



HIT Policy Committee Final Transcript September 9, 2015

Presentation

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 a meeting of the Health IT Policy Committee. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Paul Tang?

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

Here.

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

Hi, Paul. Jon White in for Karen who will be joining us later.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Jon White is here.

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

Hi, Jon. Alicia Staley? Anjum Khurshid?

Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute

Yes I'm here.

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

Hi, Anjum.

Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute

Hi.

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

Aury Nagy? Brent Snyder?

Brent G. Snyder, MBA, Esq. – Chief Information Officer - Adventist Health System

Here.

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

Hi, Brent. Chesley Richards? Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Good morning, Michelle.

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

Hi, Chris. David Kotz?

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

Good morning.

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

Hi, David. And David Lansky?

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

Hi, Michelle.

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

Hi, David. Devin Mann?

Devin M. Mann, MD, MS – Assistant Professor – Boston University School of Medicine; Attending Physician – Boston Medical Center

Hi, Michelle.

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

Hi, Devin. Donna Cryer?

Donna R. Cryer, JD – Principal – CryerHealth, LLC

Good morning, this is Donna.

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

Hi, Donna. Gayle Harrell?

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

Gayle is here.

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

Hi, Gayle. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Here.

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

Hi, Kathy.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Good morning.

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

Kim Schofield? I know Kim is here. Mad Agarwal or Terry Cullen from the VA? Neal Patterson? I know Neal is here as well. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

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

Hi, Paul. Scott Gottlieb?

Scott Gottlieb, MD – Resident Fellow & Practicing Physician – American Enterprise Institute

I'm here, thanks.

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

Hi, Scott. Thomas Greig? And Troy Seagondollar?

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

I'm here.

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

Hi, Troy. Okay, with that I'll turn it over to you Paul.

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

Okay, thank you, Michelle.

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

Or Jon, sorry.

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

And thank you for everyone joining us on this virtual and thanks for your flexibility in the last minute conversion. We will have a full agenda in October so plan to spend the entire day with us please. Let me just go over the agenda and then turn it over to Jon White who is representing Karen she's going to be a little bit later coming today.

So, we'll start off with some of Jon's remarks and continue on with Dustin Charles giving us a data update about Meaningful Use. I'll be presenting some of our early findings and recommendations from the Interoperability Task Force for your review and comment before we present the finals in the next couple months and Gretchen Wyatt is going to review the now final five-year Federal HIT Strategic Plan...I think there's an echo. And then we'll close with public comment as we always do.

Before I get started let's see, did we have...yeah, we had the minutes distributed earlier may I entertain a motion to approve those please?

W

So moved.

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

Second.

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

Thank you and any additions? I submitted some corrections to Michelle earlier. All in favor?

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

Aye.

W

Aye.

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

Aye.

W

Aye.

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

Aye.

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

And any opposed or abstained? Thank you and let me turn it over to Jon White.

P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology

Well, thank you very much Paul. Good morning everybody, wonderful to hear all of your voices. Greetings from the Standards Committee I kind of feel like I'm making a cameo appearance here. Karen will be joining you all later this morning but had one of those unavoidable conflicts.

So really I just want to say I appreciate your attention. We're going to hear great stuff from Dustin. He and I had a chance to talk yesterday to describe the data update we're going to get and I'm looking forward actually personally to hearing Paul's thoughts and the committee's discussion on the Interoperability Task Force and then finally we're going to cap off your morning with the strategic plan from Gretchen.

I want to remind you that there are a couple of documents that, you know, you all have been reviewing over the past several months. The strategic plan is the broad five-year outlook for federal activities around Health IT as well as commitments of actions by us and the federal government to move ahead with that strategic plan. It is of course different from the interoperability roadmap which is a much longer much more detailed document but both are important in their own way but they're different. I know that there had potentially previously had been some confusion. I don't think there's any confusion now but just want to make sure. So we're going to hear a good talk about that and I'm looking forward to hearing your discussion and thoughts on that as well. So, with that, thank you Paul and back to you.

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

Great, thank you, Jon. And as you mentioned Karen will be joining us little bit later and maybe she'll have some remarks at that point. So the next up is going to be Dustin Charles from ONC presenting some data updates.

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Hello, everyone. So, some of you may remember over a year ago ONC used to present data on the availability of 2014 certified EHR technology, CEHRT, and so today's presentation will be a follow-up of that data using the results from the 2014 Meaningful Use Program here. Next slide, please.

So what we're going to do today is we will describe the 2014 certified product availability by determining whether providers could obtain 2014 CEHRT using their current EHR vendors. Then we will describe what they actually did to obtain 2014 CEHRT. Next slide, please.

So we first looked at hospitals and what we did was we compared what hospitals attested to, what EHR vendor that they attested to in their prior program year with the availability of 2014 certified EHRs and looked at that over time. What we asked ourselves was when could these hospitals obtain 2014 CEHRT at the base definition of an EHR from their current vendor and there are two approaches we used.

The first we looked at was could they take their current 2011 edition product and upgrade it to a 2014 edition product? So it's the same product just up to the next certification edition.

Then we looked, well if they couldn't do that could they get new products from their current vendor that would also get them to that base definition EHR? So that's represented in this figure by the dotted in dashed lines. And so if we add those lines up that gives us whether they could obtain 2014 CEHRT from their current EHR vendor.

So what we found was that for hospitals 90% of them, at the beginning of the 2014 Meaningful Use Program year, could obtain 2014 CEHRT from their current EHR vendor and then by their last day that they could begin their attestation period for 2014 98% of hospitals could get their 2014 CEHRT from their current vendor. Next slide, please.

So we ran the same analysis on the eligible professionals and what we found was 77% could get the 2014 CEHRT from their current EHR vendor at the beginning of their MU period and then by the end 94% could do it.

So, what we've noticed here is this number is a little bit lagging for what the hospitals were in their situation and this is not unreasonable. The EP market is much larger. There are hundreds of thousands of EPs and also the vendor base is much more diverse with...we're looking at nearly 600 vendors for EPs compared to maybe 150 for the hospitals. So, Next slide, please.

So, there was concern about the availability of 2014 CEHRT. So, CMS, as part of this concern, released a flexibility rule and in that rule it allowed some providers to continue to attest in Meaningful Use in 2014 using their 2011 edition product and using the 2013 definition of Meaningful Use. So we decided to take our analysis and apply it just to those providers who took the flexibility rule and to see whether or not they could obtain 2014 CEHRT from their current EHR vendor.

So what we found was 96% of hospitals and 89% of professionals could obtain their 2014 CEHRT from their current EHR vendor and in fact 20% of each are already at that base definition with the EHR systems that they last reported testing with. However, 4% of hospitals and 11% would still need to get a product or products from a different EHR vendor. This could mean they might have to do a complete rip and replace or maybe they just need one or two products from a different vendor. And it's also possible that their EHR vendors could attest 2014 between now and their next attestation. Next slide, please.

So among those who did attest to 2014 definition of Meaningful Use we just wanted to look at what did they actually do? Did they use their current vendor or not? And we found that 88% of hospitals and 90% of professionals did use their current EHR vendor to attest to 2014 CEHRT and in fact, as we can see, 76% of hospitals and 82% of professionals actually did that upgrade, they took their 2011 product and just converted it to a 2014 version.

But what we also found was about 10% of each chose to get their 2014 CEHRT from different vendors and this was a little bit higher than what we'd predicted previously in the first few slides what the

capability was. So, we wanted to look a little bit into this and compare just the different approaches that hospitals and professionals were taking to get their 2014 CEHRT. So, this is just the 2014 CEHRT. Next slide.

