maybe that they were just focused on one particular aspect of it, so again we don't have the ability to go back and forth with them, but, you know, many of the functions highlighted in the software architecture are actually performed by EHR systems today, maybe not, you know, system wide, but certainly they point to things like UI applications, semantic and language translation, search and index functionality again within the enterprise so, you know, not across enterprise which is, you know, part of the challenge here, you know, but to suggest that EHRs don't do any of that I think is probably an under representation of the things that current EHRs systems do today.

It's also true that many vendors already support APIs and have numerous third-party Apps integrated into workflows. So, a number of vendors, you know, do have APIs that are, you know, sort of published in a way that you, you know, can go to.

However, it's certainly true that current APIs are vendor proprietary, that's, you know, absolutely true of the world today. And they do, you know, thus reduce the market opportunity for entrepreneurial developers which we heard from the listening session and it certainly could mean that could easily lead to vendor lock-in without some external market coordination to try to make these APIs more standardized, you know, you could easily have a situation where the top two or three big players end up defining what an API means which I think, you know, we'd probably all agree is not a good thing for the industry.

The second point market demand for interoperability is growing rapidly and the supply side is beginning to respond. So, again, you know, there are technical barriers but some of those are eclipsed by policy, legal, business and socio-technical barriers to greater interoperability as well and we just, you know, sort of point that out to note that it isn't just a question of the existing vendors there a lot of other issues at play as we think about this and some of the barriers and challenges that we face.

And then, you know, finally, a final note that we would just note is that, you know, innovation entrepreneurialism we believe are best promoted by focusing on functional interoperability goals and open architecture through standardized APIs rather than on the internal software design of core, clinical and financial systems, you know, whether a system is based on MUMPS or based on something else it seems that, you know, the industry ought to be agnostic to that it's more about how does it communicate with the outside world and does it do that in a way that achieves the functional goals that we want and that does it in a standardized way that allows that to be open, you know, in terms of the definition of what, you know, open means with respect to interoperability. So, I believe I am turning it over to you now.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Okay.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
For another meaty discussion.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Yeah, so this is our focus on the actual API recommendations and you will have already heard what we're going to recommend here echoed in the previous discussion but you'll hear it again. So, the JASONs refer to the notion of a public API as the step beyond what they kind of dismissively refer to as current large-scale interoperability amounting to more…little more than replacing fax machines with electronic delivery of page formatted medical records.

So, as we've noted we think that was a little bit of an unfair assessment because the CDA and the current implementation of the C-CDA are in fact capable of moving structured data from place to place within the limits of the fact that not everybody can parse them, produce them and parse them correctly. But nonetheless, the JASONs are arguing for a step beyond just doing a better job with CDAs, they're talking about actual data APIs and they propose to do this through regulatory requirements.

As Micky Tripathi mentioned we used the word certification as one…we've discussed the use of certification as one way to move things forward the tension there that we'll come back to I think in the discussion is avoiding premature certification. If you certify something that's a moving target in a rapidly changing part of the industry you could lock yourself into some of the mistakes that we've had to deal with already.

Whoops, okay…and then I think we've have covered the point that the JASONs have a concern that we wouldn't get past the document era if you would and I think we've covered that. So, let me go to the next one.

I've got the right one up there. I have to read from the local screen here because I can't see that very well from back here. Preliminary recommendations, so first recommendation is, you've heard us say already, is that ONC and industry should support and pursue the JASON's call for development and adoption of published standards-based APIs and data models or data element models for documents and atomic data in the proper framework for legal policy and business rules of the road. The JASONs focused on the technology side but they admit obviously that governance is a critical issue as well.

And to this end C-CDA refinement, that's the document encoding that we have today, and HL7 FHIR for data element modeling and data APIs should be targeted and accelerated through ONC perhaps contracting with existing initiatives and SDOs for development of sufficiently tight specifications and implementation guides focused on high-value use cases and licensed available for public use. Now this is obviously a point of some discussion.
We have focused on FHIR as our target because it is at the moment the best candidate that any of the Task Force members could identify and from our panelists in the hearing likewise it was the approach that came up most frequently and was in fact, I think, positively reviewed by everyone.

And then we think all of this should occur in leveraging existing structures. There has been some talk about the need for some new structures we didn't identify the need for any new kinds of standards organizations in this process. So here is a little bit of the background on these recommendations.

So the JASONs refer to a public API. We have probably got a little bit of work to do to define what we think they mean by public API but we're choosing to, at the moment, interpret it as a standards-based and open API. So, it is available for use and is based on a standard. And we think that they should be published and documented in a sufficient level of detail so that a third-party could implement and use those APIs without intervention of the source system hosting the API. In other words it's well-defined enough so that you can, assuming licensing and appropriate security policies are in place, access and use that API.

The growing industry adoption of standards-based APIs such as HL7 FHIR focused on high-value use cases is the most appropriate and sustainable path to move towards standardized APIs. I think I covered that point a second ago.

We see the HL7 FHIR as the best current candidate we'll certainly be happy to discuss that and we will in our follow-up sessions review it in a little bit more detail but we also need to, in the meantime, while we're waiting for the emergence and acceptance of FHIR-based data APIs, continue to work on improving the document encoding of those data elements since that's the state-of-the-art today.

So, we're moving documents around today through the CDA, C-CDA and we need to make sure that those documents are able to be parsed properly and that has come up in some of the other recommendations from the Standards Committee and Implementation Workgroup.

A published open API framework can partially offset the need for strict standardization of APIs. I mentioned earlier the tension that we have that if you certify around a very narrow API you may close yourself out of innovative ideas that emerge when people try to use the APIs and discover it didn't cover every use case they needed.

So we will do a little bit of additional works in specifying how do you deal with the ability to specify a core subset of the API that everyone expects to work the way it's defined but at the same time allow for expansion through publishing of the API but not necessarily incorporation into the certification process.

And then, I think we'll cover that last point when we talk about the acceleration. So in hopes of keeping the time going here I'm going to hand it back to Micky…

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Okay.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Because I know we're short on time.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes and I just checked with Michelle, we have until 11:30 with the new time so we have still an hour. So I think it seems like we're doing pretty well.

So, one other point I would just like to make on the point that David was just making about that first bullet, a published open API framework can partially offset the need for strict standardization, is that, you know, there was a very interesting point that came up in the listening sessions where App developers who work in other industry verticals as well and are trying to get into healthcare just noted that for example as you think about payment mechanisms, I think one of the App developers noted that, you know, when they integrate with PayPal or with some of the other competitive payment, you know, sort of payment systems out there those systems aren't standardized, aren't strictly standardized but because they are published open APIs they're able to integrate with them relatively easily and the APIs are, you know, as we defined earlier the open API concept that it should be published to a level of detail and maturity that someone can implement it without having to have an engineer from the source system, you know, go back and forth for a month on all of the back and forth of doing that.

So, you know, it was a very interesting point I thought that, you know, in some sense there were some of the App developers saying just publish something that's relatively modern and that we can implement without having to talk to your engineers and, you know, we'll be fine.

Now I think that, you know, there is I think a balance between wanting to have some standardization but again I think there is, you know, that was a very interesting point I think that came out from that conversation.

So jumping to the next point, topic five here, consumer access and control of data, as I noted they aren't specific recommendations if you look at the recommendation list, so, but we did, you know, certainly glean some very strong viewpoints from the report about consumer access and the importance of it and how the recommendations that they were making clearly see consumer access as being one of the goals.

So just a point of clarification, for those who are reading the report, the report does assert that patient's own their healthcare data and while we had a number of attorneys leaping out of their seats at that characterization we did have the opportunity to sort of go back through some mysterious process and get a little bit of clarification that, you know, they agree that as legal matter patients don't own their data and so they modified the proposition to say patients participate in the management of their data. It's just a small technical point. I don't…I mean sorry, Deven, I know it's an important point, but I don't think that changes any of our views of the spirit of what they're trying to say, right? You know I think that's, you know, overall the major point.

The JASON report calls for granting fine grained consumer patient control over uses of health data through what they call privacy bundles that would capture common access patterns that fit most patient's needs for a wide variety of use cases. Under girding that and less explicitly stated in some ways, although they do certainly talk about it, is that if you're going to fine grained privacy bundles that does, you know, sort of impose a requirement on the source systems to have sufficient level of data tagging and segmentation to allow that granularity in the privacy bundles, right, so there is a corresponding requirement that flows down into the EHR and PMS systems to be able to deliver and segment the data according to the privacy bundle granularity that is promised there.

And then, you know, finally, JASON calls for providing consumer access to healthcare data via the same discrete data APIs that would address clinician and research data access needs. So, that's this concept of the overarching software architecture that serves multiple needs.

So, our recommendations are as follows, one is that patient facing EHR functions should expose similar discrete data APIs as discussed for clinical care and research needs. So, you know, we agree with that JASON approach. Blue Button Plus offers a logical starting point for that, you know, based on the current set of maturity by expanding the current use of FHIR and OAuth 2 to include a richer set of APIs. You get to, you know, the same thing and once we get to the accelerating interoperability issues of well, you know, how far along is that and what's the timeline for being able to incorporate that in certification? It doesn't make that any easier by saying "oh, you should use those on the consumer side."

But and then the second point is that we believe that HHS and in particular OCR should help to clarify the degree to which patients and consumers can control access and usage of their personal health data. Much confusion exists even among HIT experts or we might even say, particularly or especially among HIT experts, but be that as it may, and I think, you know, Deven is a member of the Task Force and has been very articulate on this point as well, that there is a lot of confusion out in the market and OCR particularly in a world where consumers would have greater access to their data, there is lot of room for clarification there about, you know, how does the delineation of the responsibilities flow once the consumers have accessed and are directly controlling their own data. Yes?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Just a comment on that, I think one of the things that a number of us on the Task Force felt was an exciting opportunity was to enable a new class of applications that consumers are actually in control of that could use standards-based APIs via the portals to actually pull data into something they control and can decide what to do with.

And so that's going to scare people, it's going to scare providers, it's going to scare lawyers, it's going to scare companies that want to get into that space. So, our call here is just for clarity about what are you able to do if you're a consumer who has access through a proper authenticated login to a provider portal and you pull that data into your SMART device and start doing things with it, donating it to research, selling it to marketers, whatever it is you want to do, that is a huge opportunity but it needs to be…people need to be really clear what the rules of the road are for that space. And I think it's pretty clear but not everybody understands what that is.

And just an editorial here, this may be one of the places where we can push our experience with these APIs a little bit faster because it's a little bit more open and less critical to patient care. If we experiment by enabling these Apps we may have a chance to see what's working and what's not working about the APIs with less regret if we didn't get it right then if we're doing it for say HIE to HIE interchange and discover that we're dropping data along the way because the profiles weren't properly structured. So, just a thought that this consumer access is a really important avenue.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes and I think that really speaks to the second point there which is about, you know, it could be that that's really a major source of innovation in part also because a lot of the vendors on the consumer facing side are new vendors. They don't have a lot of the legacy kinds of issues that an existing vendor would have in terms of trying to, you know, sort of modify their existing infrastructure to keep up, to keep pace with what might be seen as more modern conventions.
So, and then David's point about the legal side of it I think is on the fourth bullet there. I will, you know, note that we haven't yet spent enough time on the privacy bundle concept so we will, you know, sort of enrich our discussion of that and come back, you know, in the final recommendation with a little bit more to say about that.

And then the third bullet is related to APIs in general. It's certainly true on the patient side; it's true in the provider to provider side that the technical availability of APIs needs to be accompanied by business processes to support healthcare's specific concerns, privacy, appropriate use of data, as well as just general business concerns, data rights, liability.

So the point there is that you can have a public API and actually publish it so it's open, but that doesn't mean that no conversation happens, right, so there…and as you think about healthcare even more conversation probably needs to happen because of the privacy issues both regulatory and ethical but also about, you know, there is a greater need for some kind of conventions around what's appropriate use of data. How are people going to interpret the data that has gotten out of a Cerner system versus an Epic system and you can imagine that the provider as well as the vendor has a great interest in making sure that data is interpreted correctly before it's just, you know, presented to patients to go off and do things that may be inappropriate in terms of the context of the data. So, that's not a trivial thing. I think it's a relatively important thing. So I think our last…second to last topic is research and HIE. I'll turn it back to you.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Hang in there we're going to land this thing eventually. We did not spend as much time…we have not yet spent as much time on the research question as probably we will over the course of our remaining sessions but we did have some initial recommendations.

The JASON's approach the research use case as sort of an automatic benefit or side-effect of these standards-based APIs and you could argue that they kind of don't differentiate that researchers might have special needs different from other uses of those APIs. So, I'll just note that they seem to think of all of this as sort of a common architecture and you'll see that we may be raised some questions about that.

The sort of exciting part of their vision is both exciting and quite challenging if you think about it. In the quote there in the middle they refer to this federated database will provide a large effective sample size and what amounts to an ongoing clinical trial with over 300 million potential enrollees. We had some pushback that's not really the definition of a clinical trial and that obviously the technical and policy issues, I'm sorry the legal and policy issues governing access to a 300 million potential enrollees is something that requires more than just a technical architecture. But we agree with them that the absence of a consistent data level API and associated data element model does inhibit access to data that could be very beneficial to certain kinds of observational research.

So, on the next slide here, our preliminary recommendations are that a standards-based discrete data API and associated data element models to improve researchers access to routine clinical data should be strongly supported through both technical and policy development.

We agree with their suggestion of convening the research community to identify proper use cases of these APIs, the technical requirements and then alignment with existing approaches that are already fairly well developed in the research community.
We had some feedback from some of our…some of the panelists during our hearing that there are already pretty good standards in use through CDISC and RFD and the question came up of why should we replace those with a different approach, there is similar tension in the research community that you'll get from the vendors who are currently moving CDA documents around saying this is working pretty well why do we need to change things.

And we suggest that there are numerous groups out already working on aggregating large observational data sets and that those groups, those communities should be included in the discussion such as the work being done at Kaiser and with i2b2 across many academic sites.

We also recommend that policy work to address the regulatory governance and business barriers to greater research access to routine clinical data should be done in parallel with the API development. So, push the policy track forward at the same time that we refine the APIs.

I think on the discussion points here, yeah so we…as I mentioned we debated the distinction between observational data research which is research that drives directly from the side-effects of clinical care versus controlled trial research which has much more rigorous requirements on the capture of the data in the first place and the JASONs sort of blur over that distinction, which is not to say that the observational data isn't important, it could be very important for hypothesis generation and the kinds of things that we understand how to do with observational research but when it comes time to actually run a clinical trial you may need more than just the data API you need to understand, the providers need to understand that there is a protocol that has to be followed and that the data is captured under rigid conditions.

Additional work will be necessary to reconcile the JASON vision of common data level APIs with existing approaches. I mentioned that CDISC and other groups focused on standardizing the research process consider that these ideas may be useful but they don't want it to disrupt what they've already accomplished.

We detected some potential inconsistencies in the report around their advocacy of consumer control over these downstream uses of their data with a flat-out statement that researchers should have access to the complete record unfiltered and unpurged by the consumer. So, there was some tension in the report that's not actually resolved. It's not a new tension, we're familiar with it, but I think we thought it needed to be called out that they didn't propose particularly innovative or a new way to deal with that tension.

The report also in alignment with more, one of the more recent PCAST Reports calls for additional work on standards for how to deal with de-identified data and perhaps reconsideration of the regulatory framework around whether penalties are assessed for attempted re-identification of the data as opposed to penalties around inappropriate access to de-identified data that you don't ever actually try to re-identify.

