



**HIT Standards Committee
HIT Policy Committee
Joint Meeting
Final Transcript
October 6, 2015**

Presentation

Operator

All lines are 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 joint Health IT Policy Committee and Health IT Standards Committee. This is a public meeting and there will be time for public comment before lunch and at the end of today's meeting. As a reminder to those making a public comment, it is limited to 3 minutes. Also as a reminder to those in the room and on the phone, if you could please state your name before speaking, as this meeting is being transcribed and recorded it would be appreciated. And we'll take roll by going around the room. There are a few new faces in the room today which we'll introduce afterwards and we'll start with Kate Goodrich.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Hi, I'm Kate Goodrich, Director of the Quality Measurement and Value-Based Incentives Group at CMS.

John S. Scott, MD - Program Director, Clinical Informatics Policy, Office of the Assistant Secretary of Defense, Health Affairs - Department of Defense

I'm John Scott from the Office of the Assistant Secretary of Defense for Health Affairs representing DoD.

Kevin Brady, MS – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology

Kevin Brady from NIST.

Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP; International Health Terminology Standards Development (SNOMED)

Andy Wiesenthal from Deloitte Consulting.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

John Derr representing long-term post-acute care.

Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services – Health & Human Services

Lorraine Doo with the Centers for Medicare & Medicaid Services.

Paul Egerman – Businessman/Software Entrepreneur

Paul Egerman and new title, grandfather.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Eric Rose, Intelligent Medical Objects.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Arien Malec, RelayHealth.

Angela Kennedy, EdD, MBA, RHIA – Head & Professor Health information Management – Louisiana Tech University

Angela Kennedy, Louisiana Tech University; I represent the consumer.

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children’s Hospital

Josh Mandel, Boston Children's Hospital, Harvard Medical School.

Richard Elmore – President, Strategic Initiatives – Allscripts

Rich Elmore, Allscripts.

Brian P. Burns, MA - Deputy Director, Office of Information and Technology - Department of Veterans Affairs

Brian Burns, Department of Veterans Affairs.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Steve Posnack, ONC.

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

Jon White, ONC.

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

Paul Tang, Palo Alto Medical Foundation.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

John Halamka, Beth Israel Deaconess Medical Center.

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

Karen DeSalvo, ONC.

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

Jodi Daniel, ONC.

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

Patty Sengstack, Bon Secours Health System.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Leslie Kelly Hall, Healthwise and the Informed Medical Decision Making Foundation.

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

David Kotz, Dartmouth College.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Lisa Gallagher, HIMSS.

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

Anjum Khurshid, representing Louisiana Public Health Institute.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Liz Johnson, Tenet Healthcare.

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

Chris Lehmann, Vanderbilt University and representing under-represented populations.

Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health

Anne LeMaistre, Ascension.

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

Neal Patterson, Cerner.

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

Troy Seagondollar, Kaiser Permanente and labor representative.

Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)

Becky Kush, CDISC, representing clinical research standards.

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

Brent Snyder, Adventist Health System.

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy – Kaiser Permanente, Institute for Health Policy

Jamie Ferguson, Kaiser Permanente.

Dixie Baker, MS, PhD – Senior Partner - Martin, Blanck & Associates

Dixie Baker, Martin, Blanck & Associates.

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

Elise Sweeney Anthony, ONC.

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

On the phone caught do we have David Lansky?

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

Yes; thank you, Michelle.

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

Hi David. Scott Gottlieb?

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

I'm here; how are you?

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

Hi, Scott. And Cris Ross.

Cris Ross, MBA – Chief Information Officer – Mayo Clinic

Good morning; this is Cris Ross from Mayo.

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

Hi, Cris. Anyone else on the phone?

Wes Rishel – Independent Consultant

Wes Rishel.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Yes, Anne Castro...

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

I heard Anne Castro and Wes Rishel.

Wes Rishel – Independent Consultant

Yup.

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Yes.

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

Okay. Well thank you, it's a cozy room today but we'll make it work. And so with that, I'm going to turn it over to you, Karen.

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

Thank you, Michelle. Good morning, so, do you want me to do the introductions of new members or did you want to do that?

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

I'm sorry, I meant to do that.

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

Okay.

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

So we have a few new members. We did announce the Standards Committee members on the last call, but they're here with us in person. Jitin Asnaani unfortunately is not here with us but we do have Angela Kennedy, Rich Elmore, Josh Mandel and Patty Sengstack here with us today, so welcome them. It's so nice to meet you in person and it's an exciting first meeting to have both Policy and Standards Committee together. And we also from the Policy Committee have Brian Burns with us, who was our new VA representative, so welcome to Brian as well.

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

Wonderful. Thank you, Michelle and thanks everybody for being here today and we appreciate you all adjusting to the close quarters. We had heard a lot of feedback that having joint committee meetings was really helpful, especially when we're talking about work like the Interoperability Road Map that has policy and technology considerations in it and that it's a good chance for us to have some shared dialogue in this space.

I want to just make some overall remarks about framing our conversation today and give you all a sense of what we are wanting to accomplish and get some feedback from you all on. We're going to start with a sort of check-in about where we are with data on the Meaningful Use Program, which has been a very successful program at encouraging adoption and starting to advance the exchange of electronic health information. It's a program that you all...many of you had a hand in helping us develop for this country and was one that rewarded doctors and hospitals to use technology.

I think clearly where the world is moving very quickly and where we at HHS want to help lead that transition is to reward doctors and hospitals for better care and see that technology is an integral part of that care delivery. And that is this delivery system reform effort the department has had is really about that; it's a three-pronged effort that changes the way we pay for care, the way care is delivered and the way information is distributed.

I'm going to walk us through that in the delivery system reform update which some of you have been through and I want to tell you where that is today and just remind everybody that our work here is nested within a really important short-term priority that we have in the department and the administration to see that we build a person-centered system that is going to enable them. Because they have the kind of information available to make their own decisions, but that the health care system can make better decisions because the information is there for them and quite frankly so we can take new payment models to scale, which we won't be able to do unless we have the information available.

Then I'm going to hand it over to my colleague at CMS. Kate's going to talk about this opportunity that we have going forward in the MACRA legislation. This is the...came out of the SGR fix. This is front on our minds; we just put out an RFI recently to help get some feedback about not just the payment models, but please for this group remember that there are expectations for ONC in that legislation about how we help technology advance in such a way that it can support new payment models.

Again we're already working on a delivery system reform, but very acute and clear timelines within the MACRA legislation. So this is moving us from a world of fee-for-service to value-based, not just payment, the value-based models that support community and overall health. So we're going to need you all's assistance in thinking through how we can enable and make those real for doctors on the ground and hospitals out in the field as we think more broadly about payment reform; so that's what Kate's going to talk about.

Then we're going to take a break and then we're going to talk about one of these really important streams of work in this better care, smarter spending, healthier people delivery system reform model which is we're going to get information available to make better decisions for everybody on the front line, and that's the interoperability roadmap that so many of you have had a hand in developing.

We really appreciate the thoughtful input and I think we've had some conversations with a lot of folks in the last few days as we're thinking about how...what we're going to commit to as federal partners is going to match up with what the private sector is able to commit to and how we're going to really catalyze this. Thinking a lot about this in the last few days and I'll just make two closing comments.

So one is, whenever we're not sure where to go, we always remind ourselves at ONC that this is about the people of this country, this is about the average American whether they live in a rural community or an urban community, no matter the time zone. I wore my Walking Gallery jacket today on purpose to help me and all of us remember that this is about the, not just the patient but the consumer and the community that we're here to serve. So whenever things feel sticky, let's keep that in mind, that we're doing this for them.

In the second place, I just want to make a comment about the importance of federal and private sector partnership throughout all of this work. It's why we're reaching out to get feedback on things like MACRA. The work that we do as the federal partner in this across administration is, we have broad blunt instruments that set broad guardrails and direction and can enable and push policy that sometimes doesn't touch the ground, doesn't touch the clinic room for some period of time. And so we're really counting on you guys to work with us so that feels palpably different to average doctor, average patient, every day, as soon as possible. Because the sense of urgency that they feel, we share but it's going to require all of us working in concert.

So that's what we're...our agenda is for today, to tell you where we are with our program to encourage the use of technology and really move us to this new world which we in of encouraging better care. And technology is a key part of that and start to think about how we're going to iterate technology to make that a reality and what we are proposing in the roadmap. So thank you guys very much; thank you again for being here.

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

Good. Thank you, Karen and Karen went over the agenda and it's really logical from where we've been and where we're headed and just echo some comments about Meaningful Use. If you remember the...of course the first part of that Stage 1 was to get data in these systems and in front of people. Did a great job at doing that. The second one is to get the data all over the place where it needs to be and not where doesn't need to be, and we're in the middle of that.

And the thirdly was always focused on outcomes and I think it was also we knew ahead of time there was going to be a handoff or we're hoping for a handoff, Meaningful Use having preceded ACA by a year. But hoping there'd be a handoff to the delivery system reform in a sense, of having the right kind of payment model and also having the right kind of systems where we have team-based care to coordinate ways that we both support health and healthcare.

So I think this is the nexus between where we were in getting these systems in place to where we're headed, which is to reconfigure to reform the delivery system. So, it's a nice spin off to point. John?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Do you want to get your minutes approved now or later?

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

So we have two minutes now to approve. One, and I realize you got this very recently; if you had a chance to look at it is we were asking for approval of the minutes that were distributed for the Policy Committee and John's going to do the Standards Committee. I entertain the moment...a movement to approve the Policy Committee minutes.

Paul Egerman – Businessman/Software Entrepreneur

So moved.

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

Thank you, Paul. Second?

M

Second.

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

Thank you. And any further discussion or amendments? Okay, all in favor?

Multiple speakers

Aye.

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

And opposed or abstain? Thank you. John?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you. And of course, do want to welcome our new members, Josh, Patty, Angela, Rich and Jitin, who couldn't be here today. And it is great to see infusion of new ideas and new energy. I think you know what is this, our 75th meeting or something of the Standards Committee. So if nothing else, we have lots of frequent flyer miles.

But again, thank you for your service and look forward to the day, as Karen has said, as I look at the accountable care organization activity in my state, the kind of interoperability we need are no longer just driven by Meaningful Use, they're existential; if we don't share data for care coordination, reducing redundancy and waste, improving quality, safety and efficiency, we can't survive. The margins of our healthcare systems in Massachusetts are about 1% and so it is now driving us to build new kinds of databases and new kinds of, as you say, team-based care and thinking about new ways to be go beyond transition of care summaries.

So today is going to be very interesting; we'll hear the framing remarks, as Karen said, and then in the afternoon we'll be talking about the interoperability roadmap and there will be lots of opportunity for discussion. And so I look forward to that. Other than that I did ask, as I always do, I said Jon White, so are we going to hear about MU 2, MU 3, anything in the future? Not yet. So there you go, free for politicos listening, you know, we're going to do all the substantive stuff, no rumor, no innuendo.

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

Right.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

But most importantly I think I want to turn it over to Jon White to talk about Jodi because Jodi and I have served together since what, the very earliest days of David Brailer and so Jon.

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

Yeah, all right. This is the job that I really don't want, but I'm going to take. Okay, so first, I do want to welcome everybody. It's really nice to see you all here, you know in a location that has a lot of history in Washington. The Omni Shoreham has been around for a long time, a lot of things have happened here. And similarly, this meeting and this week really kind of mark a bittersweet close to a chapter in ONC history and the history of health IT in our country and that is because Jodi Daniel, the Director of our Office of Policy, is leaving us after over a decade of service at ONC.

You know, as somebody who has recently left a job that I loved for...where I spent a decade, I have a lot of sympathetic feelings about this and I know kind of probably the struggle that you went through to try to make the decision. And it's bittersweet because, not only are we having to say goodbye to you, but we know that amazing things lie ahead in your future and our future work together.

So, you know, there's really no way for me to capture not just, you know, 10 years' worth of public service, but really all of the things that Jodi does and has done. So I'm not going to try; there's just no way. My ask for all of you here who have worked with Jodi over the years is please take the time to come find Jodi today and speak with her and tell her what her services meant to you because really at the end of the day, it's the connections with those of us here in the room and listening who...that really mean a tremendous amount to us as individuals who...so, I'll simply say this; Jodi, you are fiercely intelligent, you are a staunchly loyal colleague and co-worker for those that you work with, for and who work for you and is extremely valued by all of us, more than probably you will ever know.

And most importantly, you are the most...one of the most deeply committed public servants that I have ever met in my life. And as somebody who has committed their life to public service that has meaning not just for me and not just for the people here, but for the people across the entire country. And there is really no better honorific that this son of Virginia can offer to you than to say, it has been an honor to serve with you. Thank you, Jodi.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And we do have the matter of the minutes from the Standards Committee. So, we do things a little bit differently in the Standards Committee; it's all by consensus and collaboration, it's a lovely thing. Are there any objections to the minutes?

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

You're balloting?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

None being heard, they are approved by consensus. Thank you.

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

...this way. I want to thank Jodi, too. I've worked with her the entire tenure I've had here and this has been an incredibly productive Federal Advisory Committees, sub-committees and Jodi's been at the heart of that. Jodi did have a career before the ONC and she actually played a big role in HIPAA as well. So, there's a lot of ways that her work has touched all of our lives and the lives of the residents of this country so thank you so much.

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

Thank you, Paul. Can I just...I just want to step on all that and say...

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

Are you going to try to make me cry?

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

I am...didn't have a tissue, so no, I won't do that to you Jodi. But I, you know, they're right in everything that they say. Jodi has an extraordinary intellect and she's just...in addition to all the contributions that she's made for actually 15 years of public service and 10 at ONC and...including her deep understanding of HIPAA, her deep understanding of health IT policy, not just within the federal government, but more broadly. She's a great mentor and teacher and I have learned so much from her about public service and about what...the way that we can use, as Jodi says, our superpowers for good and also how when it's appropriate, for us to step down.

So I think there's a really nice balance and she's just done a great job of...as an advisor and a mentor and a she's done a great job with her staff. I think she's just really helped develop some very fine talent in her shop. So I just want to thank her as a citizen for her public service but also as someone who's been on this team with her for the last couple of years, it's really been terrific. We're going to miss you.

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

I'm sitting next to a nurse so I've got tissue.

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

...take care of that.

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

Okay, and that's maudlin. Beth here?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So I believe we, Michelle are now turning the meeting over to Elizabeth Holland?

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

She is on the phone.

Elizabeth Holland, MPA – Senior Technical Advisor - Centers for Medicare & Medicaid Services

Hi, I'm on the phone; can you hear me?

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

We can hear you.

Elizabeth Holland, MPA – Senior Technical Advisor - Centers for Medicare & Medicaid

Okay, great. So I'm going to talk about the Medicare & Medicaid EHR Incentive Programs, just what I can say. I am with the Quality Measurement and Value-Based Incentives Group, so I work with Kate Goodrich at CMS. First, we'll talk about registrations for the program.

So, registration has continued to be open for the programs throughout the year. So you can see our August numbers; we're continuing to have providers register. It is interesting that we've had as many Medicare eligible professionals register as we have; it's too late now for them to initiate the program and earn an incentive payment, but they continue to register. For the Medicaid eligible professionals, they can still initiate and earn incentive.

So next slide to the Medicare provider count. So this is your breakout between Stage 1 and Stage 2. And I'll remind everyone, as has been discussed before, the Stage 2 numbers are reduced because of the flexibility that we did offer last year. So, we offered flexibility for those who had difficulty implementing their EHR technology certified to the 2014 Edition, so we enabled them to have the opportunity to either use 2011 or technology certified to the 2014. So some providers who were choosing to use their 2011 certified products, had to do Stage 1, they couldn't Stage 2 even if they wanted to because their technology didn't offer them the appropriate measures that they needed to do Stage 2. So, those are our divisions between the stages.

Next slide, attestation for 2015. So as I previously stated, we have the registration numbers for 2015 because registration has been open, but for 2015 attestation has not been open. Due to the proposed modifications that we proposed, as you know, on April 15 we released a proposed rule that included modifications for 2015 through 2017. And due to the changes we proposed, such as a change to the EHR reporting period in 2015 and other proposals meant to make the program more flexible and simpler, we have not been able to have attestation open.

So we did hear from some hospitals who were first-time hospital participants, who wanted to be first-time participants who had worked really hard implementing their electronic health records and were finally ready to attest and then they came to us and said well attestation is not open, what can we do? So we did open a special window for them to come in and to attest because first-year providers do have a 90-day reporting period, according to the current rules. So we did have probably between 60 and 70 eligible hospitals and CAHs who were in their first year of participation come through with...using the window that was in July and August.

So once we release our final rule, hopefully soon, we will be able to modify our attestation system and then we will be able to open attestation in January. So it is our intention that attestation will be open from January 4, 2016 through February 29, 2016 for all providers to attest for 2015 or EHR reporting periods in 2015.

Moving on to the provider summary. As you see, there's a big gap in providers paid for the 2015 program year and that's because of attestation. Medicaid, many states still have their attestation open for 2015, so that's why you see that there are numbers for Medicaid in 2015. And as I mentioned, we had hospitals come in and some of them had been paid. It usually takes us a little longer to pay critical access hospitals, so that's why the number isn't as high as the 60-70 that I mentioned, but those numbers should be going up throughout the fall, as we get documentation we need to pay CAHs and they'll get paid as well.