This is any change to their EHR vendor and we looked at this over time over the last three program years for Meaningful Use and we wanted to see if it was any different and what we found for professionals here 16% made a change to their EHR vendor compared to 4 to 5% in the previous Meaningful Use...in the previous years. However, about half of them did that rip and replace, they took their old vendor and just replaced it with a new one and the other half kept at least one of their vendors but made some other kind of change to their system using a different vendor either adding or dropping a module or product and in fact we found half of that 8%, actually 59%, of them all they did was just add in a new module or product from the different vendor. Next slide, please.

So, we did the same analysis when we looked at the hospitals and it looked a lot more striking where 40% made at least some change to their EHR vendor. However, only 4% did this rip and replace and that 36% is very similar to the professionals were more than half of them just added a new vendor while keeping their old ones. So, next slide, please.

So in summary, 2014 CEHRT was available to the majority of providers by the start of their 2014 Meaningful Use Program year. For those that attested to the 2014 edition of...2014 definition of Meaningful Use most obtained their 2014 CEHRT from the current vendor and for those that did use the flex rule most had a 2014 CEHRT option available from their current EHR vendor. Next slide, please.

So, thank you all very much. If you have any questions I'll be happy to take them.

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

Thanks, Dustin. Comments, questions? I have the hand raising tool up. Chris Lehmann?

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

I'm sorry, did you call on me? This is Chris Lehmann.

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

Yes, go ahead, Chris.

Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine

Yeah, thank you. So, I think this was a very interesting presentation thank you for that. I just have a comment to make and I want to frame it in a paper that was published by JAMIA today that looks at the vendor certification and comments on the fact that a striking number of vendors do not use clinicians or use only a handful of clinicians in testing the capability of their products. I just...and there is a lot of...there was a comment on that about enforcing of the products for certification by ONC is critical to achieve functional and safety goals for electronic health records.

So while I do appreciate these numbers and they are impressive about how many are able to get the needed pieces from their vendor. I think we also need to look a little bit deeper and look how

meaningful those changes that have been implemented in the EHRs truly are and how easily they are usable for clinicians.

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Thanks, Chris, that's an excellent point and we are very interested in doing more research on this. I'd like to remind people that the data that I used to run this analysis is all publicly available. You can get it from...we have a Meaningful Use attestation file that lists who has attested under the Medicare Program and their EHR vendor and products. We also have our Certified Health IT Products List, the CHPL, which lists all of the certified products and the functionalities that they've been tested and certified for. Are there any other questions?

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

Yes, Gayle Harrell.

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

Thanks so much Paul. I do have a question about what the cost of rip and replace are. It seems that even 4% doing that among eligible hospitals and perhaps 8% among eligible providers might have a huge cost. Did you get any figures along that line or any detail as to why they chose to rip and replace?

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Unfortunately, we don't have any cost estimates ourselves and we don't know why they decided to rip and replace. There are many reasons why providers would want to change their own vendor. We just looked at this mostly from the certification perspective and we wanted to see whether or not the 2014 CEHRT was available and how many providers were using it and from that perspective we found the majority are using their 2014 CEHRT and getting it from their current vendor without needing to switch but we would like to look more into those who did switch and understand what's going on there.

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

That would be very helpful in understanding the entire market and understanding why things are happening so that it would give us a better decision-making at this end.

Dustin Charles, MPH – Public Health Analyst – 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

Just to piggyback a little bit on that, Dustin, do you know, so the majority of the hospitals for example who made some kind of a change just added a module, do know whether that module was sort of...was HIE related?

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

No I didn't look specifically at what was HIE related and unfortunately our data doesn't really allow us or tell us what they are always using their modules for at this time.

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

Okay. Thank you. Next is Paul Egerman.

Paul Egerman – Businessman/Software Entrepreneur

Yes, thank you Dustin for your presentation. A couple questions. One is, is it possible to interpret this data as indicating that there is increasing dominance by a small number of larger vendors which is why the data looks the way it is and relative to that do you have any data about the number of vendors who continue to be certified in particular are there...is there attrition on small vendors? Are small vendors failing to continue to go with the program and as a result that might be one of the explanations why some healthcare providers need to switch?

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Yes, those are good questions. We didn't look at specific vendors in doing this analysis. We wanted to understand the overall market but we do want to look at attrition rates and that's something we were planning to look at in the future.

Paul Egerman – Businessman/Software Entrepreneur

I assume you have that data? You know the names of the vendors? I know ONC...

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

I don't have them offhand and we're not going to...we don't want to share...we're not going to publicly shame or do anything to the vendors who have or haven't done things. But I will tell you that the data is available online and if anyone wants to run their own analysis they can get that information.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and I'm not looking to publicly shame the vendor I'm just looking at the numbers.

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

No, I...

Paul Egerman – Businessman/Software Entrepreneur

How many vendors are being certified now? Because there have been some claims that small vendors have had a great deal of difficulties with the 2014 edition and I'm just curious to know if the numbers bear out those claims?

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Yeah, unfortunately that's not captured in this particular analysis but it is something we're going to be looking into in the future. Thank you.

Paul Egerman – Businessman/Software Entrepreneur

Okay. Thank you.

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

Okay, thank you, any other questions or comments for Dustin? Okay, thank you very much, Dustin and we look forward to future reports perhaps answering some of the questions that have come up.

Dustin Charles, MPH – Public Health Analyst – Office of the National Coordinator for Health Information Technology

Yeah, they were great questions by the way.

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

Thanks. All right, next up I'm going to present some of the interim work of the Interoperability Task Force. And next slide, please. So, I'll talk about the charge to the Task Force, the structure of our report to congress, summary of the hearing that we had on financial business barriers to interoperability, some of our draft findings and recommendations and get your feedback as we prepare for the final report. Next slide, please.

So the way this report is structured is, you know, we'll will talk about the overall context of interoperability its certainly been a hot topic over the past couple of years and a lot of people are interested in it not the least of which are providers, vendors and congress.

What we wanted to do is...we have people on the committee are aware that we've had a number of workgroup work streams and reports and the JASON Task Force all dealing with large segments of interoperability so what we did is we're putting that together. The Task Force reviewed some of those findings, recommendations and are distilling that into a summary report to include in this. Staff is currently working on that and we'll be presenting that to you next time.

The main thing we're going to talk about today is the summary of our hearings. We had a couple of virtual hearings on the financial and business barriers to interoperability, we'll summarize that for you and then present...and then we'll be presenting, in the report, the findings and draft recommendations. Next slide, please.

This is a list of the members of the Task Force; it draws from all of the working groups on the Policy Committee. Next slide, please.

And this is a charge directly from the 2015 Omnibus Bill that asked for the HIT Policy Committee, in addition to the annual report that's produced by ONC, asked the HIT Policy Committee to report to congress on the challenges and barriers to interoperability. They asked us to cover the technical, operational and financial barriers and look at the role of certification so that's what this Task Force is all about. Next slide, please.

And this is our process, as I said, we began by looking at what we had said about the topic before and we've got a big spreadsheet on that and we sort of split up and tried to digest that into what I might have called an elevator speech, something that really helps everyone including congress to understand more of the global context for the barriers and the challenges but also the opportunities with interoperability.

We spent most of our time, in the past couple of months, looking at the financial aspects, the business barriers to interoperability and how can we overcome those that at a faster pace? Next slide, please.