And our observation, our discussion centered around some of the PCAST observations that as more and more data is captured it gets harder and harder to really properly de-identify the data. So, again, more policy issue then technical at the moment. And then, okay, I think that's…yeah that covers the research.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes.
David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
So, last slide, the last observation.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes we're over heartbreak hill, we're coming into Boston. So, the last category is accelerating interoperability. There is this very specific, you know, set of recommendations related to the urgency that the JASON Report, you know, I think, you know, sort of nicely states around, you know, the need to really move to the next level here and some specific recommendations with some specific timelines about, you know, how to do that and when to do some of those things.

So, the first thing is that the JASON advocates using Meaningful Use Stage 3 as the primary lever for provoking the industry changes that it would like to see. And then second, you know, just as a point of background again we've already talked about this, JASON began its work in late 2012. So, you know, it did not have the benefit of lessons learned. It also assumed more time to define, gain consensus and prepare for Meaningful Use Stage 3. So, just, you know, sort of important context things as we think about it.

In terms of our recommendations about, you know, accelerating interoperability given that we are where we are now, so Meaningful Use Stage 3 with the current, you know, sort of, the finalization, the final rule that was just passed that pushes it out one year, we're now two years away from the beginning of the Meaningful Use Stage 3 attestation period for hospitals roughly two months away from that now. I mean two years away from the now. So, that suggests that Meaningful Use Stage 3 unless there are changes would really need to be considered as one of many levers to promote advancement toward the JASON goals.

It…the current timetable doesn't appear to allow sufficient time for widespread adoption but, you know, we do think that we ought to accelerate, you know, some of the current processes and the current thinking about how to incorporate new approaches for example with, you know, sort of some foundational elements of FHIR in the certification process.

So, we're not saying you can't do anything but in terms of being able to do, you know, a whole lot through Meaningful Use Stage 3 it seems like there are some constraints there some of which would have to be lifted in order for us to think about that being a bigger lever.

Second recommendation is that the federal government should align and leverage the many other means at its disposal to promote advancement of JASON goals. There are many, many levers that the federal government has that lined up could in the aggregate be much more powerful than any of the Meaningful Use, you know, sort of stages and the certification, the accompanying ONC certification that goes along with that.

Finally, we recommend that ONC should immediately assess and implement where possible streamlined approaches for incorporating new standards into federal certification which is something I've, you know, talked about before and we recommend seeking HIT Standards Committee guidance on this topic. So, you know, we'll talk a little bit about that, you know, on the next slide.

First off, you know, I think we've already discussed how Meaningful Use Stage 3 and the accompanying 2017 edition certification not as powerful as presumed by JASON. A barrier to maximizing the power of Meaningful Use in general is the long cycle required to get a technical standard included as part of the federal certification. For example, here were are 24 months away and that's seen as an impossible timeline to be able to do this.

And one of the questions that we're asking, and it was a part of the recommendation that we had I think on the EHR category, is ONC thinking themselves as well as seeking guidance from the Standards Committee on how do you shorten that timeframe? Are there some things that we can do to accelerate that so we are able within that kind of timeframe to be able to do something to push the ball forward?

You know market demand for interoperability is growing rapidly. So, you know, in part some of what the JASON Report thought the Meaningful Use Stage 3 would require some of that market may be taking care of at least directionally so, you know, that's a good thing.

But certainly, you know, in the last point, as the program ramps down and given the constraints on it the importance of effectively orchestrating and we've just listed just some of the, you know, various levers that the federal government at large…now I know that, you know, that's many, many different agencies and many, many different people, it doesn't just happen with the wave of a wand, but that said, it can be pretty powerful I think if orchestrated correctly.

In terms of our next steps, we want to, you know, gather, obviously, have a hopefully rich discussion here, gather directional inputs from the Policy Committee and the Standards Committee. We have four remaining scheduled Task Force meetings.

So we do have, you know, a fair amount of engaged time with the Task Force which is, you know, very good news and obviously we can add more if necessary and we do have two tasks that we didn't really, you know, sort of present here, one is a cross reference to the PCAST Report and the other is a cross reference to the ONC interoperability roadmap. So with that, that concludes our formal presentation and we very much look forward to the discussion.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, thank you both Micky and David, and the members of the JASON Task Force. I think it was an extraordinarily comprehensive overview of this very technical and complex area. Karen has said that interoperability in the nation…said interoperability is an extraordinarily important focus for us this year and in the next few years and it's truly a combination of technical challenges as well as the, what you didn't consider, the legal and social, cultural and privacy areas.

But so this group dealt with the technology aspects, the Governance Subgroup is going to talk to us about the other areas. But I thought this was remarkably concise for the complexity that is there and it really was a great summary if you listened closely and the materials are excellent as well fine print as it is but…and I think you were exceptionally clear.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, I think we've gotten one of the best briefings on what is the state of the practice, the recommendations and the concerns in this area and really look forward to both this discussion as well as how it's brought into the October meeting. So, thank you that was a lot of work and there is still a lot of work you've set up for yourselves between now and next month. But let me open it up to comments and questions from the committee. Marc?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Well, I want to echo what Paul said that was exceptional and really good work and I really liked the recommendations you've come through with.

And its…I suppose my comment is I'm highly skeptical of the industry's ability to do it. So what's outlined there is excellent, I love the concepts that JASON put forward and the flavor you put to it, some of the detail you put through it is excellent.

How do we get…well, maybe I just need to do it myself, but how do we get comfortable with what the right level of industry participation, which, you know, for 30 some odd years now the industry has been working towards standards that would help with interoperability or what we are trying to do with healthcare data.

You know how do we reconcile that history with where we need to go? What's so different today? And there are differences you've talked about some of the momentum in the industry and the desire that's out there but there is still a lot of competing challenges out there, you know, between, whether it's the vendors or even different organizations and what they want to do with data. I mean, can we somehow address that point? And maybe that's not your Task Force or maybe it is, but, you know, I think we need to address what is the right role of government in this?

Because, I mean, my personal belief is it needs to be very government-driven because the industry itself has not been able to do this and I'm not choking up, I'm not emotional about this. But, otherwise, I mean, really, really good work, I mean, not otherwise really, really good work that's just a point, you know, I'm interested in understanding better.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Thank you and I was hoping to hear many things I wasn't expecting to hear that we were concise so thank you for that. I'll take a first shot at it and David, you know, please jump in.

You know I think we do…we will dive more into that question I think, you know, we just start to addressed it in that conversation about, you know, the idea of loosely coupled architecture and the role that ONC can play in defining what does loosely mean, right, what are the components that ought to connect what we would see as more organic market-based implementation?

So, there is a lot of activity out there to your question of what's different. I mean, it's certainly my view, and I think in the Task Force, you know, at large, that the one thing that is different is that there is a lot more demand for interoperability than there was before. That's, you know, I guess the good news and the bad news because the demand is out pacing the standards, you know, that have been developed and that the Meaningful Use process has, you know, allowed to try to, you know, sort of corral a little bit of the market activity around it. So, demand is there, it is growing so that's a good thing.

I think that digging down further into this question of what role can the federal government play in defining what loosely coupled means and helping to convene, you know, sort of a consensus type process to define those things and then employ a number of different levers to help to drive, you know, the industry toward more, you know, sort of focus than it would otherwise do on its own, I think, I know that's a very high-level concept but I think those are the kinds of things we're going to, you know, dive into I think as we look forward here and David I hope you agree with that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Yes. We had a lot of discussion about this and I'm sure we'll have more discussion. Some of the things we talked about in the Power Team, Dixie Baker's Power Team, had very similar discussions because they were asked to address some similar questions.

We discussed, you know, if we raise the bar for the technology that needs to be certified can we compensate in either one of two ways, one by slowing down the certification process, in other words pushing out the 2017 edition to 2018 or something like that, or can you trade-off by reducing complexity of some of the other aspects that the vendors are scrambling to get certified for the 2017/18. So you either lengthen the time or you reduce the pressure by setting lower bars or easier certification attestation approaches, etcetera than we have today.

But despite the fact that the Task Force was essentially uniformly anxious to move forward as fast as possible, we got lots of pushback from the industry both from the vendors as well as from the HIEs that are consuming the data coming from the vendors that they can't handle this in the timeframes under the current Meaningful Use schedule. So, it was a tension that was in every one of our meetings is we all want to get there, we want to get there faster, but there's not enough time given how much work people feel they have to do.

Now one of the things that we discussed, it kind of was buried in our recommendation, not buried but it was mixed in with a lot of other stuff is, there is a lot of activity going on right now to get FHIR and FHIR profiles, which are those data element standards necessary to make FHIR useful, a lot of work underway to get that good and HL7 is driving forward and then there are other groups like the SMART platform, which has a process called SMART on FHIR, that a number of vendors are participating with.

And the Marc, as you know at your institution, Stan Huff is leading a group called the Health Services Platform Coalition, HSPC, that is aggressively working on development of FHIR profiles that leverage some of the learning that's been done at Intermountain through the last 20 years of understanding what clinical element models look like. That work needs to be brought into high visibility and encouraged to go forward because it's industry driven. It is the people who actually would use those APIs in the room figuring out what they want those APIs to look like and that's the best way to get a useful output is to have the people who would actually be building the software and using the software.

The over the waterfall kind of approach of standards development that we've lived within the past where an SDO would go off and spend years and years, and years thinking about an abstract problem would come up with a perfect recommendation, toss it over the wall and then expect people to implement it, that just doesn't work for lots of reasons as we have discovered, you know, in software development in general, but it's just as true of standards.

So, active engagement of the groups that are doing it on the ground, pilots aggressively, consider changing the rules around certification, the timing and/or the complexity.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Right and perhaps focusing on the scope. I think that some of the pushback that we got from the industry was an anticipation that Meaningful Use Stage 3 would encompass a whole bunch of things so they're going to have a lot of things on their plate.

But if we think about Meaningful Use Stage 3 in a very focused way, right, so we do some of the things that David was talking about, about accelerating the process for identifying and getting, at least foundational aspects of public API concept into certification to at least get a toehold and then narrow the focus of 2017 edition certification to a very narrow set that can allow the industry then to understand that, you know, there are some particular areas that we need to focus on that could be, you know, part of the compromise here to get that focus but I do somewhat agree with you.

It is my own personal view that, you know, that there is nothing…as much as the 2017 edition certification of Meaningful Use Stage 3 are sort of diminished in terms of the influence they are going to have on the market compared to, you know, 1 and 2, there's nothing like it still in terms of its market coalescing power. All the vendors will certify to it, right, absolutely they don't have a choice. They will absolutely do that and there is no substitute for it in the near-term.

So I think that there is a danger in creating some type of separate deeming authority or something like that now that would introduce a lot of confusion in the market as people understand that, all right, at least with this process they know at least through Stage 3, you know, that they're going to keep moving forward on that.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Yeah and I like your concept of narrowing the scope. The only thing I'd be careful of is we don't lose the context of the overall end goal that we narrow the scope so much that we create a set of standards that then don't fit into the larger spectrum of what we're trying to do, but, anyway, thank you, really.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
If I could just add on a little editorial to Marc's question to you and highlight some of your response. So, your response to him actually had some very specific and precise recommendations. Hopefully, you'll discuss that in your Task Force and bring them back because you didn't talk about the Meaningful Use 3, your recommendations about narrowing scope as much in your presentation and if it's been discussed you can come back with something very precise like that.

Because what you did point out is how much the market demand has grown since the 2012 start of the JASON Report. And Marc's question I heard is, what can government do that would enable closing that gap between the new demand and the supply that is trying to come along to meet that?

But so you've opened up that topping if you could address it when you come back that would be very helpful.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Absolutely, yes.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, so in my list we have a number, but thank goodness we have time, I think, I have Paul Egerman, David Kotz, Terry Cullen, David Lansky, Christine Bechtel and then Neal Patterson is the order that I have and then Charles Kennedy. So, Paul?

Paul Egerman – Businessman/Software Entrepreneur
Great, can you hear me?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yes.

Paul Egerman – Businessman/Software Entrepreneur
Thank you and thank you Micky and David. I was the Chair of the Task Force that responded to the PCAST Report so I'm sympathetic to the challenges you face with a tight time frame I think you're doing an excellent job with a challenging subject.

When we did the PCAST Report or as I used to call it the PCAST Report/Report because it was a report on the PCAST Report, that was approved by the Policy Committee and my suggestion to you is that your Task Force review that report that was produced by the Policy Committee because it does address some of the topics that you are considering relating to research, relating to some of the privacy challenges and so that is a suggestion that I would make.

I also have a comment, just a general comment that was similar to my comment in the PCAST Report, which is in the JASON Report the current systems are referred to frequently as legacy systems and the word legacy is…it basically denigrates the systems it sort of acts as if the current EHR systems are some kind of like artifact that was recently found by an archaeologist and you're kind of stuck with it and there is another word that you could use for the current EHR systems and that word is "operational."

And the current EHR systems are operational systems that perform a number of very important functions, the primary one of which is helping a physician provide care for a patient. And we are comparing operational systems with the report with a theory.

And anytime you compare an operational system with a theory the theory always wins because the theory always appears to be better until you actually put it into operation and so I think that's an important thing to keep in mind is we are simply talking about a theory that hasn't been tested. We do not know, for example, if we really produce these APIs if they'll be useful to consumers, if consumers will actually use them. We don't know the level of acceptance that will occur. It's simply a theory.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yeah I think those are great points Paul and to the first point, this is Micky, you know, as I said we haven't had the opportunity yet to cross reference with PCAST but I have read the report many times since we started this and it's been very instructive. So, I think I agree with you it will be very useful for us to do the cross mapping as well as try to build on the recommendations from that that the Policy Committee has already approved.

Paul Egerman – Businessman/Software Entrepreneur
Yes.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
And this is David. So, maybe we should call ours the "repor" in Stephen Colbert fashion. So our repor on the report.

But I think Paul to your comments about the legacy systems we…basically when you read through our recommendations you'll see that we really just sidestepped those issues and say let's focus on how to take existing systems and enable the overarching architecture that the JASONs put forward because I think all of us believe we can do that with appropriate use of these APIs. So it's not a rip and replace it's just add some capabilities that enable these loosely coupled systems to be better than we've got today by the addition of this new class of APIs.

But we weren't…I think I initially reacted to the report with some kind of anger of this is not a thoughtful assessment of the state-of-the art, but then you read it a little bit more carefully and realized the value of the report is in where we go from here and we can do that with existing systems just enhanced as they suggest.

Paul Egerman – Businessman/Software Entrepreneur
And that's a helpful comment, David, because I have tell you my own personal reaction to the report was similar to yours. When I first read it I was angry and it didn't seem necessary to denigrate the existing systems in order to put forward this theory and then you have to get past that to look at what the theory is but you also still have to understand that it's simply a theory.

I'm curious to know…you said that the authors of the JASON Report have been available to you that part is different. When I did the work with the PCAST Report the authors of that report actually were available to us and they were quite helpful in explaining what was meant because we simply misunderstood some parts of it.

So, can you explain why the JASON Report authors are unavailable to you are they in a witness protection program or something? Why can't you talk to them?

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
This is David; the way the JASON's work is they maintain a relative anonymity and therefore they can offer their opinions they feel more freely. We had a go between through AHRQ which was the convener of the report so some of our questions, particularly the one around for example the notion of the patients owning their own data, were clarified through the go-between. So it wasn't that there was no communication it just wasn't impossible to sit in a room with the authors of the report.