To my last slide, provider payments. As you see, the number of providers tracked with the provider payments are the money that we've moved this year is very small because of attestation not being open. But we expect that we will be paying lots of people after the attestation period in January and February. So, that's all I really have for today, but I'd be happy to answer any questions if there are any.

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

Okay, thanks, Beth. Questions or comments from the committee members? Okay, well thank you very much.

Elizabeth Holland, MPA – Senior Technical Advisor - Centers for Medicare & Medicaid Services

Thanks.

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

And so now we're going to move to Karen. As she said, she is going to talk about the movement towards delivery system reform and the co...and really setting the context for why do we have these systems? And why are we moving data? And it's really so that we can reconfigure our entire delivery system for the benefit of the people in the country.

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

Excellent. Thank you, Paul. Thank you, to the committees for giving us an opportunity to share for the first time with some of you and as a reminder for others the work that the department's doing in delivery system reform. This is a really critical time for the country because we have made such great progress with giving people access to care.

We have some 17.6 million people who now have new coverage and we feel, to paraphrase John Eisenberg, that now we have to make sure they have not just coverage, but coverage to something that's really high-quality. And so we have been spending the past almost a year and one-half in the department laying out a strategy and understanding where we should lead, where we should partner and where we might need to follow to get us to a place where we have a real person-centered health care system.

So, we are striving to get to a place where we're going to improve the way that providers; when I say we, I'm meaning department, it's that pronoun just for you all's edification. Improving the way providers are incentivized, the way care is delivered and the way information is distributed so we can get better care, lower-cost and a better, healthier system and communities. These three areas, we feel And we have other opportunities in the federal space where we have been having increasingly

productive conversations. For example, with the federal employee health benefits folks, but I'd say particularly the DoD and the VA, they're looking more and more at purchasing care in the private sector and as Tricare is thinking about ways that it wants to really move towards value-based and alternative payment models. All this to a goal that we want to make certain that care can be delivered in a way that meets consumer's expectations, doctor's expectations.

I think a lot of you all know my personal story, which is that I am still practicing and so is Patrick Conway and Meena Seshamani. We've been co-leading this effort, so this is personal to us inasmuch as we know what it feels like when you're working in a fee-for-service system that gets sometimes in the way, especially in primary care, of doing what it is that you want to do with that person being able to have team approaches and coordinated care. And pilot after pilot in this country has demonstrated that that works, whether it's a patient-centered medical home model, whether it's an accountable care organization, whether we think about bundles and even new models that we have yet to determine.

The more latitude that we give providers and consumers, the more opportunities there are for everyone to work at the top of their license and to be focused on a person and coordinating them and the context of their health, not just health care situation in the episode but really longitudinally. What are the conditions that are going to allow them to be healthy and how can the health care system support it? That's what we want to encourage and support. So in the second phase of care delivery it's a lot less about defining it, it's much more about supporting and encouraging and I'll share with you in a little bit how we're working to do that.

And the final piece of this for us is how to di...how we distribute information. And this is again a place where we believe we have some responsibilities to lead. We also know there are some great models in the private sector, even outside of the electronic health record and interoperability space, in transparency where we're learning a lot, and I'll get to those in a moment.

Just to walk you through what this...what this really means to us is as we think about getting a care that provi...getting a system that provides better care, spends more wisely and has healthier people. These are our three areas of work, incentives, care delivery and information. In the first phase, we want to promote value-based payment systems; that's not just those that are...where there are links to quality, but really moving forward with population -based payments, where there is opportunities for the system to work together to share risk and also to think about how we're doing a better job of measuring quality in a more seamless way so it's not an add-on but it's a part of the workflow.

We also have the opportunity from the Affordable Care Act; the Secretary does, to bring proven payment models to scale. And so where we are learning from our actuaries and other data that new models of care that are in the alternative payment space bring cost-savings, bring better quality or do both, that's an opportunity for her to bring those to scale so they can be mainstreamed.

In the second area, this is about encouraging integration and coordination of clinical services across the care continuum so not only in the acute or physical space but behavioral health, long-term acute care

and the other key component parts. Increasingly I think you're seeing us looking at ways we can work with Medicaid and SIM state efforts to make certain that we're also contextualizing health; that is, health that is more than health-care and how do we think about care delivery system as incorporating social and human services that really support a person when they leave a healthcare facility and/or keep them from having to spend all their time in the doctor's office.

And then finally, the information space is yes about electronic health information and data movement. It's also about creating transparency on cost and quality. So our work in the department to move to and open...to more open data opportunities will continue. We appreciate the private sector's partnership in that effort. We want to make it such that data available to consumers is digestible and accessible so they're able to make better decisions about cost and quality. And I'd say that the same has got to be true for other...for the providers in the system as they're thinking about their referral networks and how they want to work within their medical neighborhood.

And then this...the consumer and clinical decision-support is work this group has done on clinical decision-support for clinicians, but also for consumers. So that as new opportunities come around for treatment and cure, like precision medicine, we can bring that to the front lines for old-school doctors like me and didn't learn precision medicine in school, but also when we have challenges in our country like opioid abuse, we can help bring information to bear on the front line so that providers can tackle emerging epidemics or public health challenges.

We spent a minute on the incentives piece. So we proposed almost a year ago that we would want to define what payment reform would look like. This is from Dr. Conway and others at CMS published this paper which describes the way we're thinking about a set of categories around changing the way we pay for care. This strawman is being used now by our Learning and Action Network and which I'll share more about status of shortly. but this group of national leaders is helping us think about, is this the right definition?

Is category one really pure fee-for-service, no link to quality? The second, fee-for-service linked in some way to quality. The third, an alternative payment model but still on a fee-for-service architecture, whether that's the documentation architecture or the billing architecture of the underlying IT and other systems. And then finally, what we think is...shows the most promise is population-based payment that are not dependent on a kind of a fee-for-service architecture going forward, but really allow a lot more flexibility in the care environment and more ease of measuring outcomes and patient and provider experience.

Let me see, my next slide. We set some goals in January of 2015 around these value-based payments. We drew a line in the sand essentially and said, as a major payer we have a responsibility to lead. And so we said that by 2018, we would reach a tipping point where 50% of Medicare payments would be in alternative payment models. So flipping back on the slides that would mean at least in categories two, three or four. We also said that we would set ourselves a shorter term goal of 30% in 2016, which is basically tomorrow in federal terms.

I want to give you all some sense about where we are with the goals...excuse me, I misspoke. The category three and four are the alternative payment models for goal one. If you include category two, that's goal two. We were at 0% for goal one in 2011. We were 20% last year and we believe that we're well on our way of achieving this goal of Medicare being...moving out of fee-for-service and into alternative payment models by 2016, which sets us well on the road to being there by 2018.

I say this a lot when I talk about delivery system reform and payment reform. For us it's clear that we need to set a guide path...glide path that goes beyond this administration so that providers know where they are going, so that the CFOs know what they're building for so that the CEOs know what care models they're trying to staff up and support and so the doctors and their offices know the way they're going to be able practice medicine.

That it's not a demonstration, that it's not a short-term solution, that this is what we're hearing from providers and others is the way they want to practice medicine with more flexibility and certainly what data tells us matters more so we set this longer term tipping point goal into 2018. But backing up, it's really that we want to make certain we set ourselves a goal within this time that we're here and that we're able to continue that trajectory.

Just to give you an example of some of the kinds of work that fit into this space, so think about accountable care organizations, think about the bundled payment models, think about patient-centered medical homes. And Kate is going to talk with you all more in a little bit about all the inside work we're starting to think about and we've pushed out, asked for help in thinking about new types of alternative payment models or how to simplify what we've been putting out. I think that there's a...we don't want to just keep making new payment models because we can, we want to make it such that teams on the front lines can work with patients and communities in a way that's going to make sense for everybody.

More about goal two which is that we also said that we wanted to set some goals that by the end of 2018, 90% of payments would be somehow linked to quality or value-based and that by 2016 85% would be. We're pretty close to that number of 85% right now in all of our payment programs. But I want to be clear with folks that it doesn't...this is not a continuum, so you don't start at one and move to two and three and four.

What we believe makes a lot of sense is if we can skip over sort of that fee-for-service linked to quality model and move to something that's more population-based. So we don't want to imply with these two goals that we believe that there's a stepwise fashion, it's really about all of us starting to be able to build the care models that we know work better for people on the front lines.

This is just a reiteration of what I described before about how we're thinking about the target percentages and how fee-for-service linked to quality fits in with the overall schema and how we're working to advance our payment models in the Medicare program.

Before I get to care delivery, just another...just to talk about our Learning and Action Network. So we set out these goals in January of 2015 and we asked the private sector to come with us. The Secretary was clear that we were going to give some certainties in the marketplace, we were going to move towards models that were more person-centered and population-focused and focused on value; that it would be desirable and helpful if the private sector and Medicaid Programs would do something similar to mirror that so that when you're running your practice, when you're running your hospital, when you're working on a team you know that your revenue streams are all supporting the kind of care model that you want.

We've had 7 of the 10 largest payers agree that they want to move in the direction...in that same direction and many of the State Medicaid Programs are saying something similar. Our Learning and Action Network is a public- private partnership run out of CMS that has now...about to have a one-year

anniversary. And it has been working on defining the alternative payment models using our strawman, but thinking about what that...how we can align that with the private sector and Medicaid, thinking about some of the technical issues here, attribution, risk-adjustment, what is quality and value? How does...what does that mean for folks.

And we're coming up on the anniversary of that this month and it's in...oh, it's in March, you're right, but we're having a 6-month anniversary this month where we're going to be...there's no rest for the weary at HHS, such that we can talk about where that group is. And Mark Smith and Mark McClellan have been co-chairing it; they've done a terrific job, really kept it on track. And I think what we're trying to understand also is, what is underpinning IT that's going to support those new models going forward. That we'll talk more about after Kate's presentation.

And then there's an opportunity beyond Learning and Action Network that Medicaid has set up the Innovation Accelerators to help Medicaid Programs that want to understand how to move to alternative payment models. And that and our STM state Health IT Resource Center are just ways that we're trying to help the payers, public and private, to advance to this new world.

We also know that it's going to require support for providers. And so in the care delivery space, not that we want to so much define what's a great model of care, what we want to do is give more latitude and support and technical assistance. So think about our Regional Extension Centers and how much they helped providers on the front lines adopt and adapt to electronic health records; providers that were...the 150 thousand that we still have connections with and those that achieve meaningful use, they were twice as likely to achieve meaningful use if they had technical assistance.

And I've been on the other side, I can tell you it really matters, you need to have somebody over there helping you know what the rules are and the expectations. And so there are a variety of ways we are looking to provide technical assistance to front line clinicians that one of the them we announced last week, which was nearly 700 million in awards to 39 national and regional networks and organizations that we believe will equip more than 140,000 clinicians with the tools and support they need to move to alternative payment models and that will include areas where they may need some additional assistance in technology.

Just to give you an example of some of the organizations that were funded in the announcement that we put out last week, major physician groups like the American College of Emergency Physicians, of radiology. Work with National Rural Accountable Care Consortium so that we're not leaving anyone behind is one of our key policy goals is that every person in this country should be able to enjoy better care, no matter where they live.

And the American Board of Family Medicine, thinking about how this becomes integrated into the way that we're doing maintenance of certification. They believe they're going to be able to reach 50 million or more patients through their clinicians. And the National Nursing Center's Consortium, remembering that this is about a care team. I can see Patty sitting up straight every time I say the word doctor; I'm paying attention, Patty. This really is about care teams and we want to make certain that we're reaching everybody and helping incumbent and new workers get to the other side.

Okay, the last piece of this is about changing the way that we deliver care...I mean, the way that we

distribute information. We all know that if we're going to bring new payment models to scale so that we can do more seamless quality measurement, so that we can have evidence that the point of care, information a point of care to reduce redundancy, see that people aren't getting stuck over and over again for the same lab test, to see that on the weekend a mom or dad can pull down immunization records of their kid and have...not have to go into the healthcare system to get that information, but actually just get them enrolled in camp and move on with their lives.

We want this to be more seamless for everybody and that's going to require not only the continued progress we've made in digitizing the care experience; you know I've been working on that for a year since I heard you say that and I'm getting better aren't I. Digitize the care...that word is hard to say, but to digitize the care experience for everybody in this country and do that across the care continuum, not just within the place that we started with Meaningful Use.

But Jon is right; we have people that are getting care outside of the MU space and long-term post-acute care and behavioral health and EMS and beyond. And so we want to see that that is woven together, but we also want to know that that information doesn't get...stay trapped inside the health care continuum, that it is available for other public good uses, like public health and preparedness and most importantly, for consumer access when and where it matters to them.

And so the work that we've been doing in the third bucket of this delivery system reform space around seeing...changing the way information is distributed includes continuing the advancement of adoption and digitization. It includes interoperability, a more seamless flow of information not just between systems but data itself on behalf of consumers. And it will include more about transparency. So there will be more to come on that.

So with that I'll just stop for a minute and take questions from this group about the delivery system reform effort. I think the key take away is health IT is essential to seeing that we can get to better care. It is a means to an end and we know, very acutely that in order to get to this better world at scale, it's going to require that we have not only better data systems, but frankly transformed ones. It's going to require, in some cases, some disruptive technology that we believe will come in part from our pushing in the policy direction, but from innovation in the private sector.

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

Thank you, Karen.

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

Um hmm.

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

Comments and questions from the committee members? Eric?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thanks very much for that presentation, it really, it laid out a very coherent vision in such a clear manner; it was really helpful to me as a member of the Standards Committee. I'm interested in your perspective on the state-of-the-art of quality measurement because, of course, with these advanced payment systems, if quality isn't somehow baked in, then it's just going to be a rehashing of what we experienced in the 80s where it was...there were financial incentives that ended up being acted on...or ended up amounting to incentives to withhold care.

And yet the...I'm concerned to see evidence being published that adhering to...scoring well on quality measure is not necessarily an indication of good outcomes. And how are we going to advance the state-of-the-art in terms of assessing quality so that all of this really does create healthier populations?

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

Thank you, Eric. Such a big question and I know I should throw this one to Kate, but I'll start and if she wants to weigh in, because Kate runs the quality work at CMS. The broad picture is the following that we believe that one of the most important responsibilities that we have as a federal partner in getting to better care is to streamline and harmonize quality measurement as a first step so there's macro alignment between all of our various programs.

I hope that you all have seen that we have been advancing in that way; she can share more about it. And that's really at the macro level and we have a process at play to do the same thing with private payers and Medicaid so that as a provider you're not working against a bunch of different tasks and have 1300 quality measures that you're reporting to, but to simplify and harmonize that.

The next generation of that is to be able to do the e-Clinical quality measurement, obviously in a seamless fashion so it's not added workflow, which is, I'd say my dream. And one of the ways to get there is that we have the right fundamental building blocks in...as a part of the data collection at...in the first place so collect it once, reuse it many times. Hence the reason in work like our Interoperability Standards Advisory that you all saw a couple of weeks ago is what is this common clinical data set? What are the basic ways we're going to collect some information that's going to allow us then to use those as fundamental building blocks not just to share clinical information, but also to build...to roll those up into quality measurement. It is...if we don't get that right, just from the mechanical standpoint I agree with you, it's going to be a major challenge to take this to scale.

You're asking a second, I think even more important question which is that are we measuring the right stuff in the first place? And I think that we're all still trying to get this right. The IOM came out with a report a few months ago on measures that matter which proposed thinking about new domains including the context of somebody's health where they live, learn, work and play and how that influences health. So you could begin to reshape our thinking in many ways and it's important work to do.

Here's what I would say our philosophy is though, we've got to make it more simple. And we've got to make it more straightforward and we've got to make it more seamless for the providers because otherwise, we're losing them and that's not what we want to happen. We want everyone to be engaged in understanding not just about process but about outcomes. We also have to make it such that the consumer's voice is heard in this and that there's room for those kinds of outcomes, for person-centered outcomes. Kate, do you want to add any?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yes, I do want to add. So your comment about how performance on a number of these measures doesn't lead to better outcomes is absolutely true. I think there's a body of evidence that is now more robust that shows that performance on a process measure has very little relationship to performance on the related outcome measure, and that is absolutely true.

And I think, as we are able to start moving away from sort of the traditional administrative claims measures that we have used and, for example, the PQRS Program and that private payers also used to hold their clinicians accountable, which really are very dependent upon clinical processes of care. And we can start to move towards more robust meaningful use of electronic data that will afford us the ability to be able to actually capture outcomes, particularly as we improve on interoperability and sharing of information when you really can capture those outcomes.

I would invite you to look at the portfolio of measures that CMS currently uses both for the physician and the hospital and other facility programs and I think you'll see that over time we've really started to rebalance that portfolio away from as many of those clinical process measures and towards more not only outcome and patient reported outcome, but I would submit that measures like appropriate use of technology and diagnostics and services are also critically important measures. Last year we removed 50 measures from the PQRS Program that were low bar clinical process measures and our intent is to continue to do that, especially as those measures top out. But you bring up a marvelous point that I think we have to keep in mind with all of the DSR efforts.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thank you.