So, we've had a number of calls, and as I said, hearings to go through this and we have some planned for the next month as we work towards our final report. Next slide, please.

Specifically ONC asked us to look at these questions. What are those financial and business barriers? Which stakeholders have a role either maybe not getting the information they need or playing a role in the actual ecosystem of interoperability? What's being addressed currently by ongoing initiatives and efforts? Is the pace fast enough and what can we do to quicken the pace? Next slide, please.

So, I want to start with first what's the goal? Why do we want to have interoperability? We don't just want to move electrons around between different computer systems. Above all we want to improve the health and healthcare for all Americans. And so what we wanted to do...that means facilitating coordination across the health and healthcare continuum.

We focused in on an activity and a noun and a verb. So in the past we've talked about something we labeled as dynamic shared care plan. And the dynamic nature means that it is updated in an ongoing way. The shared means that it is not only the traditional players, the physicians but really the broader healthcare team and those who are involved and impact health. But most importantly it also involves folks that have typically left out of the "care plan" instrument and that is the people that the health pertains to and their families.

The reason I have "care plan" in quotes is because it sort of just in the word care sort of traps it into the medical model and sort of the disease structure when actually we want it to be much more a plan for health. Think of a financial plan you don't think of it as a bankruptcy avoidance plan you think of it as financial help. Well, we also want to have a plan for your physical and mental health. So that's why that's in quotes we just haven't come up with a better name at the moment.

The other point to make is we're talking about this instrument, this living document, but also we want to concentrate on the verb, the care planning exercise, which as I said, involves the various stakeholders I've described earlier.

So in the sub-bullets it's really across the entire team, it certainly involves the individual and family and they're not patients at this point they're individuals and across the sites and organizations that impact the health of an individual, so that may be transitions of care. It also means coordination and we heard a lot of this and talked about it in past meetings in the advanced health models. It's not just a care provider as the traditional healthcare delivery system but it includes the social services that are in our communities.

It is a big ask but in a sense we can't build this house of health or the culture of health, as the Robert Wood Johnson Foundation would say, without having all the stakeholders involved and so that's why this figure is prominently in the why have interoperability and who has to participate.

Other reasons, next, is to improve patient safety. Lots of things have the potential for falling through the cracks when we don't have good communication. We've heard stories about that. If people don't know what other members of the team are doing we can have conflict in the treatment and that can cause patient harm.

We also, next, want to improve the efficiency and reduce waste. For example we don't need to be ordering unnecessary or duplicative testing. The IOM in the past has talked about as much as 30% of what we do may be duplicative or unnecessary. That's a big amount in a \$3 trillion business per year.

And finally, next slide, is supporting the learning health system which was talked a lot about in the interoperability roadmap. Next slide, please.

So what are the underlying business and financial barriers? Next. Well, first of all, we heard from all the panelists that the motivation exists this whole moving from volume to value. Everybody seems to know about it, it's widely acknowledged but the global and specific actions and who is responsible for what that's less clear. And when there is less clarity then there may be hesitation or is this really going to happen and that sort of slows things down.

So, the other thing that people uniformly agreed is...the Secretary has announced her timeframe, 30% involved in alternative payment models by the end of next year, 50% by the end of 2018. That's an aggressive but achievable timeline. But at the current pace of moving towards true semantic interoperability the pace is not fast enough to meet that timeline to give us the information we need to be operating under these advanced payment models.

Along with that is although people understand where we are going, probably the impact of this pay for value model has not yet been palpable and we think that you'll see our desire to align the palpable financial impact with the pace of change of getting the information exchange going. Next.

We considered an example of where we've seen successes at this interoperability before. Well, electronic prescribing is one of those cases that there was a clear use case. There were really clear incentives in fact it was in statue of what would be the incentives and what would be the penalties for not meeting that. In that situation there really were a small number, a relatively small number of stakeholders, for example the providers didn't need to work on the backend stuff. There were a relatively small number of stakeholders who had engage to create the infrastructure and there were a limited number of competitors in fact only a couple Surescripts and RxHub who became one. So, that sort of took care of that issue.

And then in order to get the electronic prescribing to work there were standards that needed to be created and because of the drive and the timeline, and everybody needed certain of these things to happen it sort of organically drove the standards development. So, that is an example of interoperability coming to being even though in a simpler case. Next slide, please.

The next theme, next topic is, next, is really the definition or what's involved in interoperability. So, we talked about electronic prescribing it is interoperability but it sort of with a small "I." To really deal with what we're asking for, which is to move important relevant information amongst the various stakeholders who need to know in order to improve the health of individuals and communities, it's a big heavy lift. You know from the interoperability roadmap that it's more than hundred pages of lift.

So to pick on that, so we're asking for information, relevant information to be sent, received, not only sent but received, not only received but integrated into the record, and not only integrated but acted upon in a meaningful way so that the individual would benefit from that.

And on top of that this all has to be done with collective action at the same time. Probably those two bullets really represents a lot in the sense so much has to happen with so many different kinds of data all at the same time. We saw with Meaningful Use attestations we may have some players ready but if you don't have receivers ready then you still can't complete the job. So that's one of the biggest challenges of interoperability with the big "I."

We also heard about cost. There's interfacing costs, some were quoting anywhere from \$5000 to \$25,000 so it just added up in terms of both to small and large providers. And even when you had costs under control or you could afford it the internal competing priorities of your organization would be a challenge in terms of how do you juggle these things around and when do you quit doing the interface when there are so many things do.

Technology and standards certainly play a role. They may not have been the biggest thing. They're sort of necessary but not sufficient maybe is a good way to say it. So if you look at this it's a lot that has to happen and one of the things is by a lot of people and all at the same time in order for this to work. Next.

So it would be really nice to have a clear, and we struggled with how to call this, an operational definition of what's the pathway to nationwide interoperability. This is where the ONC interoperability roadmap does a yeoman's job in laying out the various things that have to happen. They put out a timeline and really did a lot of work in describing the rationale in the background so that's an excellent place to build upon.

And in terms of definition we wanted to clarify is this really one universal national platform that everybody connects to or is it more like bridging networks in common services? We already know from past presentations how many local efforts and really healthcare and healthcare information is local largely but there's a lot of exchange going on but we probably need it to be connected in a broader framework and that's what's being asked for here. Next slide please. Next.

So speaking of certification, a lot of time is spent on certification but yet it is a delicate balance between trying to get everybody to do the same thing that's the uniformity and the specificity of standards which if they are very specific would help people know exactly what we're talking about and promote adoption and interoperability but if they're very specific they also have the chance of being very prescriptive that's in the functions and the methods, the how.

And that we've also seen in our Meaningful Use Program can have some unintended adverse effects because if you bake in a workflow then that actually causes a lot of change that has to happen not all of which is constructive or productive and so that's the trade-off. You'd like to have as much defined as possible so everybody's working off the same page yet leave specifics about the "how" or the "functions" up for more innovation.

Another thing we heard about is how people get certified but then in real life either whatever is certified isn't that widely or affordably available, or it just actually may not work as described. So the thought is that there is some need for ongoing some kind of surveillance to make sure that what is tested in the lab actually gets implemented. Next.

So speaking of surveillance, there's a notion of...so we talk about interoperability, we talk about certification as a thing. We really want to get, as we mentioned in the goals, we want to have information used in the care and promotion of health in individuals and communities so there needs to be better measures that this is happening.