On the other hand, the key author of the report did produce or did do a public presentation of the report at a recent Robert Wood Johnson Foundation discussion I think a couple of weeks ago. Karen and I were both with her on the panel but even there her comments were not for attribution. So it's just a process that they use. I'm not sure how we got there.

Paul Egerman – Businessman/Software Entrepreneur
And I think that's unfortunate. I think that it's irresponsible on their part to put forward a theory that they want to change the whole country with but they won't answer any questions about it. So, I would encourage you to push back. They should have some people come to our meetings and I think it's a way to understand things even if they disagree for us to have some dialogue with them.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, Paul, I'll reference your comment about theory and operations and this is the operations of the JASON. So, I'll beg people's indulgence to try to keep your comments and replies on the brief side so we can get through all the comments. Next one is David Kotz?

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College
Yeah, this is David Kotz, I was interested in your segment on consumer access and control, and in particular the ability for consumers to export information from their EHRs and into SMART devices or I suppose cloud-based PHRs and so forth.

And I guess I have two questions, one is what are the protections for that kind of information once it leaves the usual HIPAA covered entities, are there mechanisms in place or do we need to help develop policies to protect patients and consumers once that data is out floating around?

And the second is what about patient push? Can they upload data? There is a lot of demand for that these days with mHealth devices and so forth of uploading basically self-report and device collected information back into their EHR for clinical use.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yeah, I mean, I think on the first point I would certainly defer to Deven but I don't think that it's, you know, specified, once the patient is in control I think that the patient is then in control and there are really no rules beyond that. I'll just answer the second question, Deven if you have anything further to add on that, Deven is a member of the Task Force so I can call on her.

On your second point, the APIs while we tended to frame them as being about query in principle they're bidirectional. So, you could get, you could put, so, you know, I think there's no constraint in that sense and I don't think that the JASON Report saw there being any constraints.

There is, you know, just more of the issues about, you know, how that data gets used and around the business and clinical, you know, sort of conventions that would need to be developed around receiving that data and consuming it in a way that would enhance both the patient and the provider's experience and ability to deliver care. Do you have anything else?

Deven McGraw, JD, MPH, LLM – Partner – Manatt, Phelps & Phillips, LLP
So, without taking us totally off-topic, it's not…I mean, it's relevant but it wasn't really addressed in the JASON Report at all. The rules for consumer facing tools there are FTC unfair and deceptive trade practices, as you know, the State of California recently extended its medical privacy law to Apps that gather data directly from healthcare providers, it's just recently done, it's sort of unclear what impact that's going to have on the market.

But it is a case and we've had discussions about this in previous Policy Committee meetings that ultimately that the patient has that responsibility and needs to sort of self-educate frankly on the policies of the App developers in terms of sort of what the terms of the deal are with respect to the data use.

Apple actually just recently announced that for its platform, Healthkit, that it is going to prohibit as a matter of policy for any data that is exchanged through Healthkit that it cannot be sold to data brokers or advertisers which is a very interesting development.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
But there are certainly unintended consequences and possibilities. So, I think that's…there are a lot of business conventions that have to get, you know, aside from, you know, legal, I mean, there was a, sort of a somewhat infamous case a couple of years ago with the website Foursquare that some of you may be familiar with, the location site that people started developing Apps to link up Foursquare location of individuals with Facebook and so all of which was an unintended consequence and then Foursquare shut down that part of the API that would enable that, but, again, you know, just imagine that something simple like that, you know, could create those kinds of unintended consequences, you know, we're talking about risks that could be exponentially greater without a set of legal and policy, and business protections around it.

David F. Kotz, PhD – Associate Dean of the Faculty for the Sciences – Dartmouth College
Yeah, I think this opportunity is huge and important. The opportunity for consumers to extract the data and have it in various forms but I am worried. I have no confidence that consumers will self-educate and take care of their data. And I also have no confidence in general that App developers will be well behaved.

And there's lots and lots of examples of where application developers and service providers misbehave or take liberties. And so I just think that's something we need to be, maybe not this committee, but we as a nation need to be thinking about very carefully.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
This is David, one comment on the notion of trusting App developers. We didn't highlight in our findings today but we had quite a bit of discussion in the Task Force about the fact that just because the API exists and is well-documented and is "public" doesn't mean that the owners and controllers of the data behind that API would let any old App connect to it.

There will be a process, there has to be a process to validate and certify that the Apps are in fact well behaving in some definition of what well behaving means and that's work that needs to be done obviously above and beyond the technology issues but it will be something that initially, I suspect, individual vendors will probably deal with through their own processes because they all have some kind of API today and they have a process for vetting Apps before they allow them to connect up.

But if we increase the availability of Apps because of the standardization of these APIs then having a process in place to certify and managed trusted Apps will be a critical part of the process both for providers and for consumers.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Right and I guess just a final last point, it's not that there aren't some, you know, tiny precedence for this, I mean, you know, labs will typically review how labs are presented in the EHR system, Surescripts is a part of the certifications that they do with vendors will certify how information is presented in the different EHR systems. So, it's not as if there is, you know, sort of no precedent for this kind of validation.

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

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Hi, first off thanks a lot. This is great. I echo everybody but I really want to take off on what Marc said because it was my first reaction. So, while we all we know that App developers may not regulate themselves I'm not sure the vendor community regulates itself that well either other than in response to different fiscal incentives. So, I think that there is some inherent disconnect here.

So, on slide three, you guys mention, I think appropriately, that current APIs are vendor proprietary and I'm not sure if that's your comment or the JASON, but I would agree with it.

And then we're to go to this open APIs were we believe that the vendor community will be able to self-regulate and self-initiate for the greater good. And I guess I see a disconnect there and I think you guys captured in this public APIs versus open APIs so my plea would be for you to spend some more time looking at that to figure out how do we truly get to whatever it should be called. And I'm not going to posit that I know whether it should be open or public but I think this sense that people will for goodwill purposes make the decision to make their data accessible and easy for other vendors to utilize has not been proven by the marketplace so far other than in perhaps the open source community. So, I think it's an important step.

The other thing is I think there is tons of interdependencies here which I'm sure you guys know, and it's not like I want to give you more work, but I'm wondering if at the end of it when I look at what the outcome is going to be in terms of your next steps, is this further specific recommendations coming out of the four remaining Task Force and I'm wondering if you envision being able or having a pathway forward as opposed to saying these are recommendations for APIs, these recommendations here, these recommendations for here, but being able to create the path that acknowledges the interdependencies that actually might be very difficult to do, Micky and Dave, so I'm not saying you have to do it.

But I think for us to believe that what we are going to need we're going to get by a MU Stage 3 as we've talked to is magical thinking. But what we know is that there are steps that could happen by MU Stage 3 and then further work that we're going to need to do as we go out. So, first off I really want to echo again how great this is so though.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Great, thanks and, you know, we're…that's the kind of feedback that we want. So, even though it's more work I'm sure David's up to it.

So, no, I think as we've thought about how we move from this format to what we want to be able to present I think it's exact exactly as you're suggesting that there is sort of a crosscutting element where we want to make sort of a more coherent, you know, sort of focus set of summary recommendations that I think hang together and as you note, you know, sort of capture some of the interdependencies there and some of the redundancy, you know, we're saying the same thing over and over again.

So, I think that's a fair point and I think you'll see in the final recommendation that we'll, you know, try to present them in a different way with this kind of detail presented in backup.

To the first point, that was our language actually that the current APIs that are out there to the extent that they're there are vendor proprietary and it was our expressing the concern that this could lead to vendor lock-in.

So, you know, we agree with you and I think as a Task Force we agree that standards-based APIs are what the industry needs and if we don't do it through some type of process involving, you know, some type of, you know, government role either in a convening role or, you know, perhaps another role and that's part of the discussion that we'll have, you know, we would head down the path toward I think what you're expressing as a concern that we agree with.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Yeah, I think, you know, maybe to come to the defense of the vendors a little bit, that's part of my role and who I represent on the Task Force, the three vendors that presented at our hearing all have well-defined APIs and many Apps in their App stores that take advantage of them but they are in fact proprietary. So an App that works for Vendor A would have to be rewritten to some degree to work with Vendor B.

And so what we're calling for in-line with the JASON is to say, you know, vendors understand how to expose access to their services through an API but we're doing it ad hoc and that's just because there was no choice. We have a choice now, at least a strong choice to consider with FHIR, so the question is, is there a way to converge the existing work onto this new standard such that the vendors find that not an odious challenge from a regulatory point-of-view and would see the benefit of having less work maintaining proprietary approaches because there is a standard that they can use.

Vendors prefer things that are well defined and standardized all other things being equal, proprietary work is you have to invent something and you'd really rather just use something that's well-defined if it's good enough. So, we have to get to the where it's good enough part and I think we're on trajectory to do that, timetable unclear.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
But I would also just highlight the point that came up in the listening session that I did talk about before that if they are open in the sense that we've described open meaning it's an open API published and has a sufficient level of detail and maturity that someone could actually take it, write code to it, and it would be implemented under a certain set of business rules that this, you know, somewhat diminishes the requirement of having an absolutely tight, you know, specification that everyone, you know, that everyone implements, right, that you could have App developers who bridge the gap. If we can't get one vendor to talk to another, if they're both published open APIs you could see a whole sort of constellation of App developers who come in and say "well, we'll bridge that gap because we can do it."

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, we're going to have watch our time even more closely. Next on the list is David Lansky, please?

David Lansky, PhD – President & Chief Executive Officer – Pacific Business Group on Health
Thank you Paul and thanks Micky and David that's a great report I echo everyone's comments and compliments.

I also would pile onto Marc's initial comment about the skepticism that this can go very quickly without some external prod and agree with Terry's comments as well.

So, I'm wondering a couple things, one is whether in the further work that you all do you could address, I think it was on slide 34, that you listed the other levers besides Meaningful Use 3 that are probably critical to creating a climate in which this kind of change is accelerated and perhaps in future work going beyond the technical issue raised on the report, we, as a group, could have some more discussion about how to do the acceleration on, if you want to call it the business case, for adoption of these recommendations in support of interoperability.

The second thing is going back to the HITECH law, the two areas in which we really have not made the progress the original vision is interoperability and the quality measurement enterprise. And I was interested that the JASON Report didn't list the quality reporting requirements as part of the use cases that they were prioritizing but liked your analysis of the research uses.

I think there is needed a parallel analysis of whether the recommended changes here would facilitate an architecture that makes quality reporting more flexible and nimble that we've talked about many, many times in this committee rather than having the individual vendors hardcode these quality reporting standards into the toolkit they could instead facilitate through an API the exporting of the relevant data elements so that a third-party could produce the quality measures in a more flexible way over time.

And so if it's possible I would appreciate it if at some point your group could take a look at that issue and speak to whether the quality measurement requirements could be addressed through an adaptation like proposed by JASON.

And then finally, I'm wondering…I would at least conceptually entertain a discussion that we could, I think David you said this a minute ago, could we substantially drop other requirements for Meaningful Use 3 in order to focus the industry's attention on this interoperability goal and reduce burden on many other expected coding changes for 2017, in exchange if you like, for a really industry-wide focus on this uniform API and interoperability growth.

So, I think that's a critical national need and at some point we're tweaking around the edges of other features and functions with Meaningful Use 3 that in a sense we've accomplish the heavy lifting on some these things and I think I'd prefer to see us create national focus on something as important as this if the industry would be receptive to that kind of trade-off of burden. Thanks.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
I'll just make a quick comment on the quality measure question. I think that's a great idea. The challenge there is that the data element profiles or definitions that are necessary to feed into the numerators and denominators of all of the quality measures becomes quite a substantial set of data elements and that will be substantial work to get community agreement that those should be part of the API data element definition.

In other words, it's one thing everybody's got problems, medications, allergies, observations, vital signs, immunizations exposing those through a standards-based API is fairly straightforward work and the profiles are fairly easy to do because we've been working on that stuff for so long.

When you get into things like what happened in the physical exam of the diabetic and did they do a monofilament foot examination standardizing that via the API is a much more challenging piece of work. It ought to be doable but it's not as easy and I don't think it would happen in the first cut of profiles.

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

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Thank you. So, I'll just add my thanks to everybody else's for making this report so accessible. I mean you guys really made it plain language accessible and I really appreciate that in a very technical area.

I was just reflecting on several places in the report were you guys address kind of the tensions particularly that come up around, you know, consumers and research or consumer control, or ownership of their data things like that and they're not new, right, in healthcare.

And what strikes me is I had the opportunity last night to run focus groups of patients that are trying to help a primary care practice to redesign their registration and intake forms, right, so we're looking through all their policies, all the HIPAA notices, all the payment obligations, the assignment of benefits and the big theme that kept coming up over and over again from these patients was, you know, you're showing me these policies and you're saying I have a choice but I don't really have a choice and what I really want is a choice. And how can we make this like a two-way street? You know I understand all the legal stuff but honestly, I don't feel like I have a choice.

And I think that concept of choice and even coming back to the work that the Tiger Team did on meaningful choice continues to be a really helpful construct and so maybe my comment is more appropriate for, I think you said, the Governance Group might be taking on some of these issues, but if we can keep that idea in mind of consumer choice in these areas where there is tension between, you know, certain communities and consumers I think it would be helpful and technology today I think enables choice and transparency in the way we never really had the option before. I think it wasn't, you know, very practical previously in our paper systems to really have that choice be available at a frequent routine basis and I think it is today.

So, I just wanted to make that comment and it's reflective of an environment where particularly through this report where we continue to view consumers as really equal participants and equal stakeholders in this architecture and so I'm really happy to see that there is a lot of emphasis on consumers and I just, you know, want to reinforce and make sure that continues.

And then I'll just say one last thing which is, I think it was David's comment around, you know, consumers taking care of their data. I think consumers today are probably more privacy educated than they've ever been and I think consumers have a natural ability as we all protect our banking and financial data they…I'm not as worried about their ability to protect and manage their own data when and where they need to, right, because there are some of us who, I don't really care if my Fitbit data is out there, right?

So, I think we know ourselves and are adult enough to do that but I do worry and I think it's a valid point about the practices of sort of downstream Apps and other data stewards and I think there is, you know, clearly work to be done there but again, if we view consumers as equal participants and sort of adults in this, I think they will self-educate and regulate because it's their own health information. So, thank you again.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
And as I said we'll dig into the privacy bundle piece of this as a part of the next phase of our work.

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

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
Thank you. I'll make a confession first, I haven't read the JASON Report, okay, this presentation was so good, I have been kind of briefed on it, I know, okay…this presentation was is so good I don't think I need to now.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
You don't need to.

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
I will find a time…

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
You can see the movie and then you really won't need to.

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
Oh, yeah. The…and I never…I totally don't…I don't quite know who JASON is, but…

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
It's a concept, it's a concept.

Neal Patterson, MBA – Chairman of the Board & Chief Executive Officer & President – Cerner Corporation
It sounds like a movie. Secondly, I think even though in the report they called…I think I was referred to as a stovepipe legacy system, I found myself agreeing with almost everything that was in the report. It was very, very good and, you know, I'd strongly recommend this…I mean, they touched the ID, those of us that do systems there is a key and we lack a national identification system here so that has to be solved. I don't think it's going to be solved in this panel but that has to be solved and hopefully you don't skim over that the way they took the liberty to do that.

I'm actually just kind of blown away with how quickly the diagram gets broad here with, you know, with research, with population health, I mean, the environment is we're changing a lot in healthcare. There are a lot of needs out there, the ecosystem around the App developers, but there is kind of a core, if you will, use case, I just don't think we can ever forget.