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

Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Right, thank you. First I just wanted to make a quick comment on something you just said Kate. I think it's terrific that we removed 50 measures that were less useful, so thank you for doing that. And I also just wanted to say Dr. DeSalvo that was a great presentation. This is very exciting work in terms of the direction that we are...HHS is going in. And I particularly personally liked your comment where you said you don't want to stick patients unnecessarily with unnecessary lab tests. I interpreted that as very literally you don't want to stick us with a needle unnecessarily and I appreciate that, personally. So I just want to say, thank you for that. The question that I have...

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

Unless it's for vaccination.

Paul Egerman – Businessman/Software Entrepreneur

Unless what?

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

Unless it's for your vaccination.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

You had yours already.

Paul Egerman – Businessman/Software Entrepreneur

Absolutely.

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

If you want to me to do that, I'm really good at that.

Paul Egerman – Businessman/Software Entrepreneur

Absolutely and that certainly makes perfect sense also. The question I have as I look at this model is how does this correlate with the interoperability roadmap? And in particular, how does ONC coordinate and schedule its activities with the CMS schedule for alternative payments?

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

Boy, that's a softball question from you, Paul. That's wonderful, thank you. Thanks for the feedback and so the department's delivery system reform work has been co-led by myself, Patrick Conway from CMS and Meena Seshamani from the Office of Health Reform. So we meet about 425 times a week and that's probably not an exaggeration.

There's continuous conversation between not just ONC and CMS, but we have involvement from AHRQ, the Office of Health Reform, from HRSA, from SAMSHA, from all across the department, CDC. So it's all across the department everyone is engaged at some level, depending on the...so for example, when we're working on payment reform, clearly CMS has a major role to play in that space. But we're...we have a team and we are coordinating all of this work, including the interoperability roadmap, which in a similar fashion to what we did with the announcements about payment reform as one of the major

efforts that we wanted to lead in that space, this will be an announcement from us about the interoperability roadmap.

And I think what you'll see in the slides and in the document that will come out later today is we believe that critical to the drivers of getting data to move, getting the right business environment is alternative payment models. So we are leaning heavily on the need to have alternative payment models evolve and move in that business environment so that data will not just be pushed but also be pulled.

Paul Egerman – Businessman/Software Entrepreneur

Great. So basically that the Meaningful Use program give physicians and hospitals the foundation to respond to bundled payments?

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

Well that's a...that's another question. And can I...I want to add one more thing about working with CMS which is to say, in addition to just the sort of the general notion that CMS is advancing alternative payment models and we think that's going to...we believe that that creates the milieu that's necessary for interoperability to flourish. Very specifically, we're looking at ways through all of the Medicare payment programs and recommending to Medicaid Programs ways that they might be able to advance health IT, including interoperability, within the rural space. So we're getting more explicit as it's relevant.

Meaningful Use has given us a rich set of resources of data to move so there is information available that needs to be liquid, freed, released, available and that does that needs to be liquid, freed, released, available and that is...that does allow us to have even a conversation about how we would take these models to scale. I think the reality also is though, Paul, certainly what we know from front line providers who are further out who are...and Pioneer ACOs is an example like sort of more advanced systems is they know their IT systems are having to evolve to keep up with them in the new care models. So MU laid a foundation yes, but we have some work to do to iterate the IT systems and the expectations on them so that they can work better for providers as they move to alternative payment models.

Paul Egerman – Businessman/Software Entrepreneur

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.

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

And thank you. Wes, on the phone?

Wes Rishel – Independent Consultant

Thank you. You had a slide with blue dots and gray dots and dark blue dots earlier in your presentation, Incentives, slide 6. I just, just because I'm a Medicare person now that is a patient; I'm curious where you would put...where you would overlay Medicare Advantage with the fee-for-service information here. In particular, how big would the circles be? Would they be any of the gray, light blue or dark blue? Just kind of give me a sense of what's the impact of Medicare Advantage on this and how it would fit in.

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

Thanks, Wes. You're touching on this important concept that Medicare fee-for-service is but one opportunity that we may have and/or that the...one revenue stream. Medicare Advantage Programs, as you're aware, have been able to innovate in many ways and so though we don't...we have some estimates of percentage, we don't have, right now, a great percentage yet that we feel is accurate enough to insert in the circle. So it is something we're working on with the Medicare Advantage Programs. But lots of those programs have already moved to value-based payment models and to population-based payment models and have seen success in terms of quality, but also consumer experience. Kate did you, you know...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

I would just add that as we work through the Learning and Action Network with the private payers, of course many of whom run these Medicare Advantage plans. You know as Karen said, 7 of 10 major payers have developed consensus around these goals. So, we sort of see that running in parallel with what we plan to do with the fee-for-service system as part of the engagement with the private sector as well.

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

Good, thank you. Arien?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Thank you. This was a great presentation. I want to underscore a few things that you said that I think are particularly important right now. We work with a number of health systems across the country, all of whom are in the curious...have the curious sensation of being in two worlds at the same time. This notion of a tipping point, right now you can primarily manage your organization around fee-for-service and then do some special things on the side to manage...do an ACO or some of the program.

As we start to see more lives in alternative payment programs, particularly as those programs have a harmonized set of quality measures and the other important thing that you talked about is and to the extent that commercial payers and Medicare Advantage payers are aligned with those same outcome associated measures, we're going to see organizations stop experimenting around fee-for-service and start committing to models that are value-based by design. And we've got really good models across the country with organizations that fully own their own risk, so we kind of know how to do this.

So I guess...so to turn this from a comment to a question, the important piece of this you've already touched on, aligning quality measures is, what is CMS and HHS broadly doing to encourage commercial payers and Medicare Advantage payers to use a streamlined set at least of outcome measures and programmatic design measures to make sure there's at least a known solid target for health systems to attack?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

So as many of you may know, there's a collaborative now called the Core Measure Collaborative that is being convened by America's Health Insurance Plans. Patrick Conway and I have been active participants in this collaborative for the past gosh, going on two years...a year and a half I guess probably is better.

And the idea here is to get the payers together initially and then bringing in other stakeholders such as the relevant specialty societies and providers and patients and...or consumer and purchaser organizations to develop consensus on aligned measures that can be used across the public and private sector with the end goal being that with these aligned we are calling core sets of measures that CMS would implement those measures in our programs and private payers would require the use of those measures within their contracts.

This is very weedy complex work. There are about five or six working groups, we've got to include all of those stakeholders now going on around key topic areas like primary care, cardiology, HIV and hepatitis C, maternal health, etcetera. And so I think the good news is there is actually some pretty good consensus amongst the payers about what the right measures should be and what our principles around the type measures should be, including outcome-based measures, patient-reported outcome measures.

There is a reality that particularly with, and this is not a criticism it's just a reality that I think we talk about very openly in the group that many of the private payers are reliant on administrative claims measures, which does...those do have some limitations in terms of the types of measures that can be used. But there's also a very widespread recognition of the need to move more across-the-board to electronics sources of data, including from electronic health records, through registries to be able to get to those better measures.

So I think this is a journey that we're on to try to develop these core sets and it's going to take some time to get to full implementation. But it is also, I believe, the first time where you've actually been able to get everybody together at the table and develop consensus around what core sets should be; so to me, that's some pretty good progress.

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

I might draw...thank you Kate. I might draw a parallel actually with standards in that in the effort to define value and quality, we've made lots of quality measures and we keep making them. What we need to do is refine the ones that are working today and make sure we get those right and make those accessible to everyone.

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

Good. Thank you. Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Hi, great presentation. I appreciate the jacket; I appreciate the emphasis on consumer. And with that in mind, I'm very encouraged by what you said Kate, about the appropriate care measures as we've seen in new cancer screening. And hope that those in the future will include the patient voice and not...just a more clinical and medical setting and review. Can you speak a little bit to how we can combine this vision of simplified measures, of good patient outcomes and shared decision-making that could help to define appropriate care with the patient?

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

You can...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Sure. So I love that comment, that's exactly right. Appropriate use measures are very, very high priority for us. We could end up with a portfolio of umm...and we will have some of these sort of clinical appropriate use measures that are based upon, for example, the Choosing Wisely campaign concept. There's a lot of energy around doing that.

I will tell you that in the last couple of years, at least in our work at CMS around measure development for all settings of care, we do require now that we have patients, not just patient advocacy organizations but actual patients and caregivers as part of the measure development process, so that their voice can be heard. And I think the most important place to have them involved is upfront, as we're deciding what are the right areas to measure where there are true performance gaps that are really important to patients.

And so I will tell you that as we start to involve patients and families in these conversations in a very meaningful way that it absolutely changes the conversation about what we should measure. It's been, I think, very eye-opening to us at CMS and a very good experience. I think we're still learning how to do it well, how to engage patients well in that process.

And then through MACRA, the Secretary has \$15 million dollars a year for five years to develop quality measures for the clinician setting, so the ambulatory care setting primarily. And I think one of our guiding principles as we think about how we want to use those precious resources, because \$75 million sounds like a lot but it's actually not, is making sure that the patients voice is at the center but that we also get patients and providers together at the table to develop consensus around what needs to be measured.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Not only the measure, but the actual decision-making itself in what like the appropriate care definition should include the patient, their values...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Correct.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

...and direction and not just a new opportunity for medical only decision-making would be our hope.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yes, thank you.

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

Just to add a couple of things and a recommendation honestly to the committees about that. We agree, yes and as part of the...one of the information spaces that we had consumer and clinical support, that's really meant to be some of the tools and models that are available, for example, for consumers that allow them to make trade-offs that are necessary. Not just about where to go to the doctor, but what procedures to have and where that is in their lifespan and circumstance.

There are a number of efforts though, this is the recommendation I think to the committee or committees is, so for example, we just announced last week at our e-Consumer Health Summit that we're launching an initiative on patient-generated health data, which is not just the data, but looking at other ways that we're going to do person-centered measures. We're going to call it the Jodi Daniel Project.

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

Yeah you can.

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

And then...so there's that effort. Within PCOR, as I think you're aware, there is effort and there's work that we are engaged in with some of the other federal partners about how to develop discrete standards in that space and some other work going on.

Since you're so engaged in the precision medicine work, I think that it's worth saying this to this group in the context of delivery system reform, this is not the only use case for a better health IT infrastructure, there are other use cases. I mention public health a lot and preparedness, but scientific advancement like we are about to launch into with the Precision Medicine Initiative is another example and in that context, to really understand the inputs to somebody's health we're going to have to...and the outputs, we're going to have to have standards and ways to capture experience, environmental risk, behaviors and really satisfaction and toleration of treatment.

I mean, there's just a whole range of things that you know, so, it's a new chapter. But we're pretty focused on getting this part right in the short run. Because we think if we get this right, it creates a foundation for us to launch the rest of it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

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

Good. Thank you. Andy?

Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP; International Health Terminology Standards Development (SNOMED)

A nonevent that's just happened that I think is relevant here and the nonevent is the implementation of ICD-10 in the United States. And, you know nobody's been paid on that basis yet, but so far, all the data flow is going well. And there's a lesson and I think the lesson is the relevant lesson. If we finally decide, put a stake in the ground and say this is what we're going to do and this is when we're going to do it by, with a lot of complaining and ripping of clothes and garments and gnashing of teeth and so on, we get there and we can do it with a reasonable degree of competency.

In my work with all the delivery systems around the country, what they're crying out for, as somebody else alluded to is a clear path that takes from fee-for-service to payment for value. And it's kind of like getting off one of those giant Ferris wheels, you know those that are sort of constantly moving at a steady pace and then you have a kind of platform that's next to the bubble that's moving at the same pace. Is there a plan for setting those kinds of moving pasts so that you can get off the fee-for-service car when you're ready between date A and date B and then everybody's got to be off of the date by date B?

When we do that, Congress will complain, everybody will complain, you know we'll reset the dates a couple of times, we'll do what we usually do. But we need to have that path. Is there a plan for that kind of path so that we can set a target for all these big delivery systems to do this, because it's what they want to do?

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

You're asking a couple of questions in there and I'm going to start with them...

Andrew M. Wiesenhal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP; International Health Terminology Standards Development (SNOMED)

Sure.

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

...and may turn some this over to Kate, but I wish HRSA were here, I wish the Medicaid Program was here. There are a lot of places where we want to provide help to get there. So let me start with the fact that we drew a line in the sand and we said for prov...this is provider level payments, we want to get there. The question was asked earlier by Wes about Medicare Advantage. One of the reasons it's not been a top priority for us is because that's the way we pay a plan, not a provider. They're already, in many cases, paying their providers for value -based payment.

So, we...we're really thinking about how we can give some certainty and move the needle. The reason for the Learning and Action Network is as is allowable to get all of us aligned so that they'll also declare, they the private payers, by this date, this is how things are going to look. And we'll do that for Medicaid and make the revenue streams and quality expectations and attribution models as similar as possible so you can build your infrastructure. But the...so this is our...and so far, that's all sticking and working and I think we're going to...and we have, by the way, a lot of common ground to get to this place.

There are a couple of...so there's a transition piece and there's a pain point I want to talk about. The transition piece is how do you actually go from being fee-for-service to being in a population -based payment? One of the common refrains of feedback that we receive is that the downside risk needs to be minimized so that there is more confidence for big systems and even small ones as they move to alternative payment models. So we do hear that and we're listening about it.

And I think as we're hearing from people about the MACRA RFI, because of the pain point, the individual physician practice and specialists are particularly, I think, going to have a challenge to get through to this new payment models and to know how to change their business practices and their teams. That's one of the reasons that for the nearly \$700 million in support that we hope is going to touch some 140,000 providers directly and help them to get to the other side, but also help them help others to get there. So we do recognize that people need to have minimized downside risk and they're going to need actual help, like real tools and ways to do it so they can take the pause to move.

But there's, I think there's a peer learning opportunity here that CMS has done a lot of work in also, and that Medi...and that HRSA, for the FQHC has been pretty successful in. And in many ways, all health care is local so if we say do it this way, federally; I just don't think that's the solution, frankly. It's got to be, I'm going to adapt this this model for what's going to work for my team and my consumer's.

But on the other hand, there's a lot of concrete things that people can learn from their peers about how to build the teams, how to look at data, how to divide up the care models. And so I hope that starts to answer your question. We've clearly said when we think it'll happen and we've created this Learning and Action Network to get the other payers to the same place, but we don't think it's as simple as just saying, this is going to happen. I just...like with ICD-10, we need to help folks. Kate?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

I think that's all exactly right. The only thing I would add is at least on the physician's side, what is in MACRA is the opportunity for physicians to move into a value-based payment structure and alternative payment structure. And so part of what our responsibility is going to be, as we go through the rulemaking process and all of our communications and education and outreach and all those things we do is to be able to more clearly define what that pathway could look like for the front line practicing physician, group practice manager, etcetera. So as we define what our policies are going to be and what the programs are going to look like, that has to be a major part of it is making the pathway clear; that's just very much on our minds.

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

And I know we have other questions and we're getting close, I just wanted to follow-up with a philosophical comment for you about the department is that, we was...where we should do something, we want to, but in some cases what we hear is we should do less. So this is a really fine balance and we're trying to help and so people are going to figure it out very often on the front lines if we give them the bandwidth to be able to do it and that that's sort of part of the balance we're trying to achieve.

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

I'll add to your lesson, Andy. There was another nonevent that was Y2K. In that sense, Congress did not have a say, so. Okay...

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

All right, we'll try to answer more briefly the following...

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

Here's the following order that I have is Richard, Dixie, is it David Lansky, is...David, Cris, Josh and then Stan. And I think that will wrap it up.

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

And Gayle is on the phone, could Gayle get in, too?

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

Okay, Gayle.

Richard Elmore – President, Strategic Initiatives – Allscripts

So Karen, first of all thanks, that was a terrific presentation and it's clear there's a...see change in how care is going to be provided in a \$3.2 trillion segment of our economy that is being driven off of this vision. That's a big deal and it's going to be effecting not only as you said electronic health records and traditional settings of care, but also post-acute, the entire way in which care is being provided.

And with payment reform and MACRA both driving towards some fairly rapid change, which I think is good, I mean Arien talked about, you know this kind of one foot in each camp. That's hard to navigate; it's inefficient, not desirable. So we get your sense of urgency on the health IT front to be able to support that in these fairly rapid timelines. What...as your team has looked at this, what do you see as the short-term HIT priorities that we need to be focusing on as joint committee to support these efforts?

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

We're going to spend the afternoon looking at that. I would say that from a high-level philosophically, it seems that where data can move today, we ought to unblock it and allow it to move. And where we can create comfort that incentives will arrive or where private payers can help us give that sense of data's going to...got to flow, that we should create that kind of a set of drivers and environment and be clear in our signals.

And that a policy that encourages the opening of data architecture, the freeing of existing data through shared API technology is, we think, some of the short-term ways that we can get there, even in that last space, the private sector can do a lot. It can make choices early, before any rules or expectations come out. We've proposed what we thought last spring and what we heard a lot from folks was the right next step to get data moving. So those are some ways that we would set high level goals. We would work with partners like at the DoD to say, this is the glide path where we're going.