So we talked about HIE sensitive, health information exchange sensitive, measures but more importantly measures that matter particularly to consumers, to individuals and patients. So what that's trying to say is outcomes that matter like functional status if you're going to have an elective joint procedure I'd like to know when I'm going to walk again and how pain-free that experience would be not just some of the process measures like postop infections and things like that so much more of the things that matter to an individual. Individuals are very concerned and frustrated by a lack of coordination of care. How do we measure whether that is going on effectively? So those are what we mean by HIE sensitive measures that matter.

The other concept is measures that matter to providers looking to judge vendors on whether they are facilitating true health information exchange in a meaningful way. So we thought of two classes of measures that matter. One that matters to the individuals and two that matters...that measure vendor performance. Next slide, please.

So, we're coming up on two major recommendations. The one is that we convene major stakeholders as co-led by the public, the federal government, and the private sector really to act on the ONC roadmap. As I mentioned really the roadmap is very...is an excellent document that lays out where we are today and where we want to go, why do we want to go there and some of the steps sort of a blueprint, but in order for it to not just be a book on the shelf, the Institute of Medicine always wants to make sure that their reports don't just sit on bookshelves but get acted upon.

We think, this is open for committee discussion, but the Task Force believes that we need to educate the multiple stakeholders that are involved in this and as I say it's not just the vendors, it's not just the providers but it really is a broad effort and we really need to get together and understand what are the activities that must take place in order to get us there. Next.

And the question is, well people thought about that before, but so why do we think calling for that now is different. Well, because the landscape has changed dramatically. So as we saw, just five years ago, maybe 4% of practicing physicians and clinicians had a comprehensive EHR that wouldn't even meet today's Meaningful Use 2 standards. So, we've gone from 0 to 60 basically in a few short years. That's wonderful news. So, more than 95% of hospitals, more than 65% of physicians, providers now have very functioning electronic health record systems.

The other thing that wasn't around before 2010, before ACA, is really the notion of ACOs or accountable organizations that have much more of a population and global health perspective than just the whole fee for volume. That's dramatically different and we have the timeline that goes along with that.

And finally, we didn't actually have a plan sort of a national plan for getting to better interoperability. So those things are really different. We have the plan, we have the motivation, we have the incentive and we have the data in electronic form. It seems that we need to get together and figure out who needs to do what at what time. Next.

So that's why we think that we need the power of the federal government to convene the major stakeholders, but the enduring private sector business interest to sustain the effort. We don't think that everybody going on their own, so let's say in the football season that we're in we can't have all the specialty teams working on their own without a game plan and without knowing who does what, when on what signal. And it goes back to that synchronous collective action challenge. So that's why we're thinking that we need to have this convening of the major stakeholders and a continuing effort. Next slide, please.

The second part of our recommendation is, next, is to develop the pull essentially to measure where we are, who is doing what and where we need to go. Next. So we think we need to develop...to fund the development of these measures that matter that I talked about. So, the frustration about lack of coordination, about having duplicate testing from...these are all from the individual's point-of-view, it's not going to be solved by each of us working in our own silos we really have to come together and figure out...in fact even figure out what does a game plan look like that's that dynamic shared care plan. What does that look like and who has to participate and that has to start all the way back in professional training like medical school, nursing school, allied health professional school so we know how to work on a team and how to construct a game plan that we all follow.

Another...so an example of a HIE sensitive measure might be no reimbursement for medically unnecessary duplicate orders. Well that makes a whole lot of sense but you can right away see that we would need, one, a game plan, two, the goals and three the information about what everybody on the team is doing. So, that's an example of what an HIE sensitive measure that matters that would be important to the individual and family. Next.

The other measurement we talked about was the measure of vendor performance. So currently we use number of exchanges of external data while that's helpful that's just the denominator. We really do need the numerator of, well, there's plenty of information that's been sent or even received but how often is that even viewed and it turns out that a small fraction of that is already transmitted now are even view let alone sub-bullet three which is and how is...is that data, are those data being incorporated and reconciled with the thought process in the record in these organizations.

And then finally does it make a difference, that's that fourth bullet. One indicator of making a difference is if you see something and you're in the middle of doing some order and you change that order that's an indication that this new information made a difference in the care of this individual. So it's almost...these are just examples of course but it's almost these four kinds of things that create a measure that matter to individual care providers working with an individual patient or person.

So we're talking about different kinds of measures. There's lots of process measures on either the vendor or the provider side. What the public is hungry for is really the measure that impacts their decision-making about their health and there's a paucity of those measures.

Now the reason for asking about funding is because those measures aren't happening by themselves. A lot of the traditional measure developers are much more used to developing things that relate to process and, you know, from chart review frankly. In this new world that just happen overnight, within the past five years, means that there is different data available, there's different ways to instrument the workflow and what's going on. We need to think of measures differently and that may require different kind of funding not relying on the same funding mechanisms that we've had. Next slide, please.

So, speaking of funding, and we're not asking for a whole lot here, we do think there is this kickoff it's this convening summit in the sense of do we even know who are all the stakeholders that have to play a role? For example, in talking about this dynamic shared care plan, it has to go all the way upstream to professional education and training for example. And how do we define the blueprint and get people to work off of it? It's sort of a global view because we really are making a huge change in this moving from paying for transactions to recognizing, understanding and improving the outcomes of a population and individuals.

So we think about this convening summit, the reason I call it a summit is sort of its a one-time or small number of meetings before you have this ongoing activity that involves both the public and the private sector. So, we think of it as funding, speaking of which, as both a public and private kind of activity. And as I just mentioned, there is development required for these measures that matter.

And we also ask, in the second bullet, that says we need to create that palpable difference that palpable feeling that the incentives, the payment, is really tied to these HIE sensitive activities and the HIE sensitive goals such as the communities health outcome, coordination, coordination across both healthcare and social services and having informed and engaged individuals and families who, by the way, are paying the first dollar out of their pockets nowadays.

And so I'll conclude, next slide, please, saying really what we found is the market is moving. They understand what the direction is. The pace is probably not fast enough in order to create this affordable, high quality care for all and a big challenge is the complexity of it but a lot is the synchronicity that has to happen with the multiple stakeholders all during their role with the game plan in mind.

So, we're calling on this convening function of the multiple stakeholders for sustained collective action and meet development as these meaningful incentives with aligned payment behind them. So, that was a lot. Next slide, please.

We're now open for your discussion and comments. We really welcome your feedback. Our plan is over the next two months to incorporate your feedback, bring back also the summary of our past recommendations as we develop the support that we owe congress by the end of the year. First comment, Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Great. Thank you, Dr. Tang that was an extremely important and really great presentation. I really like the way that you described interoperability and what it means to an end it's not the end, it is a means to an end for better care, better patient care.

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

Lonnie, could you move the previous slide just to have something there on it, thanks.

Paul Egerman – Businessman/Software Entrepreneur

Pardon me?

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

No, I was just talking to Lonnie, thanks.

Paul Egerman – Businessman/Software Entrepreneur

But I also...I said I liked the means to the end concept. I really like your concept of financial measures the idea that perhaps CMS might simply say at some point we're not going to pay for duplicate lab tests. I know there is some difficulty in defining that but if CMS were to say we're not going to pay for duplicate lab tests that would cause a lot of interoperability very fast. That would be a great way to help motivate that. So, I think that's also a really excellent suggestion.

Yet I found it problematic your comments about the vendor measures however and the reason I was concerned about the vendor measures was I wasn't sure which vendors you were talking about because there are a lot vendors involved with interoperability, I mean, there's EHR vendors, there might be laboratory vendors, there might be commercial labs, there might be HIE organizations and I was also concerned about the metrics where you talked about the quantity of data being transmitted because if you start to measure that what you might discover is vendors will send a ton of data so that's not necessarily useful. I mean, the records are hard enough to read when there is no interoperability where people...physicians have trouble finding the data they need to start sending tons of data into the record may make the EHR less usable.