So, the taxpayers of this country invested heavily in basically modernizing the current delivery system and digitizing the content, the core use case has to be the people who we're serving through the health system where they have complex medical conditions and they end up in different parts of the delivery system talking to different physicians, we have to eliminate the bags that we carry when we go to see other doctors, okay, and so we have failed as a country, we've failed…the taxpayers basically didn't get what they invested in if we cannot solve interoperability and there has to be liquidity, given consent of our information that goes into these systems.

I think the JASON Report touched on, did not exactly call it out, but the way they can make these very clear aggressive statements that says it's non…it was nonexistent, interoperability was nonexistent they basically had to be differentiating the difference between interoperability and intra because there is a bunch of narrative in here where if I'm sending information from one version of my system to another version I'm calling that interoperability that is not what is intended here.

So, they…when they did their research they couldn't find it there's a reason why and the reason why their research and the narrative that you hear in this industry don't match I don't think it's because they did a particularly bad job, I don't think it's exactly because of the timing.

So, my last comment then is, it seems like to me, and I am the new kid on the block here, that Meaningful Use 3 is kind of the last train leaving the station. For this level of investment we've made as a country to really define…to put the standard out there that basically we have to drive to both as provider organizations and as companies that sell to the provider organizations around these technologies.

So, I think we have to look as hard as we can to get as much on that last train of Meaningful Use 3 as possible. There will be tons of reasons not to, but it's a huge responsibility to miss that train and I know there are other levers we're going to find, okay, but this is the biggest lever we've got.

So, I would encourage us to think and, you know, maybe it is reduce some of the other, I don't know what the strategy is but we need as much on that train, the Meaningful Use 3 as possible. So, in there I don't think there was a question.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
All right, thank you. Charles Kennedy?

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna
You know when the JASON Report came out I did a quick search, Internet search, and what came back with a series of horror films which may or may not have been appropriate for the JASON Report search.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
I was thinking of coming here with a hard mask on but…

Charles Kennedy, MD, MBA – Chief Executive Officer – Accountable Care Solutions – Aetna
Yeah, there you go. But my comment is, you know, Marc Probst asked what's different this time, right? And I think Micky you responded and the JASON Report also responds that one of the things that's really different is that there is now an economic driver when you think about ACOs, population health, there is now an economic interest to share information which you do not have in a fee for service environment and I think that's very important, but when you think about the economics associated with sharing data, you know, economics are going to drive behavior. But the changes in behavior, in other words, the use cases associated with this are still very much in their infancy and let me just give you an example.

Many Medicare Advantage Plans noticed the amount of money spent at the end-of-life and many of them build end-of-life programs, right, well, what did they do to try and leverage technology? We built predictive models and we tried to predict who we should enroll in these programs.

As EMRs became more and more available we began to use clinical data and use the EMR to try and identify the members who should be in these programs, but at the end of the day, what remains the best source of information to figure out who should be in these programs is the physician.

And I think that as we use economics now as a driver for population health a lot of the use cases are still very much in their infancy and I worry that without an increased focus on how are you going to use interoperability to take advantage of the new incentives that are out there through population health and ACOs, we still may end up with the physician still being the best source of information for, you know, enrollment in programs and creating value.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Good point as well.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Just to comment on the…you started off with what's different this time. I'm going to comment on the technology side not on the eloquent statement which I totally agree with about the economic and business drivers, but the technology difference is that we…unlike with the original PCAST Report we do have a candidate architecture in the HL7 FHIR work that really does actually fit this use case pretty will, this technical use case for exposing standard APIs.

We didn't have that before and it's a daunting task to invent these things that are comprehensive and the small team of architects inside HL7 who have done that work have really done nice work and its rallied the vendor interest in a way that I haven't seen in a long time in the HL7 community. So, there is a difference on the technology side as well the business driver. And I promise I'm not on Chuck Jaffe's payroll.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Nor am I. I guess the only other thing I would add is I think that, I mean I think it's a great point, I think that the JASON Report it has it but it sort of underplays their…what they recognize is that both documents and data are really important because a document is the physician's representation of what's going on and has a certain richness to it that atomic data elements don't have and it took us a while to figure out no they're both there it's just that they're focusing on where the biggest gap is which is the data. So, both of those are important. I think that can partly address what you're saying.

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

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
I guess the other point on interoperability I think I, you know, I agree with you and I think there is a tension between, on the one hand, interoperability, right, doesn't just happen it gets done and it gets done for very specific use cases as we've seen.

On the other hand I think data doesn't get better unless it's use, right, and people don't see the opportunities that are there until they're able to share more and use more. So, I think that's a little bit of the industry tension we'll have going forward. It won't solve all the problems but we'll start to see more and more opportunities as more and more data is made available and people start doing very creative, hopefully, creatively good things with it, there's always the creatively bad things, as we discussed, on the consumer side, with Apps and what have you.

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

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you very much Paul and I think I'm the last man standing before lunch so perhaps I'll be a little quick. I have two things I really am concerned about and really want to address with you. And I know one of them is…we're going to discuss on the Task Force as we move forward, and that is really the privacy issues and when we talk about privacy bundles, but I know in the PCAST Report, which I also read, and remember Paul's discussion on as well as in this, they really get down into privacy, the ability to use data, metadata and data tagging in order to address the privacy and put, as Christine said, put the consumer, the patient back in control and being able to make very specific decisions on use of that data.

And I would really like a little bit of discussion on that. I know this will probably get put into the next report or next discussion, but I think that is something that the Task Force really needs to look into and there was no discussion at all about metadata and data tagging today in any of these recommendations and I think as the Task Force moves forward they need to really look at that as an ability to give the consumer the control that they really want and need.

The second thing I'm really very concerned about is we've discussed a lot of the technical elements and as we go forward and really in looking at the architecture or looking at the APIs and the ability of more APIs to be out there, I have a great concern on the governance side of that.

And, yeah, there's a lot of bad players out there and there's a lot of people who might…you know APIs that do lots of things that maybe consumers might not want done with it and yes I have a lot of trust in individual responsibility, but sometimes there are bad players out there who use things inappropriately.

So it comes down to governance and I think we really need to make sure and need to know where that responsibility sits. Does that sit with the vendor in authorizing the use of an API? Does that sit in the governance element that…one of the levers that we have as a committee to recommend to ONC, to recommend to CMS? Where does that sit? And what are the consequences? Who develops those consequences? Where are we going with that? You know who is going to authenticate who that user of the API is? What authorization do they have to use that API?

So, when you get into the API realm you're opening doors that we need to discuss in depth how that information is used, whether how it's authenticated, how it's authorized, what happens after that? So, I don't know whether that's your committee or the Governance Committee, or where that goes, but that's a conversation this committee, as the ultimate Policy Committee, needs to really address.

We are really looking at Meaningful Use 3 and I think…and I agree with Charles I know that's kind of the end of the road or I don't know who said that, we have, under the HITECH provisions, we had three stages we could set and Meaningful Use may go on after this, but really we were tasked with addressing implementing HITECH through Stage 1, Stage 2, Stage 3 and our taxpayers want us to do that.

We've spent a lot of money, we're spending a lot of money. How do we get the best bang for our buck for the money? And to me, when you have…the best bang comes from interoperability. Increasing access to that information but really how do you spend…what do you do with the information? The bang for the buck comes from wise use of resources in the healthcare system and that comes from interoperability.

So, my suggestion is we need to focus and I'm a firm believer in carrots instead of sticks. The more we can put into…whether it's a certification process or whatever through Meaningful Use that targets interoperability the better we are and the better our taxpayers are going to like what we've done at the end of the day. So, I'd love your comments on all three…and the end of the conversation a lot to ingest, but I'd love your comments on that.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
A lot of good comments there, Gayle. The JASONs do call for metadata tagging as part of their model. They do not elaborate on what that means or how one sort of pays for, if you would, the cost of associating appropriate metadata tags with every piece of data.

In an ideal world everything would be tagged with usage restrictions that could be enforced at the user experience with some kind of policy enforcement mechanism and the technologies, there are technologies that exist to do that, they call for this notion of privacy bundles as a way to put that technology in the control of consumer's hands.

But the problem, at least with the report, is that it doesn't elaborate on the metadata tagging process or what those tags should say or do so we didn't dive into it. We acknowledged that it's an issue but we didn't really dive into it.

And then they get trapped in the confusion about what controls those tags would actually authorize the average patient and consumer to have. So in the regulatory framework that we have today a lot of the management of that data and usage of those data are carved out away from the consumer's control. So, it gets a little bit unclear, and they themselves stumbled on this, I'm being attacked by…they stumbled on this by sort of the naive association that consumers own their data which they then retracted and clarified that it's really co-manage the data.

So, one of the things we do call for is better education around what aspects of this data management process could be tagged by the consumer that would matter. In other words, where it would actually change downstream uses of the data and so I think there is an education process, there may be revisiting some of the regulatory framework that we have around HIPAA and the Common Rule and other things associated with who has access to that clinical data to drive forward the ability to know what to put in those tags because at the moment it's a little unclear. If the consumer says "I don't want this data shared" but in fact the provider has a right, under direct treatment of HIPAA, to share it it's a little bit confusing.

So, we do call for that increased clarity that would make the technical solution a more useful and meaningful solution. I don't know if that makes sense. Does that Micky make sense?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Yeah, absolutely.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So, Gayle that was a great intro to set us up for the afternoon in terms of the governance, the technology knot. Let me make a little clarification on the Meaningful Use Statute, at least my understanding is, it does not end with Stage 3 and it didn't even say how many stages for this immediate time.

From Neal's train metaphor the train carrying the money in is about to end and the train with money going out is going to take over. So, it's still…there is a financial incentive for people, but the Secretary has the discretion to continue it on.

And let me have Karen provide the final words, comments or questions?

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
Well, let me thank David and Micky again, and everybody who worked on that Workgroup and the staff as well it's phenomenal. I want to add a couple of ideas to why I think it's different right now.

I agree that the incentives and the business drivers have changed. I agree that there is hope that the technology has evolved. I would say that consumer expectation of the availability of their data when and where it matters to them with their consent is becoming a very strong driver and I wouldn't take it for granted that there is going to be an increasing interest and, you know, I think that because of the success of HITECH so far there is data to be shared. And so now we have digitized the content in Neal's words and so this is the push and the opportunity but there is a pull from consumers also.

I agree with Gayle and some others that the notion of open APIs and what that does to the ecosystem of potential trading partners for this data, whether its documents or discrete information changes the game and does really beg important questions around policy including privacy and security that I look forward to us taking up because it is a part of the overall roadmap that we will need to develop to give us a guide for where to go as a country.

And so your questions and comments were a perfect segue to what we'll take up beginning this afternoon and then have more in earnest going forward. But it's incredibly exciting to think about, but as David and others said, there are also concerns on the horizon and so we need to make sure we stay ahead of that to protect the people we are here to protect which is the American people. So, thank you guys, really appreciate it.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Thank you.
David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Thank you David and Micky, really your presentation and this discussion has been enormously helpful and informative even if you didn't read the entire book, the unabridged version.

Okay, so Beth and Elise are going to talk to us about the CMS rule on flexibility and I will make a little commentary about lunch. The scheduler graciously gave us time to digest our food this time but I think we've just earned our…we've just taken that away with our robust discussion. So, we'll see we might be going a little bit into our one-hour lunch period.

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
I just wanted to note that the agenda says that Elise Sweeney Anthony is with CMS but she is with ONC, just to…

Elise Sweeney Anthony, Esq. – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
That is a true statement.

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Make the record straight.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Beth and Elise, thank you.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
So, thank you, and we will maybe cut through things little bit quicker and I do apologize for this morning it seems that no matter how many times I do this drive it always comes out a different amount of time to get here so…we have some updates on the registration and payment data but we'll go through that relatively quickly because I'm pretty sure that's not what everyone wants to talk about.

We are up to almost 490,000 registrations. These are active registrations people who have signed and put their information into the registration and attestation system. Again…oh, thank you…that does not necessarily mean that they have participated in the program in the year in which they did register but it does basically register their intent to participate.

So, our numbers for payments for Medicare, for Medicare we are at about $16 billion that have been paid out and then Medicaid adds about another 8 or so, we end up at about just under $25 billion as you'll see on another slide.

Wanted to point out on the Medicare payments that we have made some payments for the 2014 reporting periods, you'll see those numbers there do not reflect the numbers for attestations. These are payments that have been processed so there is always a little bit of a lag on the payment processing time and the actual completion of their attestation time.

So, these are the Medicaid program totals. I want to highlight in that middle row the blue line over towards the end where you see Meaningful Use Program to date we are up to almost 60,000 Medicaid providers who have been paid in incentive payments for Meaningful Use not just AIU so that's a pretty significant improvement, we're getting that moving forward.

And then this is our total unique provider's page you can see that we're just over 410,000 unique providers paid through all the Medicare/Medicaid Program and that does include eligible hospitals and MAO participants.

We'll skip ahead a little bit. You can see that we are hovering just around 95% of eligible hospitals and CAHs that have registered for the program through the end of July. We have paid just about 92% of eligible hospitals for Medicare or Medicaid through the end of July.

Registered eligible professionals, you can see there are only about 10% of the EP population, again, keep in mind this is just the EP population as designated eligible for the program for the EHR incentive programs. There are other providers who may not be part of that pool. That does include just the eligible professionals who are designated for Medicare and those who are designated for Medicaid which have some slight variations and it does not include the total population that might be registered or might be considered hospital-based. So, we're at about 10% of that pool of potential eligible professionals that has not yet registered for the program.

And we're at just under 25% of eligible professionals have not received an incentive payment so we are at about 75% that have. So, this does include Medicaid, AIU payments as well but we are at about 75% of eligible professionals who could potentially receive a payment have.

So, our trends right now we're at over 92% of hospitals have received an incentive payment, about 90% of eligible professionals who could potentially participate in the program have registered.

About 75% of Medicaid and Medicare EPs have made a financial commitment and implemented an EHR. And more than 400,000 providers have received an incentive payment for participation.

These are the up-to-date, as of, I apologize for the funny date, the August 25th date, our holiday did throw off our data pool a little bit this week, but these are the most up-to-date raw attestation numbers. So, again, keep in mind these are just completed attestations. This does include completed attestations logged for payment and those who may be submitting CQMs electronically.

We have 8000 eligible professionals who have attested so far in 2014, just under 1500 of them are new participants and a little over 3000 of them have attested to Stage 2. We have 436 eligible hospitals, 136 of those are new participants and 143 have attested to Stage 2.

We expect to see the numbers continue to go up. You can see that these are significantly different than what we are getting last quarter. And as soon as we have some better data on what the measure by measure information is we'll be able to present that as well and give you an idea of how people are performing on the actual objectives and measures for Meaningful Use.

And so now what I think most people are probably interested in and I have Elise up here to help us. This is the…as you all know we released an NPRM back in May it was a joint NPRM between CMS and ONC to provide some flexibility on the use of certified EHR technology for the 2014 year for an EHR reporting period for Meaningful Use.

The reason for that was that over the course of the past year or so we've been doing a lot of tracking on the availability of certified EHR technology and there are a number of factors that we're impacting delays in that availability and the availability for providers to be able to implement.

So, in May, on May 23rd we published an NPRM and put it out for public comment. The public comment period ended on July 21st and this past Friday we published a final rule. We did adopt the provisions of the NPRM without modification. So, do you want to do the walk through?

Elise Sweeney Anthony, Esq. – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Sure, so the way the flexibility rules are set up is it allows flexibility to providers in how they attest and what CEHRT options they use to do that. What CEHRT option you use impacts the objectives and measures to which you would be reporting to and also to the CQM base that you're doing.