On the other hand what we also want to see is that where data can move today it moves and that we're making it more accessible and available for the care environment and for consumers, but that we're systematically taking steps to get to an open, connected community of health. So I think that, I said this at the out...and you're going to see this afternoon what we think are the short-term priorities, but as we really reflect on how we give comfort to, I always...that my poor husband, to my husband when he shows up for his shift, that it's going to feel better for him when he's caring for patients, it's going to require a public-private sector effort because of the speed with which the private sector can make choices and move.

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

Great, thank you. Dixie?

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Thank you. First of all, I agree with Leslie and others who've said one of the most effective means of getting outcomes data and getting compliance with treatment and avoiding duplicative testing as well is to engage the patient in making sure the tests are not redone and in getting their data from one physician for a test to take it to the other position. The...but patient engagement is one of the Meaningful Use measures that CMS is presumably planning to reduce. It's possible that the portal use-based metric that's currently in the Meaningful Use is just not the appropriate metric to use for measuring patient engagement. So I'm wondering whether CMS and more broadly HHS, is looking for alternatives means or metrics for measuring patient engagement, particularly as it relates to harvesting outcomes data?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

So in the proposed rule, we did propose that...the metric on patient engagement is a two-parter, right? So the first part is what the providers have to do to be able to provide access to patients through, by the way, not strictly the view, download and transmit, which has sort of been translated as a patient portal mechanism. But also we think, especially by the time we get further along in the program that there'll be greater us...or availability and use of APIs as well.

So we also see this as a real opportunity, and probably a better opportunity for many patients to be able to better engage with their care. So we do see it going beyond just the patient portal and we did propose in our rules that it could be patient portal or use of APIs. So we think that that will actually expand the availability of patient-generated data for clinicians to be able to use and for patients to be able to communicate not only with their clinicians and care team, but also with anybody else that they want to share information with.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

So that's the certification criteria side of things, will the metric for measuring also be adjusted?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

The proposed metric, and I don't remember the exact details of it, the proposed metric actually does allow for of either portal, VDT, view, download transmit or APIs; so that actually is part of the proposed regulation.

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

You know Dixie, the next-generation of this may be that if we do move to a place where we all agree and make happen, consumers have ready access to their data and can share it where they want, then trusted third parties can begin to host our own...our data longitudinally and so I don't need to go begging and borrowing or logging into portals to get my immunization records, my last cholesterol, whatever that is that it's available to me and if I choose, I could open my portal to my provider to show them what my data has shown.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Totally agree. Thank you, thank you.

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

Good, thanks. David Lansky?

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

Thanks, Paul. Thank you, Karen and Kate both, this...well the direction you're describing is very valuable and I think we're all very supportive. I'm trying to think about ways we can map some of this directly to what our two committees are working on this year and next and I'm wondering about how we can help forge the connection between payment reform, the quality measurement issues we've all talked about today and the HIT infrastructure of course we're focused on.

And one example that comes to mind and maybe, Kate you comment on this is a relatively new comprehensive care for joint replacement bundle that CMS is intending to implement after the comment period. It seems like a good test case where you have a very concrete APM being put forward with CMS support and it's a nice stress test of many of the issues we've all talked about, even this morning.

The outcome measures have been specified and they're good patient reported outcomes measures. There's a set of risk adjustment variables that have to be captured from the clinical IT systems to interpret those outcome measures. There's an issue of appropriateness and a potential overuse of bundles, and we don't yet have measures of that in this case. There's a patient-generated data component because the patient-reported outcomes will especially postop come from patient directly, not in the clinical setting. We don't have the standards fully articulated for all the components of this implementation of an APM.

And so the question of how to devise the standards, the IT infrastructure, the analytics and feedback, seem like, Kate you can speak to it, open questions right now. And it might be an opportunity for our two committees to work together in a Tiger Team kind of a structure, to take one of these new APMS and actually work it through, within the guard rails of the larger strategic and interoperability roadmap so that we help the agencies design, and the private sector, pull together the components that are needed for a successful APM that would teach us all a good deal about how to make this move forward.

Is that the kind of...obviously we could do the same for other APMS as they're articulated. Could we be helpful to the process in that way Kate or Karen?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

David hi, this is Kate. So absolutely, I think, you know one of the...two comments here. So one of the things about the MACRA legislation and the work that we're starting now on MIPS and APMS is the recognition that there needs to be robust stakeholder input in order for these programs to ultimately have the success that we want them to have. And that this is going to be an ongoing iterative process. I would absolutely love it if we could get that kind of concrete, detailed, meaningful input from these two committees.

I think that would be tremendously helpful not only in terms of the near-term response to the Request for Information, but this program...these programs are going to evolve and iterate and improve, we hope, over time. So I think the ongoing input is nothing but helpful.

I do want to make one quick comment on the CC...the joint replacement model, sorry, we have to change the name of it I think, in that the patient-reported outcome measures, this is a very exciting thing that we were able to propose in this regulation which is, essentially being able to use this model to receive data on a very novel patient-reported outcome measure related to change in functional status over time after a hip or knee replacement. And yes, most of these data are to be derived from electronic health records and we have tried to provide incentives within the context of the model for providers to send us that information.

Nobody will be scored on that initially, but that way that'll actually give us the opportunity to see what the right risk adjusters are, how the measure should work. And hopefully we'll incentivize providers to actually start using...measuring patient-reported outcomes of these very, very important outcomes for these very, very common procedures. So I'm glad you highlighted that. It is...just to make everybody recognize that it is not a fully-baked, tested, NQF-endorsed measure yet, but we think this a novel pathway to try to get there.

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

Great, thank you. Josh?

Joshua C. Mandel, MD, SB – Research Scientist – Boston Children's Hospital

Thanks, I just have a very brief clarifying question. In terms of the goals that you articulated, the 30% number, for example, for 2016. And I just wanted to make sure I understood, when you described 30%, is that a percent of dollars laid out? Is it a percent of patients or is it a percent of payments where you just count each payment equally?

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

It's the percent of dollars.

Joshua C. Mandel, MD, SB – Research Scientist- Boston Children's Hospital

Okay, thanks.

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

Great. Chris?

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

Thank you, Karen. As the person here representing vulnerable populations, I applaud the focus on the patient and what it really means for the end-user. I want to talk briefly about the fact that any quality care is specialty-specific to some point. And, you know I mean the mention of ICD-10 was just brought up. We know that four states, for example, will not be ready for ICD-10 including I think California and Louisiana and that will affect certain, I'm sorry, I had to...that will affect certain populations, especially pediatric populations when it comes to...

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

We do have Napoleonic law in Louisiana, so you never know how it is affecting things.

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

But my point is that 25% of patients are children, but in 2012 only 8% of pediatricians had EHRs that had pediatric functionality built in. If you want to, excuse me, if you want to report on quality, if you want to drive value driven care, you have to have EHRs that support that care that allow you to document and report it out. And it is very clear that for certain subspecialties, this is more difficult than others and in order to do this, I think there might be a need to look back at the certification process and a look at what we need in from of functionalities for subspecialties to actually make your vision come true. I can't report on quality in how many patients I actually follow development and refer them unless these things are appropriately documentable in an EHR.

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

Chris thanks for the comments and the question. I would answer it in this way is, what you saw in our proposed rule that we put out last spring was our work to move towards a certification program that provides kind of a core set of functionalities and security expectations and abilities to have accessibility for data for consumers and others that will be useful outside of the traditional MU Program and for other provider types including some that don't have as strong a products, like pediatrics, which you mentioned, but certainly others.

And there's probably some baseline that is really relevant and then some more tailored functionalities that would have to emerge and have to be tested for in the field to see if they work. So I think in general we agree that there needs to be, sort of like your...any device that you have, there are some basic things that it's going to do, but you need to tailor it, sometimes on the front lines, to allowing you to document and to pull out the information that you need.

And as we mature our certification program itself, this is an opportunity for us to think about the best way to do that. And so we...as many of you are aware, Steve and his team hosted a Kaizen where we brought in folks and talked about how to improve the certification program. We have laid that program open for the Standards Committee and asked for active input and gotten a lot and we are continuing to mature it. And so...and that process is not over, we look forward to new ways to do that.

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

Thank you and welcome, Patti and I think you have the last question.

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

All right, thank you. So something that you said Karen, thank you, really struck a chord with me and then Kate's comment about the core measures collaborative. So our nurses, when you talk about these value-based purchasing, bundled payments, the ACOs, the NSST, all the documentation a significant amount of that documentation is done by nurses.

So a quick story; we had a lot of our...from the CNIO for the Bon Secours Health System, so a lot of our nurses were complaining that our nursing admission assessment took almost two hours to complete the documentation. You've heard this story before I'm sure. So I had a student with me who I had count how many fields, how many clicks did it take you to fill it out if you filled out absolutely everything and so she came to the total of 537 clicks to fill it out.

And when we asked about what you really needed to provide good quality, safe clinical care to the patient, they needed this much, but they were documenting this much. So I said, what's all this...what is all this other stuff that you're documenting? And the comment, well that's core measure, that's core measure, that's core measure, that's Meaningful Use, that's Meaningful Use. So we've got 3.4 million nurses out there documenting and so my question is, are there any goals or roadmap to, you know, are we going to try and shrink it by "X" percent, by a certain period of time? You know, do we have some, you know, outcomes in mind for doing that work?

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

How many clicks?

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

Five hundred and thirty-seven.

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

In two hours on one patient?

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

Yes.

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

Got that.

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

So we're in the middle of...we're actually in the middle of going through every single one of them and determining if they really are a core measure, just making sure. We're validating right now.

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

I want to...I'm going to answer your question probably insufficiently, but I'm going to try to answer. But first it reminds me that I need to introduce Rebecca Freeman, who is the new ONC Chief Nursing Officer; would you stand?

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

By the way Karen, just to interject, I can substantiate that. It is absolutely true; that's what it takes.

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

I believe it. I don't...it's not...my question was to make sure I had the numbers right because I'm going to probably use that a bunch of times in the future.

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

I'll send you the data.

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

As we're...so, this is not this presentation but I'll kind of segue into this problems we're trying to solve thing. So we've been internally noodling, great, all this progress, right; in adoption and digitization...rats and we want to get to this better world, right. So what are the things in our way and data movement or operability we think is getting that return on investment is job one and there's lots that we can all do in that space.

Second is that the systems can be clunky and they need to evolve and mature in the marketplace that's...even what you're sold needs to evolve and mature and to be more transparent and more open and more competitive, more space for innovation. And then thirdly, are there ways that we can streamline our quality reporting to make it seamless? So there's e-Quality measurement and think about the documentation burden component so that to Kate's point, we're linking these clicks to outcomes.

And one of the questions that I've been asked by Senator Alexander, and my team's been trying to sort out how to solve; I've asked the AMA to help us think about how to answer the question, you're saying the same thing which is, there's a lot of time in documentation. And the reason that matters so much, especially for interoperability is if you don't...if it's too much to enter, you're not going to sit there and enter everything and it's not going to maybe be as accurate as it might be. So it's kind of this get some good data in so we can get good data out, sometimes people say the opposite, so we're trying to think through how do you measure something like that in aggregate for the country? How could we say to clinicians on the front lines, we want to cut your documentation time in half by 2018?

And because I don't know what the baseline is and so I was talking, we were talking earlier about the work that KLAS is doing in interoperability measurement and outcomes and I think that there's just so much need to really understand not just interoperability, but what it's like to use the health IT systems. And we use survey data that we have available to report out, but some thinking of this group on that kind of issue is, how do we...how are we going to know if the actions we're taking federally and that the private sectors taking have made a difference in the exam room or in the nurses station when somebody is trying to admit a new patient?

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

Thank you.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Just to add a couple of other quick things, so that is an impressive number; I will also use it in my talks. It is an issue we have heard a lot about, although not as well quantified as you just did and that we have been thinking a lot about. So sort of the discussions that have been going on internally, as Karen mentioned, is one thing; you know, in our...we have started to try to address that in a few ways and we probably should set some targets like you described; we haven't actually set specific targets but I think that's probably important. So with the Meaningful Use measures and what's required for documentation, we have, in our proposed rule proposed a significant reduction in requirements in terms of what...the amount that has to be documented. So we're trying to be responsive to exactly what you are saying and what we've heard from lots of other folks.

I think on the quality measures side; so one of the things that we absolutely could have done better in Stage 1 and Stage 2 of Meaningful Use is to have involved the front line providers, meaning the nurses who actually do the entry of data information, as well as the front line physicians, as well as the EHR vendors in the development of those measures with an eye towards not only having the right kinds of measures, but ensuring that the logic that relates to the workflow is created in such a way that would minimize that burden. And we did not do a very good job of that in the first couple of years; part of that is because we took administrative claims measures and we retooled them, right?

But we have an opportunity now with all of the de novo measure development to be able to not only get the statisticians and methodologists and researchers and patients at the table, but to also have people who actually are doing the work and can advise us on that. So it is much on our minds; we are starting to...we've already been involving those sorts of folks so I'm optimistic it will improve, but I do like your idea of trying to set some targets.

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

Thank you.

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

Great and the Chair recognizes the legislator from the great State of Florida, Gayle. Sorry.

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

...intently. I'm in Tallahassee in committee meetings so it's just hard to catch everything. My question really...and my questions really deal with two things. One of the comments just about front line workers and how we fail to really use the expertise that they have in how we dealt with Stage 1 and Stage 2; I hope as we move forward into moving into a new type of payment system that those front line workers are really involved in this. Especially when you get down to specialty measures because they are very different than a family practice, a clinic kind of measure.

And then the second thing I really would love to hear from Karen on is, you know as I look at the time frame you have here, and you're talking about by 2018 90% of anticipated payments will be in an alternative payment model or a fee-for-service model linked to quality. 90%. We all know, and sitting on this committee for many, many years that without an interoperability of all systems, electronic health systems across the spectrum, that's going to be very hard to achieve, especially in our small communities, our small practice groups and in rural areas. So Karen, if you could kind of give us your frameworks in where we're going; I don't see the interoperability happening in order to achieve that by 2018.

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

Well Gayle, on the first point, I'll just speak for Kate who is, right now, CMS and I...that we agree with you, going forward we have to do much more to get the front line providers and consumers voice engaged. We spend quite a lot of time and Secretary herself does, in the field, talking with front line providers, so we're really hearing what are the ways that we can make this better?

And the second point, so this is Medicare fee-for-service payments tied to quality or value in some kind of a payment model that's linked to value. We are already pretty close to 85% so we're essentially there, maybe even a little bit higher and so for the Medicare program, the way that we're paying providers is already getting us to this target. It's not entirely true for other payers like Medicaid and private payers, although it depends on how you define it. So this would be the reporting right there at the point of care, I think, Gayle, you're kind of getting to this really bigger important notion which is that to really understand the quality and the safety of somebody's care, you need to have a longitudinal broader picture and that's going to require interoperability.

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

Absolutely, I...and I think that's the goal that we're all working for. And is our, and perhaps this conversation will take place a little later today when we talk about the roadmap to interoperability; are we going to be there, to really have that be able to make those value-based payments? Especially in rural areas; and I come from a state with a lot of rural areas and we have a great deal of concern about that.

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

Well I'm so glad that you raised rural America; it's a special challenge insomuch as in some of those critical access hospitals, they're paid differently already and they are concerned. We've talked with them and they've given us some feedback on ways they think they can move to better payment models that will support better care delivery. They have a challenge because they were early adopters of health IT and now they need to upgrade and there are some financial margin issues that are pretty significant for those rural and critical access and rural providers. And I think that there is an additional challenge, which we're keenly aware of which is even just simple broadband.

So there's work that ONC has already done with our HHS and federal partners to advance broadband and provide technical assistance. We do expect that we're going to be taking the opportunity of MACRA to have a special focus on rural and critical access and small providers so that they don't get left behind. You'll see more from that as we go forward.

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

Thank you.

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

Stan?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Thank you.

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

Hi, Stan.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

Hi.

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

Stan, I was at your house and you weren't there.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

The thing that occurs to me, I focused a little bit on the care delivery example and the American College of Emergency Physicians and the American College of Radiology working to eliminate unnecessary tests and that's just really common sense. I mean, that's a wonderful, you know when you think about it, that's where you actually impact most of the cost of medicine is when people order things. And you can change things a little bit by the cost of supplies and labor, but the big thing that you can save is not doing things that don't need to be done. So that's wonderful.

But then the next thing that occurred to me, two main thoughts; it's incredibly hard, and I wondered how you were going to do it, because...and to what extent the information systems have to be a part of that, because sort of just, we've shown again and again that you can improve behavior a little bit by trying to train physicians and nurses better and telling them, don't order that or don't, but in the end, that changes things by maybe two or three or five points and what you want to do is change things by 30 points or 50 points. And so it seems like there needs to be a role for advanced decision-support in that and I wonder if that's the way people are thinking.

But then the second part of that that makes it hard is the incentive part and that is, if we're not careful and if the timing of this transition from fee-for-service to pay for quality isn't timed right, then the people who are most effective in eliminating those tests will be those who are most dramatically impacted by the financial change. They'll lose money because they provided better care instead of...and so I guess, yeah, my overall gestalt was, this is hard. And that if...and it's hard to see exactly how we can provide the kind of information systems that we need to and I don't know if you've got thoughts about that.

And I didn't know whether it was a useful comment to make because I didn't have anything really positive to contribute other than to say, I think it's going to be hard and we ought to, I guess, plan for that but...