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

Thanks, Paul. One, so first of I'll mention that both of those examples were just examples to start the discussion and thanks for the comment on the duplicate testing. I think it calls a number of things in and you're exactly right I think it would have people pay attention to that.

The second point you raised is a good one, and again, those four sub-bullets were examples, but if you just took your example of "oh, well that would cause people to start sending a lot of data around" and wouldn't that just flood people? "Yes" that's the point and so that's why the numerator is what percent is actually viewed and the third and fourth points are and actually incorporated and actually used.

So in your example of where gosh we'd have people flooding people with data they would score high on only the first of those four and actually would cause a corrective action because you would dramatically reduce the percent that are actually viewed and used. So hopefully this kind of thinking would cause people to reflect and say do we actually want to just move a lot of data around or do we want you to score the highest if you moved around a lot of data that people actually viewed, incorporated and used appropriately and that's why...

Paul Egerman – Businessman/Software Entrepreneur

And about my comments about which vendors though? There's EHR vendors, laboratory vendors, there is Surescripts, there are the HIE organizations all of those are involved in interoperability and I don't know how you piece all of that information together.

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

Well, and so that's why I called this an example that's an exercise left to the reader. In a sense we have to think through that kind of, if we do like that approach as a "measure that matters" then as part of this convening function we have to get the folks together and then find out are there ways to get everyone...motivate everybody and incent everybody to participate and adequately acknowledge and recognize the roles each party plays. You mentioned Surescripts I could dream up some measures of the amount of information flowing through them and the amount that's actually used. So you could...I

mean, I think we can try to work through those different kinds of examples and show how everybody gets credit for the roles they play. That's sort of the goal.

Paul Egerman – Businessman/Software Entrepreneur

Thank you.

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

Thank you. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Yes, oh, this is really a huge amount of work that you have presented and obviously something about which a lot of input has been received already. As I reviewed the slides and listened to your presentation, from my perspective I think slide number 10 is really the critical slide here. I'm sorry, slide 11, where you talk about the clear operational definition of pathway to nationwide interoperability and I think that the concept of bridging networks rather than one national platform is a key aspect and I would say the critical few standards-based services I think of those as the cornerstones, the foundations of building this no question with respect to patient matching, provider directories, record locators.

I would add to that perhaps a fourth and you called it an e.g. not in i.e., but the fourth I would say is really agreed upon security factors or aspects because I think that what we currently lack is a good common understanding across healthcare about what can and cannot be shared and to the degree that we can get that common understanding I think that interoperability will be much more likely to occur.

When I look at your next slide, which is slide 12, and has to do with what would be the transparent metrics, it really almost sounds as though there needs to be what we might call a consumer report or a trusted evaluator or system for being able to evaluate the various products, not just, you know, not just a Health IT system but it could be some of the others that were mentioned earlier but something where it is regularly updated, trusted by many, meets the different needs whether it's of a patient, a consumer or could be a physician practice and integrated health system and that then we'd see, just as we've seen with other aspects of public reporting, that this then leads to an improvement just by its very nature.

So I guess one last note perhaps of skepticism, perhaps, I always worry when we say that this is something that the federal government is going to pay for because we all know that budgets get tight and we know that setting appropriations is difficult. So from the get-go I think we need to think of this as a public/private partnership kind of model and that perhaps with that small amount of funding but then it needs to be sustained by all the many participants. I would not want this to turn into something that government has to fund for the long-term. Thank you.

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

Thank you, Kathy. Gayle?

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

Thank you so much I had to get my mute off. This is a tremendous report and your recommendations I think are pretty much on target but very general and I think there's some more in-depth questioning that needs to happen.

Your push/pull approach I think is the right one in that you're pushing from one side perhaps with that summit and convening of a public/private partnership but pulling along with payment and developing of measures is very significant. So I think we're definitely on the right track here.

But there's still...I just get a little leery having seen this...having been in this discussion for now six years and seeing not much movement happening in the whole realm of interoperability where we are today. Certainly we're at what may be a tipping point because we do have the volume out there but this to me is the beginning and we need much more specificity in recommendations and I have...I want to go back to the question of funding. Are you talking specifically about a public/private entity being established as the convener?

When you say the federal government is going to be basically the push there are you talking about establishing a separate entity that is going to be publicly funded with private entities part of it? Can you give us a better in-depth view of this?

And also, when you're talking about payment and measures and how we go down that road who is going to establish those measures is it CMS, you know, is it the public/private entity? Who is going to write the measures and who is going to enforce it? So I'm looking for more specifics if you could kind of elaborate a little bit more.

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

Sure, excellent points, Gayle. No, we weren't looking to create a new entity that would be expensive for one and you really have to think through what entities could we use if that was your goal. We were thinking more of it being, we called it a working summit at one point in time, it's really to help the general community understand better what do we mean when we say interoperability?

I think a lot of people may think interoperability that's sort of a technical term and so that's sort of that's the vendor, that's technology, that's standards but what we were trying to show through this report and our hearings is how many people are stakeholders meaning they're beneficiaries but also how many people have to play a role in getting this to happen, that not just "technology."

So, we really want...it's sort of an educational, it's sort of a galvanizing event which is why you might call it a summit and then beyond that to understand what are the things that have to be done, by whom and with...each of these different charges under one roof?

We did, as you point out, want it to be public and private from the start. The federal government has a huge convening capability. There are, you know, as examples, foundations that are also in this space and want to contribute to this and see it as driving so many missions so we're hopeful that this could play a role both in this convening function as well as potentially funding some of the ongoing activity. So that's one of the...your first question.

The second question is who would develop the measures? And that was the challenge and that has been the challenge in a lot of these outcomes oriented measures. As an example, NQF is an endorsing organization but they don't create the measures themselves so they have to wait for people to submit them and we probably don't have enough folks that are working on submitting these outcomes oriented measures that matter.

So, could there be...and I'll just mention that as an example, NQF has another thing they call an incubator, could there be ways that a combination of public and private interests come and get together the folks that are needed to develop these new kinds of measures and since it does have a public good aspect that's why public participation in that funding would be desirable so we can't say.

There is probably not an entity where it's pointing to right now but we know that it's not happening on its own at least with the vigor that we think it should and that's why we're calling for additional funding and again it's still in the public/private kind of partnership.

Does that help? I know it doesn't say there is an entity but we're calling for money to be available so that if it's not an entity a group of folks can come together and try to work on these things?

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

That does give us some more definition and as you come to writing the report I think you need to lay things out much more clearly than perhaps the slides that you've done here and really define that a little more specifically so that there's a better understanding, especially in the measure development because that is really where the rubber meets the road and where payment for providers and hospitals will take place and really, you know, when you speak with money, you speak very loudly so that's where you get your impact. So I think that is a key component of it and much more definition of how that would happen I think is needed.

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

Thank you, Gayle. Neal?

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

Yeah, can you hear me?

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

Yes we can.

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

Great. Hey, I've got just kind of a set of comments here. I jumped around a little bit so, but my first one is with regard to kind of the integration of the concept of the care plan, the dynamic care plan at the community level, I mean, I am a huge believer that this is kind of the next thing that we as an industry need to focus on and I think it's a huge benefit to the people that healthcare serves. It confuses the concept of interoperability to have that so tightly integrated into the pure notion of interoperability.