One of the questions that we've gotten is, can there be a mix between objectives and measures between different versions and due to operational constraints of the systems at CMS that is not the case. So, as I walk through these just keep in mind that the CEHRT option you choose and the corresponding objectives and measures is a complete set. You have to think of it in terms of having to do all that is within that bundle.

So, if in 2014 you are scheduled or were scheduled to attest to Stage 1 then you have a couple of options of what you can do. You can choose to attest using 2011 CEHRT to the 2013 objectives and measures for Stage 1 and to the corresponding 2013 CQMs.

There is also a combination option. So, for example, if you started your reporting period and in the beginning you were still on 2011 CEHRT but by the time you got around to the end you are on 2014 CEHRT you can still report for that reporting period using both of those CEHRT options.

And the way it would work is that the CHPL which is the list of products that ONC maintains would be able to provide you with a number that corresponds to both…one number that corresponds to the 2011 CEHRT and the 2014 CEHRT that you used for that reporting period.

So, if you use the combo option and you were scheduled to report to Stage 1 in 2014 then you can report to the 2013 objectives and measures for Stage 1 and the corresponding 2013 CQMs or you can report to the 2014 version of the objectives and measures for Stage 1 and the corresponding 2014 CQMs.

The last option you have is you can report using 2014 CEHRT to the 2014 Stage 1 objectives and measures. I'm sorry for the redundancy in terms here but it's important in terms of actually understanding how this would work and the impact it would have on providers. So, those are the options if you were scheduled to report to Stage 1.

If you were scheduled to report to Stage 2 then you have a different set of options and just for clarity purposes in the rule there is a chart that lays out exactly how this would work and what your options would be. We know that it is a bit confusing but we tried to make it as simple as possible.

So, if you were scheduled in 2014 to report to Stage 2 you have a number of options as well. You can still use 2011 CEHRT and report to the Stage 1 objectives and measures, the 2013 version of Stage 1 objectives and measures and the corresponding 2013 CQMs.

You can do a combo option as well and report using 2011 CEHRT and 2014 CEHRT and you'd get that special number from the CHPL and then you could report to the 2013 Stage 1 objectives and measures and corresponding 2013 CQMs or you could use the 2014 Stage 1 objectives and measures and the corresponding 2014 CQMs.

The last option is you can do 2014, use 2014, report to Stage 2 it doesn't matter if it's 2014 in that case, but Stage 2 objectives and measures and the 2014 CQMs. So, that's kind of as scheduled.

And then the last option with 2014 CEHRT you can do two options. You can do Stage 2 as scheduled with the 2014 CQMs or you can do Stage 1 under the 2014 objectives and measures with the 2014 CQMs.

So, I think the key catchall here and the question that we get a lot is if you were scheduled to go to Stage 2 in 2014 can you still report Stage 1 "yes" and the answer is yes there and there are a number of ways you can do it. You can do it with 2013 Stage 1 objectives and measures or the 2014 Stage 1 objectives and measures. So, that is how it works.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
So, that is not…it's not at all confusing. In the final rule there is a chart that looks a lot like this slide. There is also a set of examples and there is also an actual section where we've provided further clarification on how attestation works, that was one of the primary comments that we received during the comment period of how would this actually work, what will happen when I go to attest and what documentation do I need?

So, in the final rule, and I can do a quick walk through of it right now as well, it does quite literally give you a step-by-step statement of how that would work. The attestation system's, as well as Elise mentioned, ask you for your CHPL number, so you would take your numbers for your certified products, you put in the name of your product, get your number out of the CHPL and put your number in. Your number is intelligent, the registration and attestation system will recognize from your number whether you've just put in 2011, whether you've put in a combination of the two or whether you just put in 2014. So, it eliminates you having to know that off the top of your head part of it.

So, that would then direct the provider into one of two paths. The path that this is intelligently already identified 2011 or 2014 in which case it would move you towards the objectives and measures that are available for either of those two just using those options or it would take you into a middle path that says you have put in a combination certification number, do you want to do the 2013 definitions or the 2014 definitions of objectives and measures.

We have some resources that we're creating to help providers figure out which to do and how to work through that. And then each attestation option would then be pretty intelligent. It will sort of…it makes it hard for a provider to make a mistake or not know what they need to answer. It will actually walk them through each question, each objective and measure that relates to the option that they've selected and that is laid out in the rule.

So, there are a couple different ways, if you rule a couple different ways, of being able to see how it works we did try and cover our bases since people understand things in different ways and it is a little bit confusing.

We can go to questions. I can probably pre-empt a couple of them just based on what I know the most common comments are. If I don't hear them in questions I'll definitely still bring those up.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Why don't you go ahead and pre-empt them.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
Okay.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
That's fine.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
Just in case people want to get a lunch at some point. So the most common comment that we got was actually a misunderstanding of the timing for attestation. A number of providers and a whole bunch of commenters from, you know, providers that are hospitals, EPs, associations it was pretty across the board not understanding the timing of attestation which is actually pretty understandable for 2014 given that the reporting periods are very unique in 2014, we've never done quarters before, we usually do 90 days into the year so it's one of those two things.

And the quality reporting programs have different times that you attest at the end of each reporting period. So, for Meaningful Use you can attest anytime from the end of your reporting period that you select up through the end of the open attestation period for the year.

So, there isn't a requirement that, you know, if I choose the first quarter I have to attest within 60 days of the close of the first quarter that's not the case. You can choose the first quarter and attest up through February of 2015. So, we don't have a reporting period that opens and closes at the end of each quarter. Some programs do. So it isn't all that surprising that people are confused. Ours opens and stays open the whole year.

So, a lot of providers were concerned that they wouldn't be able to use an option if they suddenly discover on December 15th that they still don't have 2014 in place when they thought they would. The answer to that is that they could potentially go back and look at their data from earlier in the year.

For example, if they still had their 2011 in place on January 1st of 2014 and had a reporting period that they still had all their workflows in place and still had all their 2011 firing on all cylinders, and had all of their data collected they could potentially attest to that data even if it's at the end of the 2014 year. So, they would have up until February 28th of 2015 to attest to that data.

So, that was actually the single biggest misunderstanding or comment, or question is how would that work? Can a provider use a different reporting period, does it have to be the last one? The answer is "no" they can get any EHR reporting period in 2014 and they can attest to it through the end of the year.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, good. Marc?

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Okay, thanks that wasn't my question. And you two did a really nice job going through this so I'll start with that but it does go to kind of content. I clearly understand the JASON Report better than this and it's not because of you two.

David McCallie, Jr., MD – Senior Vice President, Medical Informatics – Cerner Corporation
I appreciate that.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Yeah. My question is with these changes what's the anticipated impact on the 2014 attestations?

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
So, we expect that we will have a lot of people who would not otherwise be able to attest who will now be able to, that's actually the single biggest impact. In order to be able to judge that we had looked at a whole bunch of different projections and Elise may have the numbers in her head better than I do, I can't remember…we've looked at a lot and came up with somewhere between 25 and 30% of providers if we did not provide some sort of extension may not have 2014 Certified EHR technology in time for an EHR reporting period in 2014.

So, in terms of what this does, we don't expect this to impact the attestations of those who have 2014 because they would be doing the same thing either way. What we're looking at is a pool of people who would not otherwise be participating who now have the opportunity to do so. Until we start seeing that happen it will be really hard to judge how many of them are able to do so.

We did try and make this a pretty wide path to allow for a pretty wide range of this is my circumstance and my facility and I can use this option. But we do expect that we will have better attestation numbers across the board because people should be able to find an option here at least we hope that a good number of them will be able to.

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Okay, but we don't…you do have a number apparently Elise that you think you will project. I mean, the numbers are pretty…so if we go back to the first part of your presentation, the numbers are very low for particularly Stage 2 attestation. I mean, they're like, what 4% of what should be, you know, currently going for Stage 2.

I'm just wondering if we have a goal. I mean is it 10% by making these changes we should now get 10%, 50%, I mean, there's no way we're going to get 50%, but, you know, I'm kind of going to why this set of rules, this very complex set of rules when there were some pretty obvious ones that we decided ONC and CMS decided not to pursue that could have had a much bigger impact.

Elise Sweeney Anthony, Esq. – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
So, I wouldn't focus as much on the numbers. I think we looked earlier on at projections to try to figure out where not only stakeholders were but very specifically providers and the impact of the availability of product and what that was turning into for providers.

I think in a lot of ways we won't see kind of how this plays out until the end of the reporting year. So, there will be some time for that. One thing to think about is that this really provides kind of an opportunity to keep providers on the track.

So, in actuality it really just extends the use of 2011 CEHRT for kind of a couple more months until we get to 2015. So, in terms of the added functionality that's in 2014 CEHRT we expect to see all of that coming to fruition in the 2015 reporting year.

But the goal was really to make sure that those providers who have done kind of what they're supposed to do, they're working on transitions of care, they're on the train, they're on the track, but because of some work that needed to be done maybe on some of the systems or some corrections that needed to occur, they needed a little bit more time before they could actually get their systems fully implemented and operational. So, that's kind of the goal in terms of the impetus for how we got to this piece of regulation.

In terms of the percentage that we would expect to see I don't know if we have a percentage because it changes so quickly as products are, one either come onto the market but more importantly as fixes occur and that's a lot of what we've seen in the last couple of months is a product maybe on the market but then there's a fix that needs to happen or there's a workflow change. So, I think all of those are the reasons why we made it so broad to capture all of the different reasons. So, percentage, pinning it down to just one probably is not the most effective way to kind of look at it at this point.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
So, I'll also add that there may have been discussions about other potential options or policies. There is a very specific reason we chose this. We know that it sounds confusing but what this effectively does is says no matter what stage you are in, no matter what year you participated in if you have certified EHR technology you can use it to meet Meaningful Use this year. So, that's sort of what it boils down to.

There are "yes" options that relate and some of that is because the technology has to support certain functions, but basically we're saying Stage 1, Stage 2 use the software you have available to meet Meaningful Use and in terms of being able to do something that's something that we could actually affect pretty quickly.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Thank you. Final question, Terry?
Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Well, I have three, so I guess I only have one. And some of them I don't think we can answer its more the impact. So, I'm actually intrigued Elisabeth by what you just said. So, use the software that you have to do something, to do Meaningful Use, I've obviously got that.

I think my question is do we believe there is any unintentional consequence of doing this that we're going to slow down stuff by facilitating this other thing.

Secondly, to follow-up on what Marc said, do we know what success looks like? Do we have a…what's our goal? And this is probably more a question for ONC given how quickly everything is transpiring. I'm hoping we have a goal set whether we're going to be able to meet it or not and it may be that we're adjusting it just like we do software development when we change what our goal is.

And thirdly, what do we believe and this is the one I don't think we can even address what the impact of this knowledge should have on Meaningful Use Stage 3? Because I think we're getting information that we should be using to help inform other decisions and I'm not sure we've figured out how to do that. So, I don't think you have to answer any of that but I'll defer to Paul because of timing.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
So, we can go very quickly on a couple of pieces. First off, again, repeating on the impact on other things. We're talking about providers who would not otherwise be able to attest. So in the rule it very explicitly states that this is an option available for those who are not able to fully implement because of this issue with software availability which we know is a real issue and as we've mentioned there are lots of impact factors including, you know, us, so, being aware of that and cognizant of that.

So, these are providers who would not otherwise be attesting. We don't believe that there is an impact on providers who are moving forward and that's part of the reason to do this is to keep the providers…the other pool moving forward, still attesting to things like doing drug on drug, doing medication allergy checks, doing, you know, clinical summaries all of the things that are part of Stage 1 and were part of Stage 1 in 2013 that are still really important things.

Second piece was a goal, an estimate. We did have preliminary estimates that had us getting…that this three month extension took the 25-30% and cut it down below 10. I think we still want to do that the problem is that we don't have, without calling each individual provider, a really good way of putting a benchmark on it. So, that's really our biggest challenge in coming up with a goal on numbers.

Elise Sweeney Anthony, Esq. – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
No I think that's right and I think the other point you raise is how that effects kind of the adoption overall and the path for Health IT. I think we're still on a good path because, like I said earlier, this is about three month window difference in terms of when the last opportunity that providers would begin to move to 2014 CEHRT, right, so let's say I was going to report, I'm a provider and I'm going to report in the last reporting opportunity which would be October, right? That means before October I was on 2011 CEHRT.

So, if I do the switchover right then that's really only a three-month difference so I know it's a complicated concept but really when it comes down to it the window that this impacts is about three months. So, by the time we get to the beginning of 2015 we've lost maybe three months but we've gained the opportunity to keep those providers on the track that might have fallen off.

And in terms of going towards interoperability and making sure that we're keeping providers working together and moving towards this goal we think it's really important for those three months to exist to provide that stretch to get them to 2015.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Can I ask one more question, I'm sure the three months was predicated on some understanding of what the marketplace was doing that this was what you needed?

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
It was also a preemptive thing that when we were working on Stage 2 we came up with these strange reporting periods for 2014 based on preliminary conversations like this where we talked with system developers, we talked with certification bodies, ONC and CMS powwowed on it trying to figure out how long it would take throughout the year and how would we get meaningful data still out of it and we came up with the single reporting period. So, when we looked at it this way sort of saying, well we're really pushing off the single reporting period by this much and looking at the wiggle room there, and that's how it comes out that way.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Good. Okay. Well thank you very much Beth and Elise.

Elisabeth Myers, MBA - Office of E-Health Standards and Services - Centers for Medicare & Medicaid Services
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
It helps us understand the flexibility rule better except for Marc.

Multiple voices

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Right, okay so now we're open for public comment, please?

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Operator, can you please open the lines and while we open the lines if there is anyone in the room who has a public comment please come up to the table. Just a reminder that public is limited to three minutes.

Alan Merritt – Web Specialist, Digital Communications Services – Altarum Institute
And if you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

Mari Savickis – Assistant Director, Medical Affairs - American Medical Association
Do I get points for being a frequent flyer? I think I need to take high blood pressure medication before I come here…okay, so these are totally unscripted comments but they speak to the data which I've been busy crunching all summer so for what it's worth I'll give you the AMA's take on this.

Obviously, I didn't get my calculator out and do the latest, but I think what did we say, like 3300, I'll focus on the eligible professionals because that's who I represent the American Medical Association.

I think the data from, I want to say it was May or June I don't have that in front of me but it was early this summer, had the percent of participants in the program at 68%, but that was Medicare and Medicaid, okay, so 68%.

Now when you break it down to Meaningful Use it was 50% of eligible professionals and of the 50% of eligible professionals it was 45% doctors. For Medicaid it was 83% of eligible professionals had participated and 58% were doctors.

So crunching all these numbers, and I can provide more detail if you'd like because I have a spreadsheet, we are estimating that it is going to be between 45 to 54% and I think that number may have changed slightly because I had 231 eligible professionals successful in Meaningful Use and that was early this summer but we're only up to 3300 so it's not a big jump, so I'd say 50% are going to be at risk of dropping out or not participating.

And there is a whole lot of contingencies that need to be factored in. So, while I do appreciate that the final rule that CMS and ONC just published focused on the fact that you have until February 28th to attest to get an incentive payment, if you are new and you don't attest by October 1, there is September 30th is the day that the 90 day reporting period closes for the last reporting period, oh so confusing to follow. July 1 to September 30th last opportunity and then the next day you attest October 1st to avoid the penalty.