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

That was a relatively positive comment, I thought. So, is this the last question, Michelle? It is going to be hard. And as we did our backward thinking about, if you want to get to a person-centered system where you cannot just think about the care of the person in front of you, but the context of their lives, where they live, learn, work, play and how that influences health and all of that stuff, what are the things that are in the way?

And the most significant thing generally is how people are paid and the behavioral economics', the reward system that drives behavior in a certain direction to do more, not do necessarily do better, to not have the time, the bandwidth, the resources to coordinate, to work with teams and to not have the kind of relationship with the consumer, the caregiver that allows time and space and information for meaningful conversations, for real engagement and decision-support.

So if we change the way that we pay for care, and we think that's a lot about freeing space for that to happen and provide some support with best practices and whatever we need to do to get people to the New World and then give them the data, the information to make better decisions, to have more...to know what the last tests were so that there's not a reason they have to repeat as just a finite example. I think we get our...we believe that we're tackling the big issues in it.

Stan, I would say from my visit last week to Intermountain, firsthand see that you all are thinking through some similar issues. You're very advanced in IT, you're able to provide decision-support, you're able to use that IT to train. You're able to think about in the care environment, the acute or otherwise, how the IT systems might be getting in the way with too many clicks, etcetera; how you can evolve and mature that. You're thinking about payment, doing it in such a way that you're freeing up the specialists and providers to pay differently; that kind of a place in a world is where systems have...systems that are successful are going; yours is amongst many in the country that we think are good models.

I will tell you also, as I've shared with this committee that when you take away all the complications of fee-for-service in the traditional U.S. healthcare system, as happened to us in New Orleans after Katrina, things like the patient-centered medical home grows in the wild, naturally. Working in teams, putting patients first, meeting them where they are, having multidisciplinary approaches and meeting data at the population and individual level to make decisions is what naturally emerges.

I say that to say that I remain convinced that what we're proposing and wanting to move towards the kind of model is the natural place that people want to go. Most of my clinician friends, my doctor friends, I'll just...would tell you that they'd rather be able to focus on care and care coordination instead of whether they have to repeat the test and so more information, better. Being paid differently is going to matter. And knowing...and I think that we're going to gravitate to the natural best practices. The hard part's going to be minimizing the downside risk for everybody in the system.

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

Very insightful, Karen; I mean, it's almost as if, if we would just lift the perverse incentive system then the things that would grow up in the wild would replace it.

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

We're trying.

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

So that's...

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

This is a little more incremental than it was which we don't want to repeat for anyone.

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

So Karen, I know you didn't think that the Senate health testimony was practiced very well, as was just experienced here, but thank you very much for all of your thoughts and for the excellent presentation. And thanks for the engagement in the committees in asking her, so thanks a lot Karen.

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

Thank you guys so much, appreciate it.

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

So there's a word here that we're not used to in privacy, I mean the Policy Committee which is break.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

They don't give us breaks; I don't know where that came from.

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

It's a typo, right?

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

It's a typo, maybe. We just used it so is it okay for us to go with Kate before lunch instead of breaking? Okay. All right, so the next part of this two-part series really is Kate speaking on behalf of CMS to talk about the other ways that we're moving forward on the delivery system reform and payment reform in talking about their RFI related to MACRA.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Great. Hi everybody; very, very nice to be with you here today. I'm going to talk...I'm going to give you a very sort of high-level overview of what is in the MACRA legislation for those of you who don't have a dog-eared and marked up copy of it on your desk like I do. And then also high-level overview of our Request for Information, which is the RFI and focusing on some specific questions we have about use of EHR technology.

So Karen's talk was a perfect segue into my discussion of MACRA with all of you because MACRA very intentionally speaks loudly to the fundamental pillars or tenants of delivery system reform, and that is not by accident. So Karen talked about sort of the three pillars of delivery system reform and I will walk through each of them and talk a little bit about how MACRA addresses them.

So she talked about providing incentives, right, for better care, smarter spending, healthier people. And of course MACRA does that; it's a fundamental component of MACRA which essentially provides an incentive structure to move physicians away from fee-for-service and into alternative payment models. And it sort of provides two pathways to do that with the idea that physicians who may start off in what is called the MIPS program or the merit-based incentive payment system into alternative payment models over time and provides significant financial incentives for physicians and other clinicians to do that.

She talked about care delivery and a focus on care coordination and patient engagement and shared decision-making and those words are everywhere within the MACRA legislation. And I can tell you I spent about a year and a half with staffers on the Hill providing technical assistance into the legislation and in very much a bipartisan way, this was foremost in folks minds is really putting the patient at the center, focusing on the care delivery piece of delivery system reform.

There's a focus on it in terms of the types of quality measures that we're required to use and the focus on a new category that physicians are to report to us around clinical practice improvement activities; tremendous focus on population health management, patient engagement, beneficiary access, care coordination, etcetera. And then finally information; so provision of information at the front lines, provision of information to patients, patients providing information back to clinicians. There's a focus throughout the legislation on the fundamental pillar of use of electronic health records in order to help transform how care is delivered.

There's also an emphasis on transparency of that information. So we are required to publicly report performance on all of the categories that I'm going to go over for you in a minute, to ensure that the information is out there for people to see and for consumers to be able to use in order to choose their clinician or their care team. So these fundamental pillars are built throughout the legislation and I have to tell you, we are very, very excited about this and about standing up this program. So I'm going to just go through a few slides here.

So of course MACRA repeals the Sustainable Growth Rate; this was passed in April of this year and we believe that the new MIPS program and the provisions around transition to alternative payment models actually provides more certainty and predictability to physician payment than what we've had thus far. And that physicians that...and clinicians that are in high quality, efficient practices are likely to benefit financially from MACRA, whether or not they are in alternative payment models or participating in the MIPS program. We are starting to develop proposals this year to implement the key elements and the core elements of MACRA and I'm going to walk through that timeline in a bit.

The other thing that MACRA does, it affords us the opportunity to develop an entirely new set of acronyms that you're all going to have to learn. So you've heard PQRS and MU, and VM and those are gone, or will be. So as I go through this, there are a few acronyms in the slide that are new; I'm very proud to introduce them to you today.

Okay, so MACRA provides for new methods of payment, primarily on two tracks. The first is the merit-based incentive payment system or MIPS. And what this does, it...the law sunsets the payment adjustments associated with the three existing programs; so that's the Physician Quality Reporting System, the physician value-based payment modifier, as well as the Meaningful Use program for Medicare eligible professionals. So it does not touch the Meaningful Use program for Medicaid eligible professionals, nor does it touch Meaningful Use for hospitals; so just want to be clear about that.

And it also provides for incentive payments for physicians and other clinicians who participate in alternative payment models. And it encourages the development of what are called in the legislation, physician-focused payment models, and I'll talk briefly about. It also provides for a higher update to the

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...things that people could be rewarded for, in addition to what is in the legislation, and we do have that flexibility. We do have questions around the quality performance category types of measures, numbers of measures and so forth. And I think I'm going to highlight in just a minute some questions on the Meaningful Use piece for...to highlight to this committee, the combined committees, that we'd love your input on.

And so just to reiterate, the Act specifies that measures and activities for Meaningful Use under the MIPS are the requirements that are established under HITECH for determining whether an EP is a meaningful user. However, we do believe that this new statutory authority does give us some flexibility that we have not really had in the existing...

[lost audio 1:57:39- Wes Rishel saying hello at 1:58:27 and Kate restarting at 1:58:34]

...achievement of Meaningful Use. Should we use a tiered methodology for determining levels of achievement that would allow EPs to receive a higher or lower score based upon their performance relative to the thresholds that are established in the program or perhaps relative to their peers? This is something that we very much want input on and then thinking about also how should such a methodology be developed and how should we score eligible professionals in this space? And then are there any other alternative methodologies that we should be considering?

We are working with our legal team to be sure that we are within our statutory boundaries, legal boundaries, to be able to, you know, how much flexibility we have, but we do think we do have some and we're definitely looking forward to input on that; we'd love to have this committee's input on that...on those topics as well.

Okay, just a little bit about alternative payment models. So our colleagues in the...just so...for those of you who are not as familiar with my work. So I work within the Center for Clinical Standards and Quality. We are responsible for standing up the MIPS program. My colleagues in the Innovation Center are responsible for putting forward the proposed requirements for the alternative payment models; we're obviously working very, very closely together. But a little bit about overarching provisions for the APM piece of the legislation.

So the legislation talks about an eligible APM entity and this has to be an...so eligible to...for providers who are in that entity to avoid or to be exempt essentially from the MIPS program. So an eligible entity, it is required that participants use certified EHR technology; again that emphasis throughout the legislation. Provides payment for measures that are quote “comparable to MIPS quality measures” and that’s as much direction as we get in the legislation for what the measures should look like under alternative payment models, but they need to be comparable to MIPS quality measures.

We are thinking about that, you know, as we’re transitioning into this sort of evolving and new payment environment where payment is tied to quality and value, we think that the measures that should be used within that space, whether you’re in category 2, 3 or 4 that Karen described in her presentation, that often times the types of measures that you need are really going to be very similar. Again, focus on outcome measures, patient-reported outcomes measures, appropriate use, patient engagement, etcetera.

And so we would hope the measures that are available for providers to report on, if you’re transitioning from the MIPS program into an alternative payment model, that it’s not all of a sudden a wholesale new set of measures and so a new focus on where you need to improve care. So there should be a lot of similarity and many of the same measures across the board. However, we do see APMs as an opportunity to test new and innovative measures as well.

And the other thing I think that we want to point out here is that the requirements in the legislation are that participants have to bear financial risk for monetary losses, so losses that are in excess of a nominal amount. So what the legislation says is more than nominal risks; that is something that we are going to need to propose to our regulatory process that will be coming forward next year.

And the other thing we want to make sure that folks, just to sort of level set a little bit here, we think that really more due to the timing than anything else that in the first year of the program, which again is payment year 2019, that a minority of providers are going to qualify for APM incentive payment, especially because we do have to...we are required to set the parameters around an eligible APM entity to bear more than nominal risk.

And it’s going to take some time to get some of these physician-focused payment models out there and continue to improve upon the existing Innovation Center models so that they can meet those qualifications over time. I think it is a glide path for clinicians to be able to do that. And so again, because the timing is fairly aggressive, we do believe the first year of the program the vast majority of providers are going to be subject to the MIPS program. But we’re hoping that over the next several years that the proportion of physicians and clinicians who are eligible for APMs will increase substantially.

As I’ve already mentioned, I think, that the APMs provide for the incentive payment I talked about that before; there are thresholds that providers must meet in order to be able to qualified for the 5% incentive payment and to be excluded from the MIPS program. There are thresholds for Medicare payments, there’s also an opportunity beginning in payment year, I think 2021, for us to set all payer thresholds.

And I don't think I have a slide on what those are, but I can tell you that in the initial years of the programs, so 2019 and 2020, those thresholds are that 25% of Medicare payments are through these alternative payment models, that again bear some...more than nominal risk or some downside risk, in order for them to qualify. Beginning in 2021, I believe, that goes up to 50% is the threshold, so it raises it fairly significantly.

And then a year or two later, it goes up to 75%; so significantly raising that bar although does also allow us to be able to take into account all payer thresholds as well. Again these thresholds are what providers must meet in order to be eligible for the incentive and be excluded from the MIPS program. Or when I say excluded, MIPS is optional; they could still participate, but they don't...they're not going to be held accountable if they don't.

So very, very broadly, topics that we are looking for input on in the RFI, there are many, but some of the ones just to highlight to you all here is for the eligible APM entity requirement. So, a lot of questions around what types of quality measures should be used within those programs. Use of certified EHR technology, that is requirement for participants in eligible APMs, but some questions around should the certification criteria look any different from what we do now for the Meaningful Use program?

Are there capabilities that participants in APMs need that they...that should be part of the certified EHR technology program; so some questions around that. And then also around what...how should we define nominal financial risk? And again, we have to go through rulemaking for all of these topics.

The Secretary is also required to develop physician-focused payment models. The law requires that the Office of the Secretary develop a technical advisory committee that will allow stakeholders to propose physician-focused payment models; so this is going to be run by the Office of the Assistant Secretary for Planning and Evaluation or ASPE. They will review and provide recommendations to the Secretary on the submissions that they receive. They will be first establishing criteria for that review process and then at CMS our team at Innovation Center will review and prioritize recommendations against a number of existing factors.

It should be noted that once a physician-focused payment model is reviewed, and as it gets accepted or approved, it still does take some time to go from concept to actual model. So we know what we've put in here is it can take anywhere from 12-24 months; that is based upon sort of our existing process for putting forward new models as well and obviously not all recommendations can be accepted.

I can tell you, as many of you probably know, the Innovation Center now receives many, many, many suggestions for alternative payment models and many of which are excellent and some of which need a lot of work; so obviously not all will be accepted. And of course CMS will also continue to develop APMs, but obviously we'll be looking to ensure that the physician-focused payments that are recommended by stakeholders and the CMS models are complementary to one another and don't overlap.

There have been some questions today about technical assistance; it's some very important questions about how rural providers and small practices are impacted by not only the current Meaningful Use program, but also about the future MIPS and APMs program. So MACRA does provide for some funding for us to enter into contracts or agreements with certain types of entities to provide technical assistance to providers in small practices and rural providers.

They...actually the legislation calls out QIOs, the RECs and regional health collaboratives; the way we're kind of thinking about this is how can we use each of those levers and use the strength of each of those types of organizations to work in concert and not to overlap. And how they can help these types of small practices and rural providers be able to be successful, not only in the MIPS program, but how they can be successful in transitioning from the MIPS program into alternative payment models.

So I think this is my last slide; so some resources and sort of our timeline here. We put out the Request for Information at the end of September. We've already received numerous requests to extend our deadline, so we are looking at that and should have something coming out soon related to the deadline. We know that this is a lot we are asking of people; there are a lot of questions in the RFI. We know not everybody is going to answer or try to address every question. And there was a lot of discussion about how much time we should give.

We are obviously on a very tight timeline and we want to...we really, really want to be able to actually use the information that we receive, but we are going to be entering into rulemaking for the first year of the program relatively soon, so there isn't a lot of time. But we understand people want to be very thoughtful and give us good input. And by the way, that input really should be ongoing not just in response to this RFI.

We're going to be hosting a number of webinars coming forth very soon, so they'll be announcements about that. Karen has already talked about the Health Care Payment Learning and Action Network, so I won't talk about that. We are looking to publish a proposed rule in March of 2016 with a final rule hopefully in October of 2016. Our goal here was to be...or is to be able to give folks more time than we normally give for our payment rules, to respond to the proposed rule, which is the big reason why we are planning on a proposed rule in March, which again sort of backing out the timeline means there's not a lot of time for the RFI at this point. But again the goal is to give folks a lot more time with the proposed regulation to be able to give us input that we need.

So I'm going to stop there and see if you all have any questions.

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

Whew.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Sorry, I know it's a lot.

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

Thank you, Kate. No, it is really a lot.

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

Paul, can I make...just one point?

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

Yes, Jodi?

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

This is Jodi Daniel. Just a couple of key points I just want to make. One, from ONCs standpoint, and Kate mentioned this; we're interested in thinking about how the certified EHR technology should be defined for purposes of both MIPS and the advanced payment models. Whether the existing CEHRT definition works, whether there are additional functionalities that might be necessary for interoperability or for population-based management, and the like. So please take a look at that and give us feedback some feedback on that.

I also want to highlight that we are...this is an RFI and everybody is encouraged to provide us feedback. We're not asking for collective feedback of the advisory committees, given the short timelines of things, but we do encourage everybody to share your input and submit comments to us. We obviously think very highly all of your input and your participation.

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

I think the deadline was end of this month, correct?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yes, I believe the dead...yeah, very end of October, but, stay tuned.

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

The very end, right? Okay, has to be right. Okay, so we have a number, I'll just go around. Neal please?

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

Thank you. Kate, that was a very good and I got the feeling we were seeing the future here in payment reform. I think all of us around the table are hoping that the future and as we reform that regressive, as Paul talked about, that regressive fee-for-service system that creates the wrong incentive, if that was to go away we'd create a blo...a blooming garden of innovation. So I think this is...this was the...is going to be that.

So hey just a real fundamental question, does this replace the coding...the E/M coding for the physician and if it doesn't it, then it looks like it's going to add more burden to the workflow and the productivity of physicians; so just juxtaposition the MIPS program with our current form of document...and getting paid in the...that old regressive fee-for-service system.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

So the MIPS program is built upon the fee-for-service architecture, right? So it's basically a multiplier up or down 4-9% over time, so it...nothing about these programs changes what providers have to do in terms of coding and billing for services. And certainly I agree with what I presume is your underlying comment that that is very onerous and that it actually drives certain behaviors related to documentation that have downstream effects and are not protective. And I would agree with that as also a practicing physician who does the same thing.

So certainly once you get to a place where you have sort of more in that category 4, so alternative payment models that are more in that category 4 related to population-based payments, in some iterations of that, you could see the reduced need for the same type of billing and coding that physicians and other clinicians are subject to now. But the MIPS program, for better or worse, is built upon the way medicine is practiced and billed for today. Probably not the answer you wanted...

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

Good try, Neal.