I think we'll know when we have interoperability because I think our kids immunization lists will go with them wherever including to the schools, our problem lists that are generated by our physicians will track us, you know, our labs, our images will track us and the transition of care will be done in a much more informed way as to what the one venue is doing and what the next venue needs to do. So the notion of the dynamic care plan is a brilliant thought but I think we have work to do that creates a truly national-based interoperable system and that becomes a foundation for creating a care plan.

The notion that there are financial barriers to this I think many times gets used as an excuse not to do it. So, I know we've...that's in this presentation and it will get communicated on up the line but I personally think that this should be done at the cost of e-mail and a few people might want to charge for e-mail services but the scale and cost of these systems interoperability should be included, so.

And then a third comment is if around we don't take a very clear stand on the difference between regional systems, regional HIE systems and a national approach, if you just take ePrescribe there is a narrative out there in the industry that helps locals so it just needs to be local interoperability. Nothing could be more true than just ePrescribe because almost by definition you're usually at the physician's office and they're going to prescribe to a pharmacy that you know where it is and you tell them where it is, but the reality is a whole fragmented set of local ePrescribe systems would be frankly interoperable. I mean, it would be wrong. So, I think we need a national concept and a national approach.

The core of interoperability, I think it's in your document here, but I think ought to be just a pure recital, is really we lack an identification, a way of identifying us, we cannot have interoperability without an identity system that's doable today without requiring anything to be done in Washington DC.

The system also has to have record location so there has to be a service that it knows about and like my pharmacy I tell the physician which pharmacy I want the prescription to go to, the reality is where all your information is basically we have to systematize that. So, record location has to be part of it. Incent has to be part of it as much as we probably prefer it to be. This will be opt in and then governance basically has...the business agreements have to be part of it.

And then just moving on, as far as metrics I think that the metrics, the focus on metrics is good but incentives are better than metrics. So if we did stop paying for redundant tests, we will get interoperability much faster.

And then my last comment is that the big summit is probably appropriate but I think there is fundamental lack, I mean, for the most part, on some of our industry as far as collaborating on this subject but there are still people who do not collaborate on the subject and I think that is a specific...that by itself prevents movement here.

So, sorry about the kind of run of thoughts there but I put them out there and Paul you don't need necessarily to try to respond to any or all of them.

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

Thank you, Neal. I think those are all good points and I'll just comment one on your last one about not full collaboration and that's probably why we wish...that's one of the benefits of a federally convened summit is to try to pull everybody in. By at any rate, no, these are all good comments and appreciate those.

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

We will be there but if it gets to be a very large meeting I'm just afraid there will be so many ways of not agreeing.

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

That's part of what we've got to get over I think.

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

Yeah, we do.

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

Yeah, thanks. Anjum?

Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute

Thank you Paul. Thanks for the presentation. I appreciate your starting with identifying the goal as being health for all, you know, across the continuum, and more and more, you know, we recognize that for achieving that goal we need to also engage other than just the healthcare providers in achieving that health.

So the point that I wanted clarification in terms of your recommendations around multi-stakeholder efforts is does that then clarify or emphasize enough the need for interoperability with public health, social services because in many ways I think when we think of stakeholders this could be integrated also as stakeholders who are engaged in the delivery of care or as you have said maybe just in the bankruptcy avoidance rather than the financial health of the person. So the point is how do we emphasize enough the need for interoperability with, you know, other sectors that are important to achieve that goal for overall health?

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

Thanks, Anjum for your question and the opportunity to emphasize. I think we had, in fact even in our draft recommendations, three and I'm trying to look, a number of times we tried...including in the struggle with how to call this plan for health instead of a care plan is deliberately to say we need to have the whole continuum that involves not only health, healthcare and social services.

The workgroup on advanced health models had a hearing actually dedicated a lot to social services and even when we talk about standards we went to expand that into the standards covering social services. So we did try to go out of our way, we'll just make sure in the final report that it's also very clear and we also will also have an example just the points that you raised which is this is really one health for everybody. There's so much...it's almost public health by definition really is how we ought to think about it and that it's not just healthcare it's everything from Meals-on-Wheels to jobs and housing, as you know the social determinants.

We also know that the IOM gave its opinion on what should be in an "EHR" electronic health record system that includes social determinants. So a lot of activities pointing in that direction and we certainly do intend and we'll emphasize how those data are part of what we mean by having interoperability to the benefit of health.

Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute

Excellent, thank you very much, appreciate that.

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

Thank you. Brent?

Brent G. Snyder, MBA, Esq. – Chief Information Officer - Adventist Health System

I appreciate the report Dr. Tang and the recommendations, I'd just like to affirm the earlier comment that slide 10 I think is very critical and particularly the critical few items patient matching, provider directories, record locators and also was referenced the security and privacy where I think we're very challenged, I know from a hospital's perspective, of having clarity on how to bifurcate that data which falls under different...like behavioral requirements and keeping...handling that separately it adds a lot of complexity and having clarity on how...appropriately of handling that, consenting that in light of that which doesn't require the additional consent requirements is going to be a component necessary.

I would also like to add that the, you know, for hospitals that the incentives are continuing to grow for the interoperability with post-acute care providers but they are even more multiple in numbers it seems than what's in the physician environment and it's going, I think, be...it's currently been very challenging working with these multitude of post-acute care providers with little to no standards that they have to interact with hospitals as we try to establish networks and working relationships with a multitude of vendors and I just hope that as you focus on the continuum that this is given significant focus even though they weren't part of the original Meaningful Use Program.

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

Thanks, Brent. As you know ONC has certainly been interested in that space and trying to work on certification areas even though they're "not part of Meaningful Use." Thanks for your comments. Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Hi, yes, Paul, I'm just speaking a second time so I hope everyone has had a chance to give their first set of comments. And one of the areas that I did not mention initially does have to do with the security aspects and the consent aspect and in the report hoping that there will be acknowledgment of the fact that there are different laws in different states and so as somebody from a big border state I can tell you that patients from New Mexico frequently go for healthcare north to Colorado, east Texas, south to Texas and west to Arizona, and so I think that realizing that we need in some effective way to be able to have information travel with the patient or with the individual across state lines would be very, very helpful.

And then, as a last point, there have been a number of people who've mentioned the whole issue of measures that matter and how those would be identified. I think there should be a statement or would hope there be a statement in the report that strongly urges collaboration amongst all of the federal agencies that have activities related to measure development. So obviously, CMS, ONC but also AHRQ, CDC, SAMHSA because we all recognize, and I should say AMA as a measure developer, so full disclosure, but we all recognize that funds are tight and that we would very definitely benefit from a

federal wide collaboration with external stakeholder input including from patients and consumers about what the most important measures are for measure development.

And as we think about measures that are important let's also be sure to look at the experience that NQF is acquiring even now about how to do appropriate socioeconomic or sociodemographic status risk adjustments because I'm fearful that if we start to measure individual patient's levels of engagement I would not want there to be, shall we say, unintended consequences of those patients who for very reasonable reasons, for very good reasons, are not engaged because they have higher priorities in their lives at that point in time, I would not want there to be the unintended consequence of those individuals not getting the healthcare they need or in some way or another be discouraged from getting care.

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

Thank you, Kathy. David Lansky?

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

Thank you, Paul. Again, I appreciate everybody's work on this topic we've all been at it for a long time of course. I think we have all felt that the changes in payment that are going on now that you alluded to at the outset are an important horse we could hitch our cart to and that the change in the payment environment should create an incentive for data sharing across a number of settings and provider types and so on.