So, there are a lot of question marks here, right? You had to…then we don't know how many people got a hardship that's another question mark. So, best data from AMA crunching your numbers is 50%. I'm open to feedback, did I get my numbers wrong anyone?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Just a reminder Mari it's public comment.

Mari Savickis – Assistant Director, Medical Affairs - American Medical Association
I know you can ask me questions. I'm always open to it okay, I feel like lonely sitting up here. You can respond to Mari in the AMA if anyone wants to e-mail me or call and discuss it I am happy to because my e-mail address is too long. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
That was Mari Savickis.

Mari Savickis – Assistant Director, Medical Affairs - American Medical Association
The one and only.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
From the AMA. Is there anyone else in the room with a comment?

Mari Savickis – Assistant Director, Medical Affairs - American Medical Association
You've got to have humor, come on.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Is there anyone on the phone with a comment? No, so, we're all set, we're ready to go to lunch.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, you can use your points to upgrade to first class Mari next time. All right, so, we are going to take a break for lunch and reconvene at 1:00 p.m. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
If everyone could take their seats we're going to get started. If everyone could take their seats we're going to get started, thank you. Jacob…operator are we open?

Operator
All lines are open.

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

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

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
He's not here.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Is he going to be on the phone? Is Chris going to be on the phone or…

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Yes, we're all set.

Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services
It's Chris on the phone he's not able to…

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Chris is traveling he's not going to be here.

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

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

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well, welcome back from lunch. Thanks for the very hearty and robust, and informative discussion we had before lunch, and thanks to Gayle for doing the transition between the technical challenges we have in achieving interoperability and transitioning over to the non-technical. Fortunately, both JASON and the JASON Task Force was able to say "well, that's not in scope." All the other stuff legal, cultural, social, privacy, business challenges that wasn't in their scope.

So, we look forward to our afternoon discussion with the Governance Subgroup who does have all of those things as in scope and we've found from our hearings on interoperability that those were front and center in terms of big barriers, in terms of preventing or at least impeding data from moving from one place to another where it needs to go.

So we're anxious to hear what you've been talking about and then we'll have a discussion and there needs to be some cross chatter between I think…the JASON Task Force, they brought forward a number of things where the technology may or may not be there in order to implement some of the things particularly related to privacy. So, if there can be a little bit of cross chatter in this next month then we can put the two recommendations together as they feed to the interoperability roadmap of ONC. So, I understand Chris left you standing for the presentation.

Carol Robinson – Principal – Robinson & Associates Consulting
He did indeed.

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

Carol Robinson – Principal – Robinson & Associates Consulting
Well, thank you very much. My name is Carol Robinson for the record and my background to present to you today was as one of the first class of…members of the first class of state coordinators for health IT in the State of Oregon a job that I held for about three and half years prior to entering the consulting field about a year and a half ago.

And so I want to thank you for having us here today and I want to express a deep gratitude to the Subgroup members and to my Co-Chair, Dr. Chris Lehmann. Dr. Lehmann sends his apologies for missing the meeting today. Unfortunately he had a long-standing conflict involving a sailboat in a distant sea. So, I want to just…as you look at the list of Subgroup members acknowledge the rich combined set of experience and backgrounds that is informing our work as the Governance Subgroup.

So our charge was really to identify substance, scope and process that ONC should use to implement an approach to establish some "rules of the road" necessary for information to flow efficiently across networks and we early on decided that efficiently should really be efficiently and securely, and with effective privacy boundaries as well.

So that substance though is really the "what" of what ONC might do in terms of governance with a set of private sector partners as well and hopefully other federal and state organizations. The scope is really how much of the "what" should be tackled and the process is, how might ONC approach this?

And as you well know and as do I having been involved in many of those conversations governance has been discussed in many forums for several years and we are cognizant of the many interests and influences who have been involved in those discussions over the past several years.

And I will also say in terms of that I've been really trying to conceptualize a visual that maybe you'll see at some point or certainly the Subgroup will about how those influencers and interests overlay each other and where, if there is an overarching governance framework, that ONC can implement as part of the 10 year roadmap, how to involve those interests and influencers in appropriate roles along the way.

There are thorny issues embedded in all of the work and I am just going to kind of skip through some of the slides, here's our work plan time line which is really just showing the compressed nature of what we're trying to accomplish in a very, very short period of time.

And I will say that in the absence, I'll go back to this timeline again, because in the absence of a clear starting place for governance at the national level many of us and I say "us" meaning state HIT officials across the country many regional HIE programs leaders who were grappling with implementing something that was very, very new and without rules or rails, or laws in many cases, and we felt like we were obligated to explore governance to deal with what looked and felt a lot like the Wild West and probably still does in many ways.

But what has happened is that we have a patchwork quilt that isn't manageable now for many multi-state health care organizations and it's going to become less manageable over time so the task for the Governance Subgroup in this very short timeframe that you can see here is daunting, but it's strategically correct and the reason why is that giving us a timeframe of basically eight weeks versus the 10 years that ONC has existed could be viewed somewhat cynically, I might say, but we're not choosing to look at the task in that frame because it was recently observed in one of the conversations that we've had around governance in a governance framework is that perhaps we might be a little bit late in terms of having this really serious discussion about where to go on a governance framework, but it may also be true that much earlier than now might have been somewhat premature. So we think this is a strategically correct timeframe and we will come forward with a set of recommendations for you on October 15th.

But my presentation today is really going to be much more high-level than what you heard from the JASON leadership, Task Force leadership this morning because the reason is that we have first of all been at work for a little bit shorter amount of time than the Task Force and it would be inappropriate for me to do too much foreshadowing of a solution before our conversations have really gotten to the place they need to as a Subgroup.

As you can see, I mean, you're very familiar with the interoperability goals of the 10 year vision and this in a very basic nutshell, for those who may be a little newer to this concept, the three year basic interoperability goals would be ready and usable to send, receive, find and use basic health information by 2017. And that's regularly that's not occasionally, that's all the time send, find, receive, use that information. So that even in and of itself is a laudable goal.

I've heard a number of people say 10 years is a really long time and that is true but I would also say that if you look at the goals in the six-year timeframe by 2020, the goals are highly functional health information exchange and by 10 years in 2024 supporting a continuously learning health system where research and clinical decision support is far more robust.

We are gamely taking on the task and we don't intend to walk up to the edge of the ocean and peer at the crashing waves and look at the sharp rocks along the shore and come back and report to you about that, that's not our intent.

We intend to build the frame of a ship to use my Co-Chair's current state of affairs where he is hopefully not listening to this will build that frame of a ship that will need a lot of additional work to become seaworthy much far past this Subgroup's charge.

But I do want to assure you in the rest of my presentation and our following discussion that while still high-level we have a very strong and I think some people have commented on some dramatic heritage in both my Co-Chair and myself and so I think we'll get it done.

We had two listening sessions five hours total as well and similar to the JASON Task Force it was set up very quickly and I have to give kudos to our ONC staffers Kory and Kate, and Michelle in terms of getting a terrific set of experts. Thank you to everyone who provided testimony and feedback to our Subgroup.

I think, as Micky Tripathi said this morning about the JASON listening sessions, we were able to get feedback from a broad set of stakeholders that while not perfect was substantive and illustrative of the dynamics in the HIE market right now.

And so I won't go through everyone's name but I will say that we divided those sessions into five panels where we received feedback from provider, payer, patient perspectives from exchange service providers. We received state and federal perspectives, governance entities, organizations that are currently serving to create a patchwork of governance for HIE and then we looked at other governance approaches across different industries. And I'm going to just give you a quick view of what we heard.

So, the first…this first slide really goes across the varying efforts of policy, frameworks, technical standards and focuses that are under way right now at the state and national levels, some are operated of course by states, some are by contract and data sharing agreements, some are private and some are regional.

And while I would say that there are similarities across that and we heard that similarities do not mean the same. And the non-sameness of the variability, I should say, of those governance approaches has created some strong…some important learnings for I think us as we go forward at this timeframe that while accreditation and certification are subcomponents on bending of the governance entities those are being approached very differently in different places.

And so, as I mentioned earlier, provider organizations functioning in multiple places or patients needing their data to move between state to state have a cacophony of policies to figure out and often times we heard from one organization that is operating in about 22 states supporting FQHCs and regional or RECs across the country had a full-time, multi-FTE effort to just try to figure out what the laws of each state really are and to try to meet those. So, I think that is an important lesson that we heard from our listening sessions.

And then on the second summary slide we definitely heard that stakeholders see an important role for ONC in the governance of HIE but they have varying perspectives on what that role should be. So I think that sometimes it's just important to acknowledge the obvious. This is enormously complex and you hear the word "tension" we heard that word used many times this morning.

Not everyone is in agreement. This is stating the obvious, about what's the substance, the what, the scope, the how much what or the process, the how that ONC should take in approaching governance and we definitely heard that.

We also heard that while there was some admission and acknowledgment of the technology issues that are inhibiting exchange and slowing HIE across the country some of those…the variability in C-CDA have been, you know, documented by researchers earlier this spring.

The implementation variation of Direct is just becoming clear in the market and it's disappointing, I guess I would say, to those of us who have been and continue to be strong supporters of the value of using Direct across a broad-based coordination of care environment and then propriety standards of course are also impeding broad interoperability.

And so we kept hearing about the aligning of incentives would be essential and I think that there was some optimism in terms of our panelists in terms of where some of those incentives are lining up, some states are creating some real new and powerful leverages across Medicaid market, the ACOs used in a very broad term for all value-based payment models in healthcare I think are really taking hold, patient's centered medical home and others. But again, stating the obvious there were a wide variety of perspectives on where the differing business interests really ended up being expressed.

So, in summarizing some of those additional barriers I would just emphasize that barriers to exchange exist at all levels. And comments address the barriers of differing forms of governance cost being one, the accreditation and certification, the rigor, clarity of governance was another important comment that we heard frequently and then the variability as we've mentioned.

The presenters, by and large, also addressed other barriers facing the implementers of HIE which I think are very important and very real, and I think that acknowledging that providers from the single doctor in a rural community to multispecialty practices, to large IDNs across the country have very legitimate resource challenges when they are thinking about how to address the workflow changes that they need to implement to really participate fully in HIE.

But, then I go back to the elephant that's sitting in the corner of the room, in every room, that any HIE governance discussion takes place in, and every past and present state HIT coordinator would agree with this, market forces are really the most difficult barrier to effective and widespread HIE and so with that growing movement toward value-based payment models in healthcare we believe that those barriers will continue to change and in terms of the timing and the strategic correctness of talking about governance now, interoperable HIE with rules of the road need to be in place to meet that new market. And this is not a chicken or egg situation. The egg must hatch inoperable HIE for the chicken to survive.

As far as other industries that we talked to one thing really came across now we heard from the administrative side of healthcare, we heard from banking, NACHA serves as a governing organization for the Automated Clearinghouse Network with two operating entities underneath. We heard from telecommunications, the FCC and we heard about the Internet governance.

And I would say that there were a variety of governance approaches tailored within each of those industries and markets and one thing that came across very clearly is that one size does not fit all.

And so where we have all heard that they complexity of healthcare is much, much different and I think that I would agree with that, and I think most of the Workgroup members, while struck by the success of some of these industry-driven governance models also understand that there are more stakeholders, and holding stakes I will say, in healthcare than any of the other industries that were brought forward.

I would also say than the voluntary approaches that we heard about from other industries are occurring very successfully in markets where noncompliance to those voluntary governance policies are actually a non-issue and so when you get to that tipping point I think a fully private sector industry-driven governance model can be very successful and that's what we heard.

I think point four on this slide is also very important, because one thing that we really heard about and I think that the Workgroup, the Subgroup is really taking to heart is around the need for repeatable processes built within any governance framework. And those repeatable processes really need to be durable to a changing environment.

And so the next slide here, and this is a little bit of a summary but it needs to be taken in context, and all the bullets on this slide I think need to be evaluated individually and then together. There were great points made by panelists some related to very known and vexing issues on patient matching and provider directories that we've heard a lot about that ONC has done some really good work on and needs to continue to do work on.

A common theme across most of these points you'll see the word standards used and the common theme is the emphasis on standards.

So, when you are thinking through the feedback that you're getting from both the Governance Subgroup and the JASON Task Force, I urge you to think fully about governance being not just specific to policies around actions, but also thinking through the idea that there is a governance process in some way to manage effective standards and I should say standard standards. So, that's something that has been coming up in our conversations at the Subgroup level.

And finally, I think the last summary slide on the listening session has some other very important points listed here. It's not a surprise and it shouldn't be a surprise that meaningful granular consent should be a goal and that came up again and again and there are some ways to get to that.

There are also some very important and specific suggestions that were made by panelists around terminology mapping and message conversion and computable interoperability taxonomy and other very specific ideas that I think can be taken to heart.

One of the things on this slide that I really want to have everyone take a quick look at and it's really the second bullet where the idea of promoting the emergence of improved tools for enabling exchange among unaffiliated entities for incentivizing desired outcomes for prioritized use cases, okay, that was an excellent summary, rather than specifying specific requirements related to how.

And so as I was mulling this particular summary of at least one panelist's viewpoint I would say that we need to make sure that as ONC focuses on incentivizing the action of exchange that we also have to ensure that the action of exchange is not running against the goals of interoperability and that's where we need to be very careful about evaluating everything on both sides of that broad scale of perspectives in terms of the listening sessions and our feedback.

So, that brings me to tell you where we are at this point and I will say that…I'd like to start by saying that I thought about wearing a hard hat and putting up a construction zone sign for this presentation because this is really a work in progress. And I do not want to get ahead of my esteemed colleagues on the Subgroup in terms of projecting or predicting a final outcome. We have three more meetings and really we're just getting to the meat of our discussion.

But back to the boat and sailing analogy we think that in terms of the goals and principles for a governance structure will really be, as I say, will create that frame of a ship that we're building to sail across those rough seas. So, imagine the dry dock where we are building that right now that's where we are at.

And the next steps we will need to outline the process needed to solve the problem. So we are agreeing, we're working to agree on the set of problems to solve and the governance process to get there and we clearly don't have enough time to do this in great detail, but we know certain things. We know that the world isn't flat and so we can map to those things that we currently know.

I was thinking about maps in terms of the third bullet here mapping the structure and process recommendations to ONC's 10 year interoperability roadmap, which isn't written yet so that is hard for us to do. So we have to be very flexible and create a plan that will have enough detail and not too much. And so we will give you a high-level process map is I think what I can commit to today.

We started off evaluating our work based on governance problems and these were divided up into eight sections, I've condensed them because it fit better on the slide, to six, but it really includes really most of the major problems impeding HIE are reflected on this slide and that includes encryption, LOA for ID proofing, some of the things that I heard you asking about today in terms of authentication, authorization, of course we talked about consent, meaningful choice, policies of when to respond and with what data, those operational and business policies and practices that are clearly impeding the market, variation of user fees, the patient matching methods and the processes to resolve duplicate records.

The multiple trust bundles around certificate management, the variation and cost for accreditation or certification. There are disclosure audit requirements that may or may not be being implemented effectively across organizations conducting HIE right now. Of course we talked about the multiple governance bodies and there are also questions around liability that I'm certainly not qualified to answer at this point.

But the bottom line is the multiple sets of problems also end up with the multiple technical standards development efforts and so we are operating without an industry portfolio approach and so that's I think indicated across many of the problems.

So, I am sure you've all seen this slide many times and in many different kinds of planning meetings that you've been part of and it's the age-old fable about the blind men feeling their own part of the elephant and this has really been part of our conversation is what are we really talking about when we talk about HIE governance.