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

I wanted it on the record.

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

Devin?

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

Thanks. Comment, leading off of that; first of all, that was a lot of acronyms I learned about, so thank you, it was a great introduction. And sort of a story for me as well, a quick one because Patty's was so effective. I was meeting with a physician informaticist the other day; we recently did an upgrade to a new EHR system; we are much better at capturing quality and data now. But unfortunately, as he's increased his clinical time, he decided to quit; he's leaving to a more well-heeled practice; we represent a safety net hospital and very much directly tied to this burden that Patty's alluding to.

And so when I'm looking through the measures, we cannot get to this fast enough and I really feel that question Neal asked, which is it does feel like on top of what we're currently enduring. So when I look at these quality measures, certification EHR issues, I guess I just need to reiterate like, it has to be baked in here.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Um hmm.

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

And it can't just be and be sensitive to workflow and number of clicks; it would literally have to be as explicit as seeing the marker for quality. Because another story that came up yesterday is I got multiple requests from high-level leadership to put in a whole bunch of new clicks to ensure we're meeting Meaningful Use and core measures, all those things. And I really do want to battle that, but I have nothing to go up against, and I don't mean against, but really partner with the COO or the financial people and say, listen, this is just as important and it's just a hard a measure. The rest is sort of always going to be, prioritize afterwards until we get something like that to kind of put it on the same level.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah. So one of the things, the way we're sort of trying to think about this as we're designing the MIPS program, I'm just going to talk about MIPS for second. We know that the way providers interface now with CMS to report on all of these programs is very burdensome. They have to go to multiple different portals to enter information for multiple different programs.

If they are reporting on quality measures, and I don't know Neal if this is what you actually meant, if you were talking about the coding that goes with quality measures specifically or if you meant just billing for services, certainly we think that, and the law is very clear about this, that we need to move away from the claim, you know G-code claims type of quality measure and reporting that. So that again incentivizes moving into more registry and EHR-based submission of data.

But we're also trying to think about how do we actually create a new program that fundamentally changes how clinicians interface with CMS to meet the requirements that they need to meet. Because we could create a program that for each of those four categories you still have to go to four different places; I mean, we could do that, right; that is not what we want to do.

And so that what is being actually captured through the electronic health record for, you know certainly for quality, certainly for meeting the Meaningful Use portion and maybe even we also we can think about how we leverage the use of the EHR for the clinical practice improvement activities, that that all sort of becomes part of a piece. And that the way that folks are interfacing with us is streamlined into just a single interface.

That is our goal. We sort of have defined that as kind of being our ideal state. I'm not sure we're going to get there immediately, but I think the law actually provides us with some more flexibility than we had underneath our statutory requirements for the PQRS program, to be able to allow for some more flexibility for what providers are able to do. Now, having said all of that, I think what would be most helpful to us is to not only hear the kinds of stories that you are describe...that you just described, but also help us think through how we can actually achieve that ideal state. I think we have some ideas about that, but it's, you know, we definitely need to hear from the front line providers on how we can do that better, and particularly thinking about the quality reporting piece, which I know even using electronic measures now is not burden-free by any means.

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

Yeah, just a quick follow-up. So, absolutely and getting to the single interface is helpful in general and would love to partner to think through that...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah.

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

...but to some degree, I'm not really asking, and I don't think this committee should be asked to figure out exactly how that works, that is what the private market can do better. But putting that milestone in there and that's the explicit nature I'm talking about, essentially one of the quality measures, and just a simple kind of like, you know, it can't add a single click to the workflow; something very concrete like that.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah.

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

Or, you know, do a time stu...I mean, we ask all sorts of burden, you know, why not put some burden on the quality measure itself to say, you have to clearly demonstrate that you're getting value without additional drag on the system.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah, yeah.

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

And until it's that concrete, I think it's going to be a very challenging argument, no matter how simple the interface is to get you the data, to make sure that the work to get the data to give you was not actually more burden.

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

I had...

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

I just wanted to know if I could contribute to what Kate is saying. And Devin, I so appreciate your view and I think that we would have a similar concern, that we don't want to propagate a fee-for-service model when there might be an opportunity to move beyond, but there are things within the fee-for-service model that sometimes makes sense for specialists. And so we want to make sure this is an opportunity to get that right.

The comment period, this is my view, not the departments, so the comment period is also an opportunity for just this kind of dialogue and I think the more input we can receive from front line providers, from people who are making clicks on the front lines, that there is an opportunity, whether it's because the providers might choose to be alternative payment model, not MIPS and there may be ways that we can help push the providers into other alternative payment models and not just be creating everything on top of the fee-for-service chassis; that would be helpful as well.

And as I've shared with some systems on the front lines, if you're doing innovative models of payment, let's get those out in the forefront and learn about them, especially if they involve physicians and specialists, so that we can sort of skip over the learning process that we might do otherwise and learn from what's already happening and working in the field.

So it's a...I guess maybe what I'm trying to say is, don't just think of this as a way to give feedback on MIPS and on EHRs, but really think about what would a better model look like. And if we were to create alternative payment models that would pull clinicians into them and not make MIPS sort of the default, what would be that opportunity there.

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

I've suggested to vendors that they have a click counter at the developers, so really it's the same thing; so that if they propose something, they better have workflow that makes it streamlined. And thinking about the gover...you know, there is a Paperwork Reduction Act, I wonder if we update that to a click stream reduction act, because...

M

If I could see that as a regulation formally.

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

...there real...yes, that would be wonderful. And, I men, Neal's comment about the documentation, clearly it's one of those things...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Oh yeah.

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

...I think that would motivate people away from MIPS into the APM if there was an...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

And the RFI is not just about MIPS, the RFI is also about APMs, probably 50:50, so I think what you're talking about is exactly the kind of thing that we would like to get feedback on and are asking explicit questions about.

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

Right. Eric and then Stan and Liz.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yeah, thank you; my question is very quick, just wondering if you could clarify. There were two...I thought I heard two really significant policy changes in your presentation and I just want to know if I heard that right. One is that the payment adjustments for Medicare, Meaningful Use nonparticipation, which of course started in 2015, are going to go away and be replaced by the MIPS payment adjustments that don't go into effect until 2019. And the second thing that I thought I heard was that PQRS, which of course a pay-for-reporting program, is being replaced by true pay-for-performance where whether and how much you get paid depend on the results of the quality measure, not just reporting. So, did I get that right?

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah, so let me start with a second one first. So, there are currently three programs; there's PQRS, which is pay-for-reporting.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Um hmm.

Kate Goodrich, MD, MHS – Director Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

There's the physician value modifier which is pay-for-performance, the entry way into the value modifier is through PQRS, so you report measures to PQRS and your results on those measures are what count for the physician value modifier. That's the way the program works right now.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Okay. Thanks.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

And then you have, of course, Meaningful Use; this is again just for Medicare EPs.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yeah.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

So the payment adjustments, which for all of these...well, they're not all downward, value modifier is up or down or neutral; for all of these, sun sets December 31, 2018. January 1, 2019 is when the payment adjustments, up, down or neutral, for the MIPS program come into effect or you get an incentive payment of 5% for being part of an eligible APM.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Okay.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Does that make sense?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yeah, so adjustment is under HITECH don't go away, they jus...they just get replaced after...starting in 2019.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah, the way the law is written, yes, you could say they get replaced. They essentially go away though, right; they sunset on December 31, 2018.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Okay, but you're still going to get penalized 2016, 17...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yes, yes. The ones that are in place now don't change through the end of 2018.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Thank you.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah.

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

Okay, Stan?

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

So there's, yeah, the new provisions perpetuate the use of certified EHR technology and I guess I was disappointed to see that, but then trying to make the best of it. I mean the burdensome certification criteria now are the vampire, they're sucking the blood out of innovation and usability of our EHR systems today.

And so I guess given that it's going to be there, the suggestion would be that we focus those criteria only on interoperability criteria that we take away completely any of the burdensome functional certification criteria that have been such a burden in the past to people who are trying to create better, more usable systems.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Um hmm. Yup.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

It's a comment more than a question, I guess.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

And we'll be continuing, I mean, despite the fact Meaningful Use for Medicare physicians goes away, obviously certification is tied into the new programs as you say and so we will continue to be working with ONC on that and I think in an ongoing fashion learning. And we have opportunities in future rulemaking to make changes as we go through...as we go forward.

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

Great; thank you. Liz?

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Thank you Kate, a great presentation; I guess unfortunately seem to be carrying a theme here, Stan and I. I want to build on the clicks and what Devin said. Two things; one is on the quality measures, and we didn't say it last round, but I think the providers among us would tell you that quality measures are not quality measures, are not quality measures. And when I see those quality measures again up here, I get really nervous. One of things that I will provide to you and to Karen is an analysis that we did of all the quality measures and the little pieces that are different.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah.

Elizabeth Johnson, MS, FHIMSS CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So when Patty talks about the number of clicks, it's because we don't just capture smoking, we capture smoking twelve different ways, so to speak; and that's a little bit of an exaggeration but I'll give you the specifics. That's really important that if we're going to continue to promote that that would not only go to outcomes, but that we go to consistency between the measures, because it doesn't exist today as hard as you've tried.

And the other part is, and when you talk about MIPS, sounds like a good idea but I am really concerned when you talk about stopping something for the physicians and not stopping it for the providers because we are then, we're then in a world as we live in today where physicians are asked to do one thing, providers...hospital providers are asked to do a different thing and we end up at a discord that we don't want. We're all about delivering care, so help us to deliver care and be rewarded on the same system.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yes, and to be clear, what is stopped in the legislation is the payment adjustments. So...but they're...and they're replaced by a different type of payment adjustment and scoring methodology, so that does create discord in terms of how people are paid for it. The law does reference back to the definition of Meaningful Use from the HITECH Act, and that is something that I think we need to be sure we're attuned to is that there is that concordance between what is being required, which we still by the way can make that very similar between hospitals and providers; the law doesn't change that.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Right, but when you and I think you've got it, but when you say the EH and EP, they're not the same thing...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Correct.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

...and you're talking about EPs.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Yeah.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

So if the penalties continue for the EHs, not for the EPs; I'm not opposed to the penalty situation changing, not at all. But what I'm saying is again you are going to cause further discord because when they get to the hospital, our physicians are engaged with us and that we're going to be asking them to do things to avoid penalties when their penalties are gone. Just reality.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

And I think it would be helpful to get some specific feedback on how we could potentially structure that particular piece of the MIPS program and what we require for APMs to do so that we have less of that discord. You know, we can't change the penalty piece for the hospitals, without a legislative change to do that.

Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics –Tenet Healthcare Corporation

Gotcha. I got it, thank you.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Right.

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

Well thank you, Kate.

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

Umm hmm.

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

Also extraordinarily important information presented very well and creates a lot of questions, because this committee works on those details. But at any rate, thank you and we all have an opportunity, in the next three weeks, to get our information in. But we can continue the dialogue, as Kate mentioned, because they still have ears, but the official period, so far...

Kate Goodrich, MD, MHS – Director, Quality Measurement and Value-Based Incentives Group, CCSQ – Centers for Medicare & Medicaid Services

So far.

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

...is to the very end of October. So thank you everyone and so we will adjourn for lunch for the next hour and return back at 1:15, is that correct?

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

After public comment.

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

After public comment, that is; after the morning public comment.

Public Comment

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

If there is anyone in the room who would like to make public comment, please come up to the table. As a reminder, public comment is limited to 3 minutes and I'll turn it over to Alan to open up the lines.

Alan Merritt – Interactive Specialist – Altarum Institute

If you'd like to make a public comment and you're listening via your computer speakers, please dial 1-877-705-6006 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue.

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

Well, it looks like we have no one in the room and no one on the phone.

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

Then we will break for lunch and resume at 1:15 PM, thank you.

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

We're going to get started, in a minute. Okay, I think we're ready; the lines are already bridged. So welcome back from lunch. Before we kick off the roadmap discussion, I did want to announce three new task forces that we're going to be starting up. All three of them are joint task forces between the Policy Committee and Standards Committee. If you could go to the ne...skip two slides. Thank you.

So the first task force will be joined to basically provide a tool to assess different certified technology vendors. This will be hopefully kicking off in October. The next task force will be API task force; there were recommendations back with the NPRMs from the Privacy and Security Workgroup and from the Consumer Workgroup. So this will be a joint group as well...if you could go to the next slide please, that discusses both the security, the consumer side and the privacy side related to APIs.

And then the last task force Steve is going to speak to. It's called the Interoperability Experience Task Force. Before I turn it over to Steve, I just want to make sure for those of you who are members of the committee and are interested in any one of these task forces, if you could just send me email that would be great. For members of the public, if you could go online and either update or fill out a FACA application, the three of these task forces are listed there, so you can just select that you want to participate in one of those. And Steve us going to talk about the Interoperability Experience Task Force. Steve.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

You want me to go first?

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

Yeah.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Okay. Sorry. We were trying to schedule a time sequence here, keeping track. Okay, so on the Interoperability Experience Task Force, as many of you may recall, at the end of the Spring we changed the way in which we were structuring the HIT Standards Committee and it's work going forward. And one of the comments, because we're always listening, that we received was, how do we deal with more strategic issues associated with interoperability and how it's working for providers and patients alike in the field.

And I've had a couple of different discussions with different members and the idea here being, because you all are jointly gathered today and because this always involves policy and technical matters from an interoperability perspective, it would be great to have a joint task force that first determines for itself among the industry priorities that are out there right now, what are the top 3-5 experiences that providers and/or patients are having where interoperability could be better?

And then to take the next step to do a detailed dive into actionable recommendations that could be taken in the near term to help resolve some of those experiences. So if it has to do with e-Prescribing or lab results or any of the like that this task force would consider, the idea being that either there will be immediate steps recommended right out of this task force back to ONC or determination there will be a determination like, hey, this is a really gnarly issue, it's a policy thing we need to think about it a little bit more. There could be a group formed within the Policy Committee to chew on that for one more cycle and then bring it back to its committee.

Similarly on the standards side there could be there's something here going on, we know that there's an issue with the standards perhaps or there's additional clarity in value sets or something along those lines, I'm making things up arbitrarily right now, and the Standards Committee would go and chew on that for a cycle and then make its recommendations through its committee.

So, kind of on the heels of The Strategic Plan and on the Interoperability roadmap, which we're about to talk to you about, the idea being that the committees would jointly work together and then if additional work would be necessary...but again, a clear focus on what experience people are having in the field and how do we resolve those experiences to make it better for providers and/or patient, depending on the particular priorities that the task force takes on.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Just a brief introduction to our next segment where we will have a 2-1/2 hour discussion of the Interoperability roadmap; so he mentioned the interoperability experience, which does sound like a great Disney World ride, I don't know about you, but that does...

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

You won't have to wait in a line for three hours.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

That'll be a promise.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So as Karen and Jon and I talked this morning about truly the experience of interoperability, I think interoperability in this country can be measured in two ways; the transaction volume, you know what are you doing actually electronically. But I think it's really important that we understand the experience of interoperability and this can be done in a couple of contexts.

Of course there's the ONC work that'll be done, that'll be very informative. And then the private sector is doing its own thing, that is, over Thursday and Friday of last week, representatives from Cerner, so Zane and Mike were there, representatives from EPIC, representatives from Meditech, from Athena, from eClinicalWorks, McKesson, gathered together, your boss I think was there too, in Salt Lake City under the auspices of KLAS. Stan was there.

And the discussion over a 2-day period was looking from a private sector standpoint, what is the experience of interoperability and how do you measure it? And do you, if you had a 100 McKesson customers and you asked them, did you have a good experience? Was it easy? Was it fast? Was it obvious? Was it in the workflow or was it just the bits and the bytes were accomplished but it wasn't as easy as you'd like? And so I think it's going to be an interesting theme as we go through this Interoperability roadmap discussion, if you start getting ONC work, you start getting private sector work, we're going to get a new visibility and transparency from the users that we've now had a couple of years of Meaningful Use experience under their belt as to what really is happening in the field.

So KLAS, as a Consumer Reports kind of organization, I think each year would actually now offer this independent, transparent view of what we're hearing from the industry. So I do look forward to the next year ahead, as we've talked about, it's kind of the next stage of maturation to do something, measure something and then refine our future actions based on that measurement.

So Steve and Erica, now I see Erica, I didn't realize you were going to be here today, welcome.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Thank you.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Look forward to your discussion; Steve did brief me ahead of time as to the refinement and focusing of these goals, so I think you'll find this form much easier to digest and understand; it's as very clear. So, take it away.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

All right.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

All right. So this is the first duet that Erica and I have had to do together, so we will do our best to, I don't want to say harmonize, but. So we'll also be in the back later to do signed copies of the roadmap. I only have one, so it might have to be an auction. And this is a bootleg version that has a typo that we caught this morning.

So I'm going to kick it over to Erica who I am very thankful to have next to me to do this presentation with me. And we're going to just dive right in and cover this. We will have a break, provided that neither one of us drone on too long, and then we'll pick up the kind of second half of the roadmap presentation after that.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Thank you, Steve. I actually...so I'm stepping out of maternity leave for a day for the pleasure of joining you all for this conversation. I'm actually going to step back into maternity leave after today. This is a huge accomplishment though, this is a big deal, we're putting out a version 1.0 of a final first Interoperability roadmap and this is something we all should really be celebrating. I think Karen wanted to kick us off a little bit with some framing before we dig into the details of the roadmap so I'll tee up just a couple of slides for her.