So, I think to get to the specificity Gayle was talking about we should strengthen the part of the report that talks about the business case and about the incentives for data sharing and that may mean some additional consultation with payers and purchasers, both public and private, to understand how to do that and get to that specificity Gayle was talking about.

I'll give you one example that's urgent right now. I think the CCJR bundle payment for orthopedics proposal that CMS has put out has a voluntary program for collecting patient reported outcome measures which would satisfy our measures that matter a goal and they have in the NPRM about 30 risk adjustment measures, many of which would have to be collected from EHRs, so as a use case analogous to the eRx use case one could take the specific requirements of the new payment model for orthopedic surgery and the 30 risk adjustment variables that are going to be required nationally to be reported along with the patient reported outcome measure and say, where are we in developing interoperability capabilities for those 30 risk adjustment variables?

Something we've talked about before is that the ability to construct a longitudinal personal health record is becoming indispensable for managing people across the continuum and across time and it's also indispensable for measuring and paying whether the right protocols are followed and whether the right outcomes are being achieved and so on.

So I think getting beyond not only the use case around individual patient care at the bedside and delivering data from point A to point B to assist in that, but equally important and actually better tied to the business case is building the dataset for measurement and evaluation, and payment.

So, I'd like to see the report address that possibility and develop several use cases and if there is a summit of some kind the agenda for that summit should include specifically laying out the data requirements in support of the new payment models. Thanks.

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

Thank you, David. David Kotz?

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

Yeah, I'd like to echo a lot of things that have already been said but I don't think I heard anyone mention the challenge of identity. How do we identify patients as you transfer records from one place to another? Currently that's done with patient matching algorithms and I've heard from some HIEs that I've talked to that this is a major, major challenge for them. They get most of it right but it continues to be a real challenge. Is something that we should be pushing for as well improvement in patient matching or other identification means or is that already underway somewhere and I'm just not aware of it?

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

That is called out as an example under the common services and Neal Patterson also mentioned it.

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

Sorry.

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

So, it definitely is part of it, yes. Any other final comments or questions? Thank you so much for everybody's help in asking the questions it will strengthen the report we'll work on those things and also once again I want to thank the Task Force members who really created this effort. Gayle?

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

Thanks so much I just wanted to get one more bite at the apple if you don't mind?

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

No problem.

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

I would really...I would really like you to call out specifically behavioral health.

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

Okay.

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

It was not part of HITECH but I think it is an extremely important aspect of being able to exchange records and have that interoperability. There are specific safeguards that have to be put in place as we all know when we do that, but we have not specifically addressed it and as you put together that

summit make sure, please, and in your report I would very much like to see specifically calling it out and making sure that they are part of the whole discussion.

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

A very important point. Thanks, Gayle. In summarizing some of these comments it sounds like there is a fair amount of consensus around these two major recommendation topic areas have I got that correct and there's some additional emphasis that people suggested? So are we working in that direction as we try to finalize things and we'll bring it back to you next month of course for further comment, but do we seem like we're on the right track?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Yes.

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

Okay.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Everybody's on mute.

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

Yes.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

We were all waiting.

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

Exactly.

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

Okay, well thank you so much for your feedback and input very helpful. Okay and we're going to close the series of presentations with Gretchen Wyatt from ONC who is going to talk to you...give us a preview of the 5-year Federal HIT Strategic Plan. Gretchen?

Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

Thanks so much Paul and thanks to everyone else. Unfortunately, it doesn't look like Karen is with us so I will be giving you...

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

Karen is here.

Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

...

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

Karen is with us.

Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

Awesome, fantastic, Karen, I go to you.

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

You said that like there was demise in the sentence.

Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

Not at all.

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

Hey, everybody sorry that I was little late this morning the Surgeon General released his call to action on walking and walk ability and I had the chance to be there and so that is now on the streets literally and figuratively.

And I got to hear a lot of this great conversation about interoperability so thank you to Paul and that committee for your work on that I look forward to the final product.

I wanted to, before Gretchen jumps in, just say a quick word for everybody about the framing of the strategic plan. So this is going to be a busy fall which is a follow-on to what was last year a busy fall and this is our first release which is this big frame about the Federal Health IT Strategic Plan you all will remember that this is one of our statutory responsibilities is to set and reset the strategic guidance for the federal partners that we had, as you'll see, an array of agencies who came together and agreed that they wanted to advance Health IT on behalf of the American people putting the person at the center and building the opportunity for Health IT to move on their behalf and with their consent and in secure ways but also so that we could advance these many important use cases some of which were described today delivery system reform, public health, advancing science and consumer engagement to name a few.

So, my words are to thank the federal partners first for all their work on this. My additional words are to thank this committee and others in the public who gave us some really great feedback and helped us shape this in such a way that I hope that you all find that we were responsive to comment and feedback, and then to remind that this is the big 5-year look but that in short order we're going to be coming back to you all with more specifics about what we can do in the near term to really impact the use of Health IT, the data movement pieces and in particular go really deep and technical in the space of interoperability reflective of some of the comments that you all just made but also some additional

areas of opportunity and work and that will be our interoperability roadmap which we still plan to release later this fall.

So, thanks to Gretchen and Matt, and Seth and others on that team for leading this charge and for doing a terrific job I think and Gretchen with that I'm going to turn it over to you.

Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology

Thanks so much Karen. As Karen said, we do not have a plan to give to you today but expect it very, very soon. So, this is, as Paul said, a preview of what you'll find in the plan. If we can go to the next slide, please.

This is just a refresher course for everybody welcome back to Health IT strategic planning and this is just to remind everybody how many groups are involved in the whole concept of strategic planning. First we went to our federal partners, as Karen said, 35 different agencies we found that either touch or engage in Health IT and health information use and they agreed to help us develop this new strategic plan and then we went to you folks and I have to thank David Lansky and Jen Covich from the Strategy and Innovation Workgroup and Christine Bechtel especially from the Consumer Workgroup, and the whole Policy Committee for helping us really finesse the draft plan and get ready for this final release.

As Karen said, we got great feedback from the public and were able to incorporate that with our federal partners into the final strategic plan that you'll see very soon. The feedback was great on what we got right on the plan, what needed improvement and where we needed to go as a nation to be able to use Health IT and health information more appropriately to improve health. If we can go to the next slide, please.

Thanks, as we mentioned back in April we did hear from you folks and from the public that we needed to modify the strategic plan. There was general support for the vision but the clear message was, you know, don't focus so much on the data in the system and the technological part but for what? What was the purpose of all this information and technology? And it was to help people get more connected for more information sources like public health and other social determinants and for consumers to be able to provide their data to the system both so they could manage their own health and to improve research so that pop health and pub health could be much better managed.

So the other message that we heard was that internally federal partners needed to coordinate better with their program as you know measure alignment and program participation requirements and so you'll see some of the strategies get toward that administrative burden as well. It was really good advice and we're trying to make sure that the strategic plan can capture this and make sure that we hold ourselves...our feet to the fire to get that accomplished. If we could move to the next slide, please.

This gives you just a general idea of what you'll see in the plan. Of course, you know, it includes the vision and goals of all the federal partners, what we'll be pursuing immediately and what are some of the more long-term goals so that we can use health information technology and the information itself, some of these things, you know, came from other vehicles such as Healthy People 2020 and the National Quality Strategy.