The analogy seems to me to be perfect because this…we fall into any conversation we get down into the weeds and all of a sudden we're not sure whether we're talking about the trunk or the ears, or the tails, or the legs and so we've been working through that as a Subgroup. And we have really been trying to think through the constraining, the grouping and how to look across various use cases of exchange to see if we can segment this work.

And so we've come up with this slide and it has had a couple of iterations over the past couple of weeks and, you know, when you say directed exchange we do not mean to be just talking about using Direct but push exchange and we know that there are many types of queries that are going on in many models and then you heard more this morning about consumer mediated exchange but what we see when you look across, horizontally across the verticals of the use case is that there are similarities and there are some issues that are going to run across and likewise each use case will have some unique business operational and technical governance needs. So this is where the Subgroup agreed to land on at our last call last week, about a week ago.

And so what's next? Well, before we go to that, I want to share with you a few of the, I thought, really insightful comments that came up on our last call. And these are slightly paraphrased but they're from my direct notes so I think that they're close enough that I can utilize them effectively and honestly in terms of this.

So, one is that I think we are in agreement that any governance framework should be built with highly repeatable processes for adding new use cases and whether we come to you with a segmented approach or more of an overarching approach I think that you will see that as a really important theme of our work. Because the various use cases, some that we know of now and some that we haven't been developed yet will have overlapping business and technical guidance needs.

One of the interesting comments that came from a Workgroup member was that lots of industries have managed to change over time and this is something that a couple of my smart siblings asked me about several years ago, they were like "what, what's your job, what are you doing and why is that not working, you know, what" because they're in manufacturing or other industries and standardization of processes has occurred at a much different rate and data has been used much quicker to drive business decisions and business processes.

And so I think walking away from that healthcare exceptionalism mindset is something that this Subgroup is committed to doing and saying it's not something that we need to stand on the shore any longer and described that we really need to dive into the ocean and try to make progress.

So, I think that there have been…there has been substantial progress made distilling business needs and this comment, the fourth bullet, was made around administrative simplification standards and some of the work that WEDI and other groups have done to ensure that processes for processing claims and creating payments are standard and are working.

And so one Workgroup member suggested that we substitute the word "clinical" for "business" and then put our, and I say "our" in the pejorative full use our interoperability decisions on a time-limited tract to get done.

And so then finally, one of the questions asked was there is this urge to simplify governance to a couple of use cases and it goes back to that elephant analogy because how do you wrap your brain around this? It's really big and unwieldy and it's thorny as we said and so we need to ask if getting to a 20% solution will be enough.

So, here's our process that we're going to be undertaking for the next few weeks and presenting on October 3rd to the HIE and Interoperability Workgroup and then again here on October 15th and so some of our sample questions, what should ONC do and/or not do? How should we map those framework recommendations to existing efforts and are there aspects of HIE that would be set back by a system or systems of governance?

There are other questions that we will be thinking of and walking through, but as we move through the next three weeks this is really the methodology that we'll be using to finalize the recommendation for the governance framework.

So, finally, I wanted to end and I was thinking about my elephant that we're all feeling and I was thinking about the term elephant architecture so I Googled it and I found this picture but I also found a number of technical architecture sites where elephant architecture is actually being used and it's a term and it is a model for developing technical architecture frameworks and so low and behold once again it's confirmed that there is no original thought.

But when…Karen you mentioned the word sustainable, flexible and durable in your opening comments this morning about the 10 year framework for interoperability. Those words really rang true for me.

And at the risk of overdoing the elephant metaphor I think we can agree that an elephant is a very strong example of durability. So, that's the goal I will offer in the next several weeks the Subgroup will be continuing to work on the framework and we will now be working on a durable governance framework to bring back to you on this timeline. So, here's our next steps and I'd be happy to answer any questions.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Good, thank you Carol. Let me ask the committee for questions/comments? Christine?

Christine Bechtel, MA – Vice President – National Partnership for Women & Families
Thanks Paul. Thank you very much Carol this is really helpful. I have sort of a very basic level, it's not even a question because it's more of a request I think.

As I'm looking at the work that you guys have done and the work that was presented to us this morning there are substantial touch points and overlap and it's not clear to me completely where sort of one begins and the other ends.

And I'm wondering if it might be helpful as part of the October 3rd draft set of recommendations to be really clear about what you mean by governance. I think governance is something that people sort of, you know, it's like a Rorschach test, you know, sort of like a patient and family engagement term, you know, right it means different things to different people.

So, I think it would be helpful to really be very concrete about what you guys are focusing on and then we can better understand well how does this relate to the technical side of, you know, open APIs and all this that we've been hearing about this morning, it would just be very grounding for me.

Carol Robinson – Principal – Robinson & Associates Consulting
I appreciate that.

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

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
You really have taken on the elephant have you not? I was just curious about process during the listening sessions. I didn't notice…you had those that were involved, you know, who gave you comment and who were partitioned for comment.

In terms of looking at the banking industry what I wanted to know, I mean, there's probably nothing more personal than your medical background, your medical history and everything like that then your financial. Nobody really likes to divulge, you know, how your finances are being managed.

But yet out there in that market, in the banking industry, there are a number of applications that I as a consumer can allow them to go access my 401K, my past tax returns, even my active banking now, even credit cards and things like that.

Did you petition any application developers that have had experience with that in looking at those different ways for consumer facing products to kind of create a parallel idea as to this is how we could actually manage it in that avenue in that respect?

Carol Robinson – Principal – Robinson & Associates Consulting
You know that's a really interesting question and so when we started talking about let's…we want to hear from other industries and it was something that came up from all of the Subgroup members. So it was something they really felt very strongly about.

And so the analogy of banking has been used many, many times since I entered this field. And you think about the transactions for your data to be shared in multiple ways. What we actually heard from NACHA is relatively constrained in terms of debit and credit transactions essentially across their network and the relationships that are put into place and the standards that have been put into place for those transactions, for the network itself, for the ATMs, you used to have to look for the right ATM, you know, years ago, I'll show my age, but, you know, now it is standardized and so we were thinking about it in that format.

But, I think that a number of us were very taken by the work that NACHA has done with full support of the largest entities in banking and so I think that is a model that could be delved into further. But in terms of getting into the technical architectural development we have not done that and I think that's out of our scope at this point in time in terms of the Subgroup's work. But that you could be a next step. I would certainly say that could be an interesting next up to see if there are similarities or…I mean, access authorization and the ability to allow certain people to see certain parts of your financial history and not others.

Of course we know that that's all blown apart by the credit industry…the credit reports can see all of that and much, much more of our data so, you know, there are parallels and then there are places where that breaks down I think in healthcare as well.

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

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you and this is something I'm very interested in and, you know, you've given us just a very light taste of where you are going to be going and you're just getting into the difficult stuff coming up.

As I look across what states are doing you have different rules of the road in different states especially on privacy and security issues things of that sort. So, I think we really need some recommendations as to how you meld those and bring those together so that if I'm here in DC and I have all my records in Florida that you have similar levels of assurance that my privacy and security is going to maintained in transferring records across or even that they're going to be able to get them.

So, you've got technical standards that the technical group and JASON is looking at those. But also then you have…and there are two levels. I think we need to define where that break is in looking at technical standards versus more of the governance level. And I see that in your work here that you're having a hard time delineating that and it's going to be difficult for this group as well in looking at that.

So, it's…and probably that's a good place to start and the two groups working together it may be necessary to have them come together for joint meetings in order to be able to delineate where the lines are.

We've had…the Policy Committee has heard previously various recommendations on governance and they were basically scrapped and left things kind of blasé fair from that point on. We're now…because, you know, let a thousand flowers bloom was kind of the philosophy.

We're getting further down the road hopefully in true interoperability that I think we're at the critical stage where we need to really delve into this in the next six months to really kind of establish whose responsibility is this? Is this going to be some federal policy that ONC is going to enforce? Is it going to be CMS that's going to enforce it? Is it OCR? Who is the entity in charge is one of the best questions to start with.

Secondly, what are the basics that we want to protect for people that they can't do for themselves? And certainly authorization, there has to be some kind of standards in my book for authorization and consent that's key.

You've got to have something on authentication. Do we know who you are? And, you know, as HIE is set up so that you're exchanging from…then you have an API out there doing this, do we know who these people are? Do we know where the stuff is going? Who…do you authenticate who you are. The whole thing is…and without the trust that people will have in that accuracy you're not going to get the kind of exchange we need.

So, this is…I have a lot of questions this is just tapping the surface. I'm looking for recommendations and I'm looking for some meat on the bones and I'm hoping…I wish your group the very best in doing this but, you know, it's not going to be easy but I think we've got to tackle it now and I think the number one issue is start defining where your limits are what you're going to do, what the JASON Task Force is going to do and kind of setting some rules of the road, some parameters around what you're going do and then work together on it to some degree because there is overlap. But thank you for your beginning and it's just a beginning.

Carol Robinson – Principal – Robinson & Associates Consulting
It absolutely is and, you know, I hope that…I really could not possibly get ahead of where we're at in terms of coming forward before you today. But I think that we do have the possibility, a strong possibility of making some real progress in terms of a framework of recommendations and I would just add, you know, in terms of the delineation between different evaluative groups that ONC tasks to look at issues if there is cross pollination or if there is, you know, learnings that come, you know, between those and where those do intersect, I think that just makes for a richer environment for the next steps to take place.

So, I don't think that…while I think it's important to really, as you say, kind of get into understand where those rails are, what your scope is and that's certainly something that has been a challenge for us to think through, and so what you saw on the presentation is a little bit of an illumination of that challenge.

And so do we scope it so tightly that we do not think about those repeatable processes? That we do not think about…we just think about the "as is state" or do really look at what governance does mean across the ecosystem and we may…you know, it's definitely going to be high-level.

We only have three more meetings. But, you know, I think that's really some of the questions that we've been trying to…that I'm trying to describe today. And so thank you for your well wishes we'll need it but I…

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
So I had some questions, I was going to wait until the end but Gayle…I think this would piggyback on what Gayle is talking about. I think one of the main questions is why and we all know the why. Gayle enumerated them and that's the original reason for the original RFI that was probably a couple of years ago.

And so the bigger question right now is why now? Back in the day when I was in med school doing senior surgery rotation a surgeon attending said "son, you never operate on someone without pain" and maybe that's part of the answer to the why now. I think at the time we all thought of this as an abstract concept, well we've got to move data around but people weren't in the trenches doing it or trying to do it.

And as we heard from the JASON Task Force there is a more palpable sense of demand and there is some response, somewhat muted, obviously we wouldn't have this discussion if it were vigorous and met the demand, but, so now we do recognize a gap. So, real people trying to do real things do recognize a gap and that's a lot of things that Gayle talked about, a lot of the thing that were on essentially your problem list.

And so I think…and we know that the gaps are both technical and non-technical and you're charge was looking at more of the non-technical which is where the body contact comes in which is why it's so hard, it's a different kind of software.

One of the things that David McCallie used to frame their question when he talked about the data model, which you think of as a data model in the sky and what he wanted us to do instead was talk about the data element model which talks about the things that flow between, the items that flow between things and individual entities, organizations, states, communities, whatever can do their own thing inside their space. Maybe this is the same thing.

Instead of saying we're going to have a governance entity that sets the policy model for the country, I'm not sure that can happen. But maybe there are policy components that need to happen between entities no matter how big or small they are and that's the charge I think is to organize what you called repeatable processes to get from here to there.

It's not…so I don't think your charge is to solve patient ID, etcetera, it's the repeatable process of engaging entities that work with each other whether at the small municipality or up to the states, how do you get data to flow in the right way?

So we talked about rules of the road maybe the two things are rules of engagement, who are the…what are the problem list, the use case, those act as stimuli, they're exemplars to test your approach against and we have a number of exemplars whether it's privacy or business practice, etcetera, where you have to get people interested and engaged so that's problem number one actually is to get people to understand, interested and to understand and be interested and engaged and then how do they work with each other the rules of the road?

Maybe that's as far as you go instead of solving each individual problem or thinking that you need to at some mega-scale solve each one but how do you put down rules of engagement and rules of the road in terms of getting people to work together? That might…I don't know whether that's an approach that may produce some more substantive or concrete recommendations. I think what Gayle was concerned about is where are we going to be a month from now are we still going to be talking about abstract?

We already have principles, ONC has already released their governance principles and those are all good. How do we make it concrete and operational? Sort of like Paul Egerman's theoretical to the operational. How do we do that in the…

Carol Robinson – Principal – Robinson & Associates Consulting
Thank you, thank you very much for that. And I fully expected to get the pushback today in terms of the high, high-level that we're coming in with. But I don't think that we're out of place right now as a group that should feel discouraging to any of you or feel worrisome. I actually feel very optimistic about the ability for this group at this point in time to put some of the stakes aside a little bit and think about the overall good of a set of recommendations versus the impediments to doing that. So…

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
I think I then had Terry, Marc, Troy and Jodi…oh, and Paul Egerman.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
First off, I don't…I'm going to give you some comments but it's not pushback. I actually think you've done a great job. I think that this is a really difficult space we've all struggled with it.

You had listening sessions and what you had was people come in and they, as people do, they use listening sessions to say "and oh, by the way I'll answer your questions but I'm also going to give you what I really think about something." So, I think a lot of what you are able to do was share with us, very appropriately, what you heard at your listening sessions.

The concern right now, and I will echo what Gayle and Paul just said, is how to constrain your scope so that…and I would give you some…my own personal guidance here is you have interoperability goals, they're pretty clear three, six and 10 years. What is the scope of governance that you need to ensure that we can meet the three-year goal knowing that governance can be iterative just like development and you can start with a focus on what you need to get to the three-year goal because this three-year goal, as you said Carol, is a substantial goal…

Carol Robinson – Principal – Robinson & Associates Consulting
It is.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
And we're not there yet. I also think the thing you've done really well is point out what the governance problems that are impeding interoperability and information sharing on your slide 17. I would say that some of these have other homes or have other groups that have looked at them and so it's really, in some ways, connecting the crossword puzzle.

I think the concern about "whoa there is overlap here" obviously for all of us I think we heard that with the JASON Report, with data standards, with interoperability, what's a data model. So for your group to try to figure out what's the cross guidance that can be developed so that you're not inconsistent with what they're doing but you may take the opportunity to go "hey, you know what there's a lot here and we're going to give security to security" and whatever.
So, I just think as you guys go forward the most important thing is really to do what the charge was, to identify substance and scope, and I would caution us I think that the scope unintentionally got expanded because like we always do we did listening sessions which was very appropriate and now the argument is how to really constrain that down knowing that those other things you heard need to go somewhere, it's not to ignore them but it's to say they're not ours right now.

Carol Robinson – Principal – Robinson & Associates Consulting
Well, I think that's an interesting comment and I think I can speak for my Co-Chair and I wish he was here, but governance does have a definition and that definition may be broader than we can achieve right now. So I'm definitely hearing that from you in terms of scoping.

I also think that what was so compelling about some of the testimony from other industries in terms of, you know, hitting a pain point that created a dynamic that hadn't been before. And so one of the things that I think that we have struggled with thus far in terms of the conversations and small group and large group is what's causing those pain points and there are so many of them as we talked about. I mean, there's so many. They're broad in scope.

And so if there is, you know, a natural way that a, for lack of a better term, you know, technology standards portfolio management or something along that line, gets set up that creates governance around that that's great. I mean, we don't…you know that's terrific.

But in the absence of that and if you look at the problem list I think one thing that we heard and we are struggling with is how many of the things on that list would simply be solved if that were to happen?