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

Erica, thank you for coming out of maternity leave and we thank Ben for letting you get away for a little bit time; Ben being the baby. The umm...and want to thank you for all your work as the Interoperability Portfolio Manager, which you've done elegantly and seamlessly from Chicago, showing us that interoperability in work actually is possible.

I want to thank Steve for stepping in. In these last few weeks, but all along the way working side-by-side with you as we're thinking about standards as being a critical component to this, as well as certification and testing.

And I want to thank Genevieve, who has also stepped in; Genevieve, stand up so everyone can see you. Yay Genevieve, who has kept the wheels on this cart and is the most unflappable worker that I think I've really ever met, and that's saying a lot because Erica's pretty unflappable.

And I want to thank Stephanie, who should stand up, who also has been doing some remote work and we're glad to have her here. She has been working on our stakeholder piece and making sure that we're keeping all the parts together.

I call those four our, but I want you to know this is truly a team effort not only at ONC. It's been an all hands on effort where every employee has had a role to play in seeing that we're able to advance this. And particularly in the last 9 months I think what has changed for us is that once we had some better clarity about direction, we were able to have, I think, more discrete conversations with our federal partners. And so my report out to you all as the advisory committees is that...is the alignment to cross the administration is quite strong in this roadmap and you'll see that in not only the public statements, but I think when you talk to the leadership. We have some pretty clear direction from the Secretary and the White House that this is a good pathway and that we should act with urgency.

To that end, want to remind everybody that we have been acting for the last 9 months since we put out the draft roadmap. We released the Standards Advisory, have an updated version with bubbles that allow us to talk about maturity of standards and get some more dimensionality...on those standards themselves. We've been...we've proposed some changes in our certification rule that strengthen testing and our certification programs, moves in a policy direction of publicly available APIs that open up data and make it more possible for consumers to have access or for data to be shared in some ways and then to create more usable systems, amongst other efforts like the DoD acquisition.

So there's been a lot of work at the federal level and it's somewhat reflected in this document, but I want to give you all the clear sense that we're not resting on documents, we're acting. And we have a lot to get done in the next 471 days while this administration's still around and we've got a clear work plan to get there. It also, I think is that as a document that lives beyond that; it's meant to not be a special thing for this administration but the reason we've developed it collectively with the private sector is because we want this to be something we all own and carry forward.

So, let me just put us back into context to where we were earlier today, which is that in the short run we have a high priority, top priority in the Department of Health and Human Services and that is to see that we get to a health system that provides better care, spends dollars more wisely and has healthier people. This is our delivery reform work; it has a 3-pronged approach.

The first is incentives; changing the way we pay for care to move to value-based payment models. The second is to encourage and support more care coordination and better care delivery more that is more person-centered. And the third is, information; bringing electronic information to bear at the point of care and for consumers, as well as some other opportunities with electronic health information.

And so this roadmap for us in the short run nests inside of care delivery. And what you'll see reflected in the expected outcomes are very healthcare focused as a use case. Please remember though that this is foundational for our opportunities to apply this data and these policies and this trust environment in many ways, so moving all the way to a learning health system in out years. But we really want to make dent in, a big one, in what we're doing in care delivery in the short run. Next slide.

You're going to hear a lot about the details of what the federal partners, and in some cases states and private sector partners, are already willing to do and move forward and to get us to roadmap what needs to happen by when and by whom. Just wanted to kind of take a minute to open an invitation to this advisory committee, to the people listening, to...organizations, around really the way we're thinking about this at a high level at the administration that broadly we are making the following commitments to the American people and to the private sector.

The first is that we want to help consumers to easily and securely access their electronic health information and be able to direct it to a desired location and to learn how their information can be shared and used and assure that this information will be effectively and safely used to benefit their health and that of their community.

The second commitment is that we want to help providers share an individuals' health information for care with other providers and their patients and others, as much as permitted by law and refrain from blocking electronic health information. That is, knowingly or unreasonably interfering with sharing of electronic health information. And the third commitment is around implementing federally recognized national interoperability standards, policies and guidance and practices for electronic health information. And adopt best practices including those related to privacy and security.

So in short, the first commitment is about to consumer access readily to their electronic health information and their ability to share that where they want. The second is that we will unblock data; we will move data now and not knowingly or unreasonably engage in the information blocking. And the third is to move us towards a set of federally recognized national interoperability standards that include privacy and cybersecurity and that are a way that we can have a set of shared standards that we can compete within as opposed to betwe...competing between standards.

Our work as a payer, a purchaser, a provider and a developer of health IT will be framed by these high-level commitments and is in much more detail in the document. It is, I guess it's our ask of you all, the private sector or the states to look at these and see if this is a place where you believe we have common ground at a high level. And then we'd love to work with you all in the weeks to come on how we get more specificity, which you'll see outlined in the roadmap that comes out online later today. But, how can we work together to see that this is the way that we're all working together on behalf of consumers in the country and that this is our touchstone for the way that we want to do business together out there.

So I put that out at the top as something for you all to reflect on. No feedback needed today unless you would like to. And I want to thank all of you who have already started some of these dialogues with us because we have a lot of conversations to have about these commitments and about the roadmap. Our work is just beginning in those conversations and we appreciate some of the thoughts and feedback that we've had already.

Just in case we're running long and I'm...I don't remember to say it at the end, I wanted to tell this group also that we're planning a public-facing event with the private sector in a few weeks where we'll have a chance to go over these and think about the commitments that the federal partners are making and whether there's common ground here and also more specificity about what needs to happen by when and how others want to commit to seeing that we can achieve interoperability.

Thank you. Back to you, Erica.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Thank you, Karen; that's helpful framing. So this is the third time that we're having a conversation as a group about the Interoperability roadmap. At this point you have probably all know that I personally like to start with a definition; I just find it helpful for grounding our thinking and our conversation. I also find it useful because I have come to learn over the last several years working on interoperability that the term itself is fairly loaded; there's quite a bit of baggage. It means different things to different people.

So for purposes of this Interoperability roadmap, we define interoperability formally as the ability of a system to exchange electronic health information with and use electronic information from other systems without special effort on the part of the user; three important components there to keep in your mind, exchange, use and without special effort. In practical terms, that basically means that people should be able to do some core functions. They should be able to send, receive, find and use their electronic health information in a manner that is appropriate, secure, timely and reliable to support good decision-making that affects their health and wellness. So with that in our minds, let's talk a little about context for the roadmap and then we'll...Steve and I will try to quickly dig into the detail.

Interoperability matters a lot for achieving the goals that we have laid out as the Department of Health and Human Services, as a nation and that are articulated in the Federal Health IT Strategic Plan. We've made pretty significant progress over the last five to seven years, certainly in aspects of exchange. I think you all had, or at least the Policy Committee had a presentation in August looking at some of our exchange data. Certainly the majority of hospitals at this point exchange patient information electronically with outside providers.

When we dig into the details on the type of information that they exchange, looking for example at care summaries, still the majority are sending and receiving that information; however, when we start to get into that use piece, when we start to look at integration, computability, giving clinicians the opportunity to really leverage a number of different tools using the same data, we actually see far lower numbers. And unfortunately, we don't see as much growth, at least in the data that we have from physicians reported thus far in terms of electronically sharing health information; still under the 50% mark although we have had some progress.

And in terms of the landscape, last October in fact when we talked about...quite a bit about the landscape of health information exchange and interoperability, we talked about how varied it is. There are a number of different network service providers that exist today, a number of different health information sharing arrangements; some are focused on very specific use cases, some serve very specific geographic areas, some focus on very specific types of technology. At this point, not all of them can exchange information across their different boundaries and so one of the things that you will see in the roadmap, one of our assumptions going in, is that a number of different networks will continue to exist. But the goal is really that information can flow across them, that we are able to knit together the existing services and infrastructure so that information really does follow people when and where they need it.

Refresher on timeline; I've heard some criticisms about the time it's taken ONC to pull together this roadmap; I have to tell you personally, I think we moved pretty quickly for a federal agency. It's remarkable how much time it takes to gather public comments, to process that and then to go through things like internal clearance; it's been about a year. You may recall this timeline slide and we are here with a final version 1.0 product.

The other thing that made, I think a significant difference in the content and also took some time, was engaging a number of different stakeholders across the ecosystem. We were committed to making sure this is a shared roadmap, not just a federal government roadmap, not just an HHS roadmap, but a roadmap that can reflect the perspectives and the actions needed by a number of different stakeholders across the ecosystem. And so I'll tell you...actually bef...let me come back to feedback in a minute; I want to talk a little bit about our principles and what you'll find in the roadmap and then I will circle back on some of the high-level public comment that we received when put this draft out in April...I'm sorry, January.

We committed to really driving the development of this roadmap based on a set of principles. We put these principles out actually when we first put out the interoperability vision paper over a year ago. We added one guiding principle along the way and last October we talked a little about trade-offs related to these principles that it is very difficult to achieve a roadmap that upholds every single one at the same time.

And so I will reinforce for you all that there are trade-offs that you will see in this roadmap. There's no way to, for example, build upon existing health IT infrastructure and really have an ideal person-centered health IT ecosystem. Our current infrastructure wasn't built necessarily as a person-centered infrastructure from the beginning and so there are some trade-offs that you'll see in the interest of making progress rapidly, and we should be very transparent about that.

In terms of structure and goals, the goals that we laid out, interoperability goals that we laid out previously, remain the same. We have a goal for the near-term focused on making sure that the majority of providers and individuals can send, receive, find and use a common set of clinical information. And we call this priority data domains in the roadmap, that is a tweak in language that we made as a result of public comment, to improve health care quality and outcomes.

Then moving in the 2018-2020 timeframe, to expand the data sources that are interoperable, so for example, moving beyond electronic health records, thinking about our human service colleagues, schools, prisons and many other data sources that need to be integrated to really wrap around a person and support well-informed decision-making. Really then focusing also on continuing to improve health and lower cost. And then focusing in the 10-year timeframe on achieving a learning health system; this is our very ambitious goal focused on improve...continuously improving care, public health, really advancing science through the use of information.

Although those goals remain the same, you'll note when you see the roadmap that the organization has changed. We originally organized it around the 5 building blocks; we have shifted to kind of a three-component organization. This was the result also of public feedback. Starts with drivers moving then into technical and policy components, that's the largest chunk of the roadmap, and then ending up with outcomes.

You'll note that each section of the roadmap now also contains milestones. So as we thought about what we had in the roadmap, the tweaks that we wanted to make to strategies and tactics, we realized that it was very important to make sure we had a sense of what exactly for a particular topic area it was we were trying to achieve in a given timeframe that advances us toward each of these goals. So you'll see that addition in the roadmap. You'll also note that it is very focused on near-term actions, for that 2015-2017 timeframe. I believe the word action is in the roadmap about 107 times; it is an action-focused document and that is very intentional.

Going back briefly to what we heard in public comment, so we released the draft as you'll recall at the end of January. Several of your workgroups commented on the roadmap, gave us very useful feedback; thank you all for those who participated in those workgroups. We also received feedback from about 250 organizations and individuals. What we generally heard through the feedback was that the requirements that were set forth, the high-level components were right, that we got the general components right and in fact in many cases, the high-level strategies were right. In some cases there was disagreement about the details, and I'll give you a few examples here and then as we go through each section of the roadmap, we'll you a slightly additional...a little more detail.

So mixed feedback on governance; the governance approach that was put forward I will say was misinterpreted by many folks and there was mixed feedback there; many requests for additional clarity on standards direction. A call...many calls for a unique health Identifier; I am sure that's not surprising to anyone. Some confusion about some of the privacy and security concepts, particularly around the permission or choice topic as we call it in roadmap; many of you may refer to this as consent. And some confusion about the structure of the document; I mentioned that already in terms of the building blocks and how those different pieces fit together.

So in order to advance interoperability, a core set of stuff has to be either done the same way across various stakeholders or has to be done in compatible ways. There also has to be the proper motivation to do that, right, because it takes work; it takes time and energy on the part of stakeholders. And in addition to alignment on the technology piece, there has to be, we have learned, alignment really on the policy and business practice piece also. If all of the things don't line up, we don't see interoperability at this scale, or of the type that's needed to achieve the goals that we put forth.

So we're going to talk about the roadmap in that order; we're going to talk about motivation, drivers, I apologize, my throat is really dry today. Then we're going to talk about technology, we'll talk about some of the standards components, Steve will go through those pieces. We will talk about policy and business practice pieces at that point; that also includes privacy and security, if Lucia Savage, our Chief Privacy Officer were here, we would have her walk through those. I believe she will join us by phone to answer questions.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

I'm on Erica.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Oh excellent Lucia, I'm glad you're on. And then we'll talk a little bit about outcomes. We'll try to go through this as quickly as possible because I know we're short on time.

So moving straight into drivers; the focus that you'll see in the roadmap is really on this shift toward value-based payment. You've had a number of discussions this morning about that shift and so I won't go through the detail of the milestones that are here on this slide, but want to note that that is the primary focus of the driver piece of the roadmap is really on this shift in payment policy from fee-for-service to value-based payment.

In terms of calls to action, you'll see a general trend. There are a few examples on this slide, this is not the complete set, by the way. In your reference slides at the very end of this slide deck you have a complete set. You'll see a focus on integration of standards and exchange in value-based payment policies, whether those exist at the state level, the commercial level or the federal level. You'll also see a push on purchasers to really consider the interoperable aspects of policies as they make purchasing decisions.

By way of commitments from federal government, I believe most of the commitments in this section have been made by CMS, which makes sense. The two that we've selected to put on this slide here; one, CMS will take advantage of opportunities, when possible, to build interoperability requirements into their relevant payment rules and programs. It's basically the same ask that we're making of the private sector. And CMS will encourage states of Medicaid managed care programs to include references to health IT or health information exchange in any of the relevant policies that surround state quality strategies. And I'll hand it over to Steve then to talk about the technology pieces.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

All right. Thanks a lot. So, Erica neglected to mention something which I am going to do now. The roadmap structure, in terms of the table of contents, goes in alphabetical order, but you may notice, those of you who have OCD like I do, that we go out of alphabetical order. So in case anyone, it occurs to anyone, there's a method behind the madness here. So I'm going to talk through a number of the technical components that are part of the roadmap starting first with semantics and then continuing onward.

So, the other thing to note as well as we go through the presentation, in the first slide for milestones, we've represented the full breadth of the 10 years' worth of milestones. When we talk about the calls to action, which are public and private oriented actions that we recommend folks take, those are inclusive of both the public and private sector actors. When we talk about commitments, those are only federal commitments that are in the commitment the section as well, so just more ground rules for the slides as we go through them.

Also when we talk about the calls to actions and commitments, those only are representative of the 2015-2017 time period. We'd be here for another two hours if we did the other 2 milestone periods. So, that's for your sanity, not ours.

So we're going to talk about semantics first. This is really again the meaning, consistently representing data. The one thing that Erica mentioned in terms of the first milestone period overall is that we moved away from the term "common clinical data set" as used in the roadmap. You may recall when the roadmap was published and then subsequently the proposed rules, there was a shared intersection between that term of art that caused confusion among stakeholders in terms of the use of common clinical data set in the roadmap vis-à-vis its use in certification criteria.

So, to create clarity around the concepts that we were structuring in the roadmap related to semantics, we've just chosen to refer to them as priority data domains. And that's important because as we look at getting more clarity and consistency around semantics usage, we see this being bite-size incremental work that can occur year after year in that priority set of data and the domains that may be composites, right; so vital signs would be example of something that's referenced but then is a composite of many different data elements. So that's a change that's included in the roadmap as published.

The other thing relative to the priority data domains is that it includes a number of clinical concepts as well as those that are related to patient matching, too. So for this first set that's come out of the roadmap, we have some patient matching data that overlaps with some clinical data and then also some clinical data as part of that first priority data domain set. And again I talk about the milestone period being about incremental progress.

So here are some calls to action that we framed. A real emphasis here is the need to include more feedback from users of health IT into the standards and technology processes, so you'll see these represented in the calls to action. And then the last bullet here I should just call out a shout-out to my other federal colleagues, having attended their workshop, there was one on semantic interoperability in labs that FDA, NLM and CDC hosted a couple of days ago which was very in the weeds, but very educational and good progress where you could see we're ready. They're already acting on this call to action to do something in this area; so kudos to them for stepping forward.

And then on the commitments; these are both ONC-oriented. The bottom line here is that we're committed to collaborating with and participating in semantics-oriented projects. So that you can see coming from us, including where we can be of value to stakeholders as a convener; so if that's the role that is necessary to move things forward, we're happy to do that as well. And again, this is about working with everyone to bite-size and incrementally make progress from a semantics perspective.

When Stan says this is hard, it always makes me smile because I'd get worried if he said something was easy and we weren't doing it. So I do...I'm always happy when I hear something from Stan that makes me smile.

All right, so we're going to move on to data formats. There's an explicit connection here between semantics and the syntax, all right. And those of you on the Standards Committee know this pretty acutely having had those conversations about the workgroups as well. So that's really what we're talking about with this section of the roadmap, the structure and the syntax. The milestones are focused again on collaborating and aligning on the different structures and syntax that are used to achieve particular interoperability needs, as well as aligning the semantics use within particular standards.