The Policy Committee asked us to revisit those national strategies and make sure that everything we did aligned directly to those and we went back and we think we did a good job, but of course as we start implementing the plan that's where the rubber is really going to hit the road.

We intentionally kept it open while we're committed to make sure that this works what we want to do is revisit this regularly and publicly hold ourselves accountable while there's lots of incredible work going on with various agencies we need to make sure that we're on track. So we will be coming back to both the committee and through our Advisory Council to stakeholders to make sure that what we're doing is actually influencing the public as we expect and that these programs actually are benefiting individuals as they start making health decisions. We can go to the next slide, please.

Some of the revisions that you'll see as far as substantive changes, it's much more comprehensive. I think we were a little bit parsimonious in our descriptions of where we wanted to go so we tried to make the story a little bit clearer so it's a little bit longer than it was before. And again, saying, how this information, for what purpose would be used?

We took the advice and we combined healthcare delivery and public health into one goal. These were goal three and objective four (b) in the draft plan and the bridge goal that the committee recommended that we address is now found in goal one really focusing on the partnerships between individuals and how they self-manage and work with their caregivers.

Goal four sort of groups the infrastructure so we flipped the order on everything, as you folks had suggested that we do, and this gets toward the privacy and security, the interoperability and some of the technical components. So if you think of the plan as a large umbrella the infrastructure is the handle of that umbrella and the ribs that really give the structure for the plan itself. Some of the strategies you will see were changed to incorporate public suggestions as well. Okay, next slide.

And this starts getting into some of the other things that we looked again at the social determinants IOM report and so the priorities you'll see talk not just about the high-quality care and lower costs and the population but the engaged individuals part and that really gets toward the person-centeredness that we're hoping to achieve with the implementation of the plan.

You'll see here as well that we align each of the visionary aspects of the plan to specific initiatives or direction from other national strategies and this we hope will keep us extremely focused as we start the implementation. Next slide, please.

This is just a list of some of those alignments. You can see it's not all-encompassing but these are the ones that we thought were most representative of the various plans that use Health IT or electronic information and the initiatives are we think especially important because these are key things to really drive toward improved health.

While the plan isn't a national health plan we think that these initiatives will get towards national better health. And we learn more every day which is amazing. There is so much work that's going on it's really quite impressive actually the more I hear what some of the federal partners are doing. Next slide if we could, please.

You might remember the vision and mission were slightly different. We flipped them so what was originally our mission is now our vision and vice versa. This was a suggestion I think directly from Mark

Savage and from David Lansky. So while our focus remains the same as it was before of better health we think that this is more encompassing of what it is that we were trying to say with the first one. It's really...our focus is, you know, what electronic health information use can achieve and then the mission is how it can do that.

The next slide just goes over our principles. They're obviously much deeper than this but each of the federal partners is committed to following these principles and to work together to accomplish these things. It's a good thing for us to revisit as we start with various new programs that we would be thinking of to make sure that they map back to these principles. Next slide, please.

Here you see the goals and as you'll see goal one is now focused mostly on the person-centeredness and goal two is healthcare delivery, goal three remains the scientific aspect and the innovative components while four is the infrastructure.

What we're hoping to do is, as I said, look at high-priority initiatives and use these as our test cases to achieve the goals. Our success in implementing the plan is going to be tested in these initiatives and how they successfully achieve their goals. So as we look at things such as precision medicine and alternative payment models, these map back to each of these goals, and we're hoping that by monitoring their progress we'll be able to also monitor the progress of Health IT use across the country.

Other activities within the Federal Trade Commission and Indian Health Service and of course within the VA and DoD are other examples of how we'll be able to upgrade the infrastructure of Health IT and use it more effectively.

Next slide gets at what Karen and others were talking about with the roadmap and the strategic plan. The two are intrinsically related and so you'll see goal four we basically just said, you know, that a key component is implementing the roadmap and because that is so dense we didn't necessarily go into the details within the strategic plan knowing that the objectives were very similar but the devil of course is going to be in the details and as Paul's presentation said earlier, we'll definitely need to focus on the how and it is a long-term effect and the difference of course between the federal plan and the roadmap is that the roadmap is a national plan with private sector participation and the strategic plan is much more of what the federal actions will be on behalf of the public with input from stakeholders.

And with that we sort of slide into just sort of a concluding slide as something that Karen had said to us as we were talking earlier about this being a shared undertaking. We think of shared of course within our federal partners and here with the committee but it's also with the public at large and we definitely want to make sure that we get as much feedback as possible as we're implementing this and as we start holding ourselves accountable.

We definitely want to know what it is that we're doing right, where we still need to make modifications and where we can make the plan even stronger. So when we do release this plan soon we hope to get feedback from you and from other stakeholders on whether we got it right and where we have some gaps that still need to be filled.

I know that's a really superfast high-level presentation but I open the floor to any questions or comments that folks have knowing full well that until its released I might not be able to give all the details that you're looking for.

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

Thank you very much Gretchen and thanks Karen. It's clear that you all were very responsive to some of the feedback that the committee and folks provided so thank you very much and it seems much more person-centered now with an underlying infrastructure to support that. Let me open it up for questions or comments from the committee please?

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

Paul, it's David, I'd just echo your appreciation that it sounds like a lot of the feedback we and others gave has accommodated and I really appreciate that and I'm looking forward to seeing a lot of the details so we can get going on doing the work.

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

Thank you. It actually integrates very nicely with this convening summit idea we have of just sort of kicking off this major effort to give the country and everyone the underpinnings we need to focus in on the individual and community health. Any other comments? I don't see any other hands.

So we will wait for the release of the official report and as David said we will dig in and get working on it. Appreciate it Gretchen and thanks to ONC, to Karen for this wonderful plan and in both regards the plan and the interoperability roadmap coming up. Okay why don't we open to public comment, please?

Public Comment

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-6006 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time. Thanks.

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

This is Michelle while we wait for public comment I just wanted to thank everybody for your patience in being...and your flexibility for us making this a virtual meeting rather than in person meeting. We just didn't want to take up more of your time with travel than was necessary and as you can see we ended at 11:00 today so it probably was good that we made it virtual, so thank you for your flexibility and it looks like we have no public comment.

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

There will be a little payback in October when we have both the FACA's. All right. Well, thank you everyone and I hope you're enjoying the last part of your summer and I look forward to seeing you in the fall.

Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute

Thank you.

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

Thank you.

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

Thank you, everyone. Thank you, Paul.

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

Thank you.

Meeting Attendance								
Name	09/09/15	08/11/15	06/30/15	05/22/15	05/12/15	04/07/15	03/10/15	02/10/15
Alicia Staley							X	
Anjum Khurshid	X	X	X	X	X	X	X	X
Aury Nagy								
Brent Snyder	X	X	X	X	X			
Chesley Richards		X				X	X	
Christoph U. Lehmann	X	X			X	X	X	
David Kotz	X	X	X			X	X	X
David Lansky	X	X	X	X	X	X	X	X
Devin Mann	X						X	X
Donna Cryer	X	X	X	X	X			
Gayle B. Harrell	X	X		X	X	X	X	X
Karen Desalvo	X	X	X	X	X		X	X
Kathleen Blake	X	X	X	X	X			
Kim Schofield	X	X	X	X		X		X
Madhulika Agarwal			X			X		
Neal Patterson	X				X	X		X
Paul Egerman	X			X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Scott Gottlieb	X			X		X		X
Thomas W. Greig			X			X	X	
Troy	X	X	X	X	X	X	X	X

Seagondollar								
Total Attendees	16	13	12	13	13	16	17	17