And so for us to avoid that conversation in our conversations to me seems irresponsible. And I think that's kind of where we've been is that need to make sure that we're not scoping so narrowly that we only see the trees and we are not looking at the forest. And that's something that I think is why this is so hard.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Paul Egerman on the phone and then we'll go to Marc, Jodi and Troy.

Paul Egerman – Businessman/Software Entrepreneur
Great, thanks, thank you Paul. And great presentation on a very challenging topic and my comments really build on what Christine and Gayle said. I think we need to know clearer what we mean by governance and I personally really want to understand what is the plan for enforcement if there is going to be any enforcement mechanism for bad actors in this kind of a governance approach?

And to me that's really important because I look at the governance issues and say they can't be viewed in a silo separate from the technical issues. These are not two totally different independent things.

So for example, if the end conclusion on governance is that ONC is going to issue some rules of the road but the rules of the road are going to be more like guidelines because there's not going to be any entity that has any power to enforce them then that kind of a governance approach should have an impact on what the technical approach is.

And however we view the JASON Report or the JASON recommendations need to be viewed through a lens of understanding what governance, if any, is going to be applied to it.

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

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Yeah, so Paul when you were making your comments I was thinking, wow we need to have some data standards. I said, well why wouldn't a surgeon just stick a pin in their arm and then do surgery if they wouldn't operate unless there is pain. So, we just weren't translating correctly. But it's clear the nuances in healthcare are massive and why this challenge is so big.

Carol I think you did a really nice job so thank you and kind of similar to what Paul was just saying, you know, there's one thing to decide on the gauge of the railroad and build the railroad. It's another thing to manage the railroad.

And I was thinking, as you were getting into scope that your scope probably has to be broad right now but it would sure be nice to address that, you know, who is going to set up those initial standards, architecture, whatever and then how is that going to be managed long-term would be really helpful I think as we try to conceptualize what this is going to look like over the next few years. But thanks, good work.

Carol Robinson – Principal – Robinson & Associates Consulting
Thank you very much Marc. One of the things that I studied when I was still a state bureaucrat trying to herd cats around these issues and talking a lot to our bordering state neighbors to some of those exact points that you raised so well Gayle. And so I went back and researched the Federal Highway Act. And you know that's really a very simple kind of set of rules but they standardized the width of lanes, the height of overpasses and bridges, and the color of signs and, you know, once you got into the state on the state roads, on the farm roads, you know, you didn't have to go by that set of rules, however, you know for a national system to work.

And, you know, these analogies always break down at some point, but I think it still has applicability that whether it is our infrastructure for, you know, wiring our nation, whether it's our infrastructure for creating power to our homes or water systems, or the roads we drive on, you know, the safety, the security, the standards are really, you know, I think a piece of governance and so how we address that scope with a very high level set of recommendations, we're not going to get to the answers of how this is going to be implemented in, you know, a multi-year kind of fashion, but I do think, you know, back to that scoping exercise, that this has been the biggest challenge for us thus far.

You saw where we're at and it was very tempting for us to try to break it down and make it manageable because that's the part of the elephant that we could understand. And I think that's, you know, something we're going to have to discuss in more detail in the next three meetings.

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

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
So, I wanted to…I felt like there was a little bit of confusion, I realize we have some new members, I just wanted to take one step back from ONC's perspective on how we've been thinking about governance just the…because people were saying what's the definition and, you know, all of that. So, how we've been thinking about it and we actually…the definition we've been using is the establishment oversight of a common set of behaviors, policies and standards that enable trusted electronic health information exchange among the set of participants.

And the statutory authority that ONC has is to establish a governance mechanism. So, the mechanism for doing that, what's the…you know, things like what are the processes, how do we get participation, who should be participating and what's the mechanism? More like the constitution then, you know, all of the regulations that folks write to address particular problems. Like what's the overarching rules of engagement, rules of process, how do we get consensus on some of these things, at what level, you know, is it, you know, minimum sets of rules that folks have to meet in order for information to be shared from one kind of organization to another?

So, I think it's a bit of a higher level and we are really interested in how do we set up the process because we don't know all the issues that are coming down the pike and Carol and Chris and the whole group are not going to, as folks said, not going to solve patient match and provider directory and, you know, name the state variability of privacy laws we're not going to solve all that in the next three meetings.

But can we have some great recommendations and I think this is the Subgroup's challenge to have some great recommendations for how to address that. What are the rules of engagement? What is the role of the federal government? Where should we step away and the industry maybe has a role to play? How can we engage together in a public/private collaborative way? Those kinds of questions which I think we can get some clarity on in three more meetings and bring back to this group for folks to weigh in on and then, you know, that still leaves some of the really hard work to do.

And it certainly is a lot of hard work for ONC in processing that but, you know, that would be, you know, from our perspective of where we've been and what we are charged with that would be very helpful. So I thank you for all of your hard work. I know it's been a grueling few weeks of trying to pull this together and digest a lot of information and trying to pull it together for this presentation. I think we have a lot to do but I think that we can get some good recommendations in a few weeks. So, thank you.

Carol Robinson – Principal – Robinson & Associates Consulting
Thanks, Jodi.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Troy did you have another?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Yes, I did. Jodi that's easy for you to say. Anyway, no I appreciate the clarification. I mean it is…

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
Some of us actually do the work, but…

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Well, no but it is a valid point. I mean one of the things we have to keep in mind is, you know, recommendations that we're coming up with it's not really doing the work, which is a great place to be. But, you know, there have to be credible solutions.

The other thing you have to do is you have to be knowledgeable about where you go to ask the right question and I think that would be beneficial. One of the things that we struggled with on the JASON Task Force was pretty much the same thing. Who do we ask?

So, you know, you have your listening sessions, you bring in the experts from the community and from the industry, you ask them and then you have to ask the next question. Okay, well if we're going to make recommendations on governance which is what Carol's group has been tasked to do, who does that? Who actually comes in? And is it a regulation? Is it guardrails? You know how do we define that at what point do we do it?

And you look at what Gayle said, you know, about the components of that authentication, authorization. We still haven't…and I think this is another…this is the gorilla in the room. We've got a menagerie of animals here. Is, you know, this situation of the national universal ID. We still haven't tackled that yet.

You know how can you authorize and authenticate if you don't know exactly who you are actually sharing what information, what person this belongs to and who you're sharing it with? We still haven't solved that and I think that's a foundational thing.

We looked at it in the JASON Task Force and determined that while we don't have any governance guidelines to really define what the technical aspects will be so we'll give it to them. And the Governance Group is now saying well, we don't know who to turn to get guidance for this. So, I don't know if we go forward. This is basically a commentary. I don't really have any questions for you because I think you've covered it very well.

But I do have a question for CMS. Where do we get this guidance from? Who do we talk to in order to figure out when they come up with something that's substantial and needs to be solidified and say, okay is this a regulation or is this guideline? Who do we turn to, to actually make that regulation? Who does that? You know in the banking industry they talk about, you know, NACHA has all of these different resources, they're a great resource to kind of direct you into the different ways. Is this a state level rule, is this a federal rule, is it international, you know, is Federal Trade Commission going coming down on you?

Carol Robinson – Principal – Robinson & Associates Consulting
Oh, yes.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Who do we have as a resource to do that for us?
Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
The regulatory body, if there is an agency that is responsible for regulating this space is that the question?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Basically, yeah, I mean that's always been my question.

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
So, ONC does have authority to create a governance mechanism and we can do that through regulations.

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

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
We haven't at this point and I think that's part of what we're looking for discussion on is what ONC's role should be.

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

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
And where we should you know…we've taken a particular approach to date and whether it's time to kind of revisit it is there something that we should be addressing and what's our role and at what level do we step in if we do step in?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
So, I take it we're at the tipping point. We've done everything we can as far as like the carrot and stick aspect of it. Carrots are still out there and we know that they're still existing but at what point do we come in with the stick and say "okay, here's the rules and here's the definition" from a regulatory stand-point not so much, okay, you know, you're going to get incentive payments to do a right, to do the right thing. I'm just curious at what point. Are we at that tipping point now where the…

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
I think we're asking for that conversation. So…

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
That's where we are?
Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
I mean, we're looking for recommendations on where we are and what needs to happen next.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente
Okay, so elephants and gorillas all aside, you know.

Jodi G. Daniel, JD, MPH – Director, Office of Policy – Office of the National Coordinator for Health Information Technology
And zebras.

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

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Yeah, I just wanted to make one more comment and I think Jodi's comments were very informative and thank you for that.

As I've seen this evolve over the last four years as we've had these conversations in the past, I want to say that I think we are at that tipping point that I think we're at the point where I hope within the next year we do have some true interoperability happening and that the public is out there kind of waiting to see where all of this is going to happen and how it's going to happen.

And to Paul's point on responsibility. Where does the ultimate responsibility sit and who is going to take action if there are bad things that happen. As a lawmaker I can tell you that you make laws when bad things happen that's what generates laws.

And if you can set up a framework that's going to perhaps prevent bad things from happening in as best a way as possible you can get at least put in place a mechanism whereby those who are not going to follow the rules of the road that there are consequences for them.

So perhaps it's a little preemptive, but I think in this case, when you're talking about the trust of the public, that we need…it's very timely to have this conversation and that we need to do this and if ONC, by statute, is the appropriate authority at the end of the day to create the guidelines, create the mechanisms and also the consequences at the end of the day for the bad actors, and perhaps prevent some of those bad actors so that you don't have to write very strict laws about things, then I think we will have done the public…we will have done what the public needs and wants to have done so that they can trust the system because it all depends on trust.

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

Carol Robinson – Principal – Robinson & Associates Consulting
Gayle, if I might just comment to that a little bit because as a state lawmaker I know you will really appreciate this. I believe…I mean there's a handful of states that have, whether through regulation or through a kind of voluntary sub-regulatory approach, are attacking the issue of governance on HIE more I guess strongly than most states have been able to do so far.

But I would predict that the pain point, that tipping pain point is becoming so real and will become so much more acute in the next 12 to 24 months as new payment models are implemented, as penalties start to move forward and on the other side of the incentives.

And, you know, as we're in my state implementing one of the most major Medicaid transformation models and have struggled, struggled to get a statewide HIE approach in place I believe that lawmakers like you are going to start hearing a lot of pain stories.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Oh, yes.

Carol Robinson – Principal – Robinson & Associates Consulting
And so then, in that case, you will address it as you responsibly should, for your state and for your constituents, but in that model again, we will be adding to that patchwork quilt.

And so guidance at the federal level with flexibility at the state or regional, or local level and for other, you know, more stringent privacy policies where those are in place and all of those kinds of things will undoubtedly need to be part of this. But in the absence of clarity I think that's another place where legislation often occurs. And so I think the time is right.

Gayle B. Harrell, MA – Florida State Representative – Florida State Legislature
Thank you. I just don't want to be the one at the end of the day in the State of Florida who is writing the law because we don't have a governance structure set up. And that's where it's going to go and what that will do at the end of the day is hamper exchange. We want to facilitate exchange not hamper it. And you're going to have that patchwork that will be across the nation and then you're not going to be able to do what this…what the vision of HITECH was.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Well said, Gayle. Thank you, Carol.

Carol Robinson – Principal – Robinson & Associates Consulting
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
And thanks to Chris in absentia.

Carol Robinson – Principal – Robinson & Associates Consulting
More to come.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
We know for the record that he owes you and we look forward to the next report in October.

Carol Robinson – Principal – Robinson & Associates Consulting
Thank you.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, I think we're ready to go to public comment, please?

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Operator can you please open the lines? And while we do that if there is anyone in the room who would like to make a public comment please come up to the table and as a reminder public comment is limited to three minutes.

Alan Merritt – Web Specialist, Digital Communications Services – Altarum Institute
And if you'd like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
We're waiting for the operator.

Operator
We have a public comment from Holt Anderson.

Holt Anderson – Executive Director – North Carolina Healthcare Information & Communications Alliance
Hi, good afternoon, thank you very much to the Policy Committee and to Carol Robinson who made an excellent presentation. As background, NCHICA has been involved in all phases of development of the EHealth Exchange, development of a DURSA which is the multiple party governance structure for the Nationwide Health Information Network now called eHealth Exchange and most recently we've been asked to be the convener for the Governance and Policy Framework Task Force for the envisioned learning health system by the learning health community which has been convening now for about two years.

There's a group that has been working on the essential standards to enable learning which are the clinical standards and research standards and now this Task Force for Governance and Policy Framework will convene its first meeting October 27th.

My concern is how do we coordinate all of these efforts so that we have a coordinated vision going forward and can get away from this patchwork quilt, patchwork that has been described by Carol. I believe everyone is beginning to embrace a vision of a learning health system where we can provide better care at the point of care by bringing previous experiences of other patients similarly situated to the point of that clinical decision point.

So it's just to inform this committee about that other effort, to ask the committee's recommendations about how do we coordinate these efforts. Thank you very much for allowing this comment.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
Thank you and thank you everyone. As a reminder…go ahead Paul?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Go ahead…yeah, I just want to remind you of what Michelle was going to tell us about which is next meeting is October 15 in person, long day and it's a combined meeting of the HIT Standards Committee and this committee to deal with a lot of the same topics, interoperability surprise, and to hear from ONC on their draft interoperability roadmap. I'll note that for 59 of the 60 meetings I've ended on time, but…

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Is that a longer meeting?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
It is, it goes until to something like 4:00 or 4:30.

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

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology
We haven't finalized the agenda, but it will go later in the day than we typically do.

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Yeah, right. So, folks on the West Coast like you and me we need…

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
Yeah, we need…

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

W
So, the meeting is…

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

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

Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare
I'll take…

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation
Okay, well, thank you so much for a very good day and we'll see you in October.

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

Public Comments Submitted

1. This still is confusing and seems to reward late adopters.. sounds like you can just remain on 2013 and do stage 1 a third year under 2011?

2. The CMS & ONC representatives did not address the fact that there is still a full year reporting required for 2015 (Oct. 1, 2014 for EH/CAHs and Jan. 1, 2015 for EPs). How can a facility be on the 2011 Edition for the last quarter or the combo of Editions and then be ready for the full year of reporting? There is still not a reasonable time to get workflows changed and staff trained.

3. Can you decompress the bullet on slide 14 -- promote the emergence of improved tools for enabling exchange by incentivizing outcomes rather than specifying how -- Are you saying locking in rules of the road risks impeding innovation?

Meeting Attendance

Name	09/03/14	08/06/14	07/08/14	06/10/14	05/08/14	05/07/14	05/06/14	04/09/14
Alicia Staley		X	X				X	X
Aury Nagy	X							
Charles Kennedy	X	X	X				X	X
Chesley Richards	X	X					X	
Christine Bechtel	X	X	X	X			X	X
Christoph U. Lehmann		X		X				
David Kotz	X	X		X			X	X
David Lansky	X	X	X	X			X	X
David W Bates			X	X			X	
Deven McGraw	X	X		X			X	X
Devin Mann			X				X	
Gayle B. Harrell	X	X	X	X			X	
Joshua M. Sharfstein		X					X	X
Karen	X	X	X	X			X	X

DeSalvo								
Kim Schofield	X	X	X	X				
Madhulika Agarwal		X					X	X
Marc Probst	X	X	X	X		X	X	X
Neal Patterson	X	X	X	X				
Patrick Conway								
Paul Egerman	X	X	X	X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Scott Gottlieb			X	X				X
Thomas W. Greig	X	X	X	X			X	X
Troy Seagondollar	X	X	X				X	X
Total Attendees	**16**	**19**	**16**	**15**	**2**	**3**	**19**	**17**