We know that we face challenges with migrating from one version of a standard to the next. There's equally, and perhaps more complex challenges in getting alignment across multiple different SDO's portfolios of standards. We've done some preliminary analyses to indicate that there is variability and, I'm sorry that I'm going to standards wonk-out on you for a second. You know, there's variation in particular data that we have identified in the priority data domains in terms of whether or not it's required in a particular standard. If it's required, but allowed to be blank, if it's optional; there's loose bindings of vocabularies and value sets, there are should and shall; they're all inconsistent for the same data across different standards.

And that's something that we shouldn't tolerate as an industry and that's something that's going to drive people nuts going forward and per our prior conversation, effective interoperability experience. And as we talked earlier as well about quality measurement, right; collecting data and having it have the same meaning and having it represented in different structures as it gets exchanged is going to be important.

Similarly, there's a lot of variation in terms of no information is represented, so this we call, you know, the flavors of null. Even though they have very important meanings when represented in a computable way, so no information versus asked but not known versus not asked. And those are all different ways in which, you know, there are variations today as we've done some analysis across the different structural standards.

So in terms of calls to action, again this is areas where we've looked and are calling out to SDOs, which we are much interested in partnering with and collaborating with to help to align the use of vocabularies and code sets in their standards and other encouragement to provider devel...provider and patient-facing technology developers as well as SDOs to follow best practices and guidance going forward.

Commitments that we've made here, it seems pretty self-explanatory. As I mentioned already, we are going to promote and participate in these activities as much as we can and work toward helping the community get better alignment in its use of the data within the structural standards.

And we move on to the section entitled consistent, secure transport techniques, this really follows the build on what you've got and build on what exists. The milestones you'll notice have some focus on around the ability to having used Direct at least as a minimum baseline for transmission of health information. As many of you know, the 2014 Edition products with respect to certification, were all required to have this functionality as part and as providers, more and more adopt and implement 2014 Edition technology. That was one thing in terms of building as you know and setting milestones that clear and tangible.

There are many other aspects as we get into the calls to action they go beyond Direct in terms of trust communities and the like, focusing on query and other areas in which getting data is going to be equally important as we look to send, receive, find and use.

So I'm going to move next to secure standard services. The roadmap trajectory here is really worked toward agreement on standardized API approaches. So you'll see reference to the recent work by the Argonaut Project and others working together. And the kind of first milestone period for 2015 through 2017 is really getting everyone aligned and together on standardized approaches for APIs. And then going forward into the milestones, setting up some metrics by which we hope that the industry will be able to work toward to meet, from a roadmap perspective.

So you'll see in a number of these milestone periods, as Erica mentioned, that were added in to each subsection, that we tried to frame out, some may say ambitious, some may say not ambitious enough milestone metrics that will be the kind of internal tracking for, are we making enough progress relative to the work that we set out to do.

Okay, calls to action here; again lots around API-related work, work for standards development organizations and technology developers to work together as well as here connection to medical devices. That was another point of feedback that Erica can certainly chime in as well that we got a lot of feedback relative to devices and connectivity to the health IT systems which was something that I think we foresee taking on with additional clarity and additional collaboration in future iterations of the roadmap. So there's not going to be, sorry to disappoint, a heavy focus on medical device interoperability, but there are mentions of it as well in the roadmap.

Commitments here; we're going to, you know, reflect our commitment as you've heard Dr. DeSalvo mention many a times related to our work around APIs and participating in the Argonaut Project and other activities that will help facilitate the use of APIs.

I think this is my last one, and keeping true to the time schedule that we're going to keep; industrywide testing and certification infrastructure. So here again the trajectory is, and earlier this year I made a plea to make testing the word of the year for 2015. You'll see the trajectory here is more testing, more testing, more testing, more testing, more testing and more testing. And the more and more that we can do this working together, ONC is involved in these efforts, our colleagues at NIST are involved in these efforts. I know a number of private sector collaborations are involved in testing.

And part of the trajectory I originally wanted to call attention to as well is, as we continue to work together for test tools and utilities that will support the industry and technology developers in this early stage of this time period of the roadmap, there's also a need that we need to start working and focusing on tools that providers and patients can use.

So I liken this kind of the Internet bandwidth test, right? So if I know from my, and I won't name cable subscribers, right, like am I really getting what I paid for? I have a tool that I can use. It's pretty simple to figure out what my download speed is, reasonably speaking. Those tools don't necessarily exist for providers today and so that's an area of focus where there's a challenge to the industry to say, there are better ways to do this and there are ways to enable and empower providers and/or patients depending on the technology involved, to test what they've got. And we'd like to work with the community to work on those areas as well.

So going forward in terms of calls to action; there are opportunities here for the industry to deliver on more testing, a collaborative approach for everyone, including standards development organizations. So I'm really going to sum this kind of calls to action slide up as collaborate, accelerate, complement and feedback. And that last element being a lot of the work that we can do to improve the testing experience that developers go through either vis-à-vis our program or other programs are really to get people to a point where they're production ready. And that's what I'd like to see from our certification program that the assurances that people get are, they're as close to production ready as possible and that will include some additional rigors but also additional ways in which to perform testing.

And then I think we've got one last slide here. We're going to continue to work with our colleagues at NIST, specifically with a focus on Consolidated CDA. We're going to look to approving non-governmental test tools within our program. We did put out a public Federal Register Notice soliciting feedback on other certification programs where there could be some reciprocity. I know ePrescribing is one of those axes that people like to grind all the time, and so we've had early conversations with the ePrescribing related networks around processes that we could look to approve their test tools and their testing approaches as part of our program.

So these are areas where, to Dr. DeSalvo's point earlier, we haven't just been resting since we published out the draft, we've been working, per our commitments that we articulated early on, to make progress here. And last but not least, we have an opportunity with the certification program to make more data available about the products as they go through certification. And so you've seen an articulation of that in our proposed rules and we're working on making open data available about products through our Certified HIT Products List.

And that gets us right at the time I committed to Michelle for FACA discussion. After you finish or get all of the discussion you want out of this period, we're going to move on to the second half after a break.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, well why don't I start with just an opening salvo and then we'll turn it over to a few folks; it looks like we only have two cards, uh three cards okay, we're getting there. So Stan, I reflect on the time we spent together in Salt Lake last week where as we went through this discussion of what is interoperability? How do you measure interoperability? What is the experience of interoperability? What we concluded is that if you have different use cases, public health submission, patient family engagement, transition of care coordination, APIs may or may not be a good architecture. Direct may or may not be a good architecture.

What we ended up doing in the definitions that we worked on just over those two days is to actually remove any statement of architecture or specific required standards, recognizing that, you know, I mean who knows, 5 years from now if Direct will be around. Who knows that version 2 of HL7 may be a perfectly good standard in 2022. We don't know. And so I only, Steve and Erica reflect on that for a minute, because I see you've actually enumerated, you know APIs, Direct protocol...Direct protocol, how future-proof is that?

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Well I think it's in part a reflection in terms of the feedback of asking for more specifics. So, and also looking at the milestone periods where the roadmap itself and I think one of the misinterpretations more broadly was that we have to wait 10 years to get interoperability, because we laid out a 10-year roadmap. That is probably the furthest thing from the truth in terms of our perspective and what we have tried to emphasize here in providing more explicit and additional information as part of the roadmap is to say, there's a lot of work going on right now, let's lay out some tangible actions that people can take.

I don't think that we're trying to prescribe as you look at the overall goal for 2015-2017 which is not architectural or particular technology-specific about send, receiving and finding and using data. That's the high-level point. In particular subsections, we did get more specific to give people guidance on actions to take. So I think there's a balance. It's well taken, you know, fair point.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So as we discussed this morning with Karen, all we need is far more specificity and far less specificity at the same time. What's the problem? Erica?

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Yeah, I just wanted to note for folks that we intentionally don't call it an architecture in the roadmap.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Sure.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

In part because we had, I suspect, conversations that sounded in some ways similar, having not been at the meeting you referenced John, may have sounded similar to some of the conversations that you all had. If you articulate an architecture upfront, it puts you on a very specific path and so that's something we held off on, even though we did try to respond to some of the public comment in terms of specifics.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great. Well, let us go around in a counter-clockwise fashion so Lorraine Doo.

Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services – Health & Human Services

Thank you; Lorraine Doo with CMS and in many ways CMS and HHS and ONC work together except in the area of administrative standards, that's one area where they've kind of separated us like children. And I think we have one of the greatest opportunities to do some work together with payment reform because we have the administrative standards for payment where providers are suffering fair amount now because of the way the standards...the payment for standards works.

So I would say that in the roadmap, one of the things that we should add to payment reform is the method we use for payment with the electronic transfer of funds. And that if we add that and change the method away from EDI, that we will have contributed greatly to that pain point .

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great. Devin?

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

Hey, Devin Mann from Boston Medical Center. I was drawn to the slide, I don't know what nu...7, where you kind of commented how "use" is lower than the other kind of bar chart items. And then I was reading the real fine print on what "use" means and it says requires that the records are integrated into the hospital's EHR system without the need for manual entry. And so I was thinking about that and what that really means.

And Erica and I were talking over lunch how I've been trying to actually sell our exchange of health records as work worth doing by all our clinicians and it's sort of like this hidden feature that they're not enough taking advantage of and in the end I kept on saying, this is one of actually the few killer Apps...the question that actually help you get your work done. But in the end we spent all our time, and what I'm about to ask is, when I'm reading through this roadmap, I still see a lot of the effort, and there's another phrase in here, something about the data elements that have been agreed upon.

Whenever I hear that, I think a lot about problems, meds, allergies, all sorts of other kind of very capturable data elements and very little about notes, you know, narratives. And when I'm doing the sales pitch to our providers that's the only thing they care about. Honestly all that other stuff that we talk a lot about, they don't even trust usually anyway and they retest it and recapture it anyway. But the notes, the narrative they're desperate for.

And I just wanted to make sure in this, I can't seem to triangulate it in a timeline is that frontloaded? Because honestly, from the clinical sector that's the very first thing that we care about exchanging and all this other stuff is great, but it's much more important for reporting, and when I sit in the...area and kind of public health. But I just want to make sure that aligns with the timeline you're putting forward.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Yeah so, I too hear the call to action, there's a third bullet there about SDOs and stakeholders should document the best practices and guidance on methods related to exchanging unstructured health information such as physician notes in an interoperable manner. So, that's a call to action for this time period that we'd like to see accelerate work around.

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

Great.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay. Arien?

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

So, just as a quick follow on from that I expect in the interoperability experience section, we're going to hear the notion that physicians want to see, the computers need computable information and physicians want to see narrative summaries as a theme for that work.

I'm going to riff off of John Halamka's comment that we need more specificity and less specificity at the same time; I definitely applaud the direction that the roadmap is taking, the level of commitments that many of us are being asked to make I think are reasonable. Except that some of the roadmap reads in...reads with a notion that we're going to be asked to look at a lot of process outcome measures and a lot of compliance-oriented, did you check this box, did you check that box, did you implement the federally recognized interoperability standard and not did you implement the outcome that the standard was trying to achieve. And I know there's a tension there in terms of specificity.

But as a comment along the same lines, the word "federally recognized standard" grates wrong for me in preference of nationally recognized standards. And again the notion is, are we going to be asked to check a bunch of boxes or are we going to be asked to deliver an outcome and be flexible in terms of the standard or standards that we use, some of which might be federally recognized, some which might be on the edge of innovation. As an example of this, when we did CommonWell there wasn't a great standard for doing some of the linking that we wanted to do and so we kind of went off in crazy path and used FHIR.

It looks like a good decision in retrospect, looked a little crazy at the time of that action; that's the kind of, I think innovation that we want to encourage. And again I worry about that trade-off between specificity and a compliance-oriented approach. I wonder if you can comment on how to manage or mitigate that implied trade-off.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Let's see if I can respond to your question in less than more words. So I think there's an important point of the roadmap itself being non-regulatory, right, in our bureaucratic-speak that allows us to adjust and accommodate different directions that we can go in. I think, I don't want to speak for Erica, but it's anticipated that are going to be things in here that people aren't, you know not everyone's going to agree with or particular words certainly that not everyone are going to agree with. But in that respect there's an opportunity for us to work together because this is a shared roadmap. And so I think if we can agree at each succeeding level of depth, once we get to that next level where there could be some disagreement, that's the place that we want to have those discussions and work together on, so.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay. Next I think is Richard Elmore.

Richard Elmore – President, Strategic Initiatives – Allscripts

So Steve and Erica, thanks; first of all, a really nice job on the presentation. Having been in the Content Standards Workgroup look at the detail around this; you did an excellent job of summarizing it up and making an understandable vision for all of us.

There's clearly a set of interdependencies between the various calls to action between semantics and formats and so on that you've outlined. And I guess my question is really, how do you see that coming together and when you talk about the 2015-2017 timeline, where are we at the end of 2017? Do we have great specificity about what needs to be done? Are we ready to go to national scale or are we at national scale? What is the broad objective in that three-year timeline?

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So, I can feel Erica looking at me; the subtle head-turn. Yeah, so I mean I think there...this is a multidimensional issue in terms of the plan of attack. So there are areas where there's reasonable industry certainty around which standard should be used to represent which particular information. And so then in that case, it's a gap analysis to say is everyone doing it the same way? And so that's one area where I think we see trying to help lead and collaborate with folks over the next three years.

There are others where there is...on the other end of the spectrum, there's no agreement or the data hasn't necessarily been prioritized and it's part of this list now that people believe should be prioritized to move forward. And at the end of 2017, we...our goal may be to reach agreement for some of those. And then in other cases it could be, everyone agrees, everyone's using it the same way, we just need to push forward and make sure that everyone is implementing it consistently across the board and we'll have, you know. It links also to testing and certification, not necessarily through our program, but through other approaches as well.

And I think there's a stepwise analysis that we'd like to be able to, as I mentioned earlier, you know bite sizing, kind of chunk this up because we can't look at, and I would encourage everyone to look at these sections, you can't do everything at once. So there's going to need to be some iterative and incremental approach to cycling through these things, using the learnings that we have through one cycle and helping them approve the next round. I hope that answers your question at some level.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

I think we also tried to be, I'm just going to riff on what Steve said and say some of the same things that he already said. I think we tried to be fairly explicit when it comes to things like format standards and say here are the most commonly used format standards given our assessment. Let's just get it right in this 3-year timeframe for a specific set of data within those format standards.

Let's not try to boil the ocean, let's start with something that we think is digestible and even as Steve noted, phase that at a more granular level by looking at what has been put forward through regulation. For example with the certification program, can we get alignment first on the elements that have been put forth there and then move on to the following chunks. This is one area where we've tried actually to be really explicit in terms of the particular format standards, particular data domains and how that could be phased .

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, thank you. So I noticed in your efforts in your slide about convening SDOs and coordinating SDOs that that is a real big role for ONC and I would like to put forward a suggestion or plea. And although we often talk about patient-centeredness, patient engagement and patient involvement, when it gets down to use cases that are being defined in standards organizations, regardless of the good intent of being patient-centered, we see that patient use cases go to the bottom of the list. And so there's really no voice that can act as a real advocate for a standard way of including patients in the HIT ecosystem.

And I think that's a strong role for ONC and actually this group or task force. Because without that we will continue to be disenfranchised...mediated and dropped to the bottom of the list when in fact a proactive and supportive standard-spaced approach to define the patient and how they integrate into HIT could be quite enabling and empowering to all of us. So, it's a plea and I would love your comment.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

It's a well taken plea; thank you for that. I will say we have tried to be very thoughtful as we've gone through the roadmap to ask ourselves does what we're talking about apply to consumers or individuals the same way it applies to providers. And if...even if it doesn't apply the same way, if there's a benefit here for consumers or individuals; how do we build that in?

I mentioned at the beginning there's a trade-off in building from existing Health IT as opposed to building from scratch. And to be really candid, I think we'd probably build a good number of things differently if we were starting from scratch to make a truly patient-centered system. There's a real tension there though in not deciding to rip and replace and instead build from what we have. It's a well-taken plea and it's something we'll keep front and center.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay. Christoph?

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

Thank you. So Erica and Steve, thank you very much; I agree with you. You've done a tremendous amount of work in very short period of time and you're to be applauded for that. My first comment is, I wonder if your numbers don't exaggerate a little bit the actual meaningful exchange of information.

As we see on that definition that was pointed out, use doesn't really imply use; use just means it's available in the EHR, it doesn't mean it's actually being used in a meaningful way by a clinician. And so I...therefore, I'm very encouraged to see we will have an Interoperability Experience Task Force that will actually dig down a little bit into what's the reality? What's the experience for clinicians and patients as end users of this? And so I think this is a fantastic effort.

At the risk of being reprimanded by Jon, I think there's a lot of special interest that you're dealing with in this room and from outside sources and I think there's a great interest for some people to maintain the status quo. We have seen in this country failed standards, you know, let's look back to VHS and Betamax and we can recover from failed standards. And I think you pointed out, we would have built a lot of things differently if we know what we know now, but I think it is time to make some bold decisions.

Stagnation if not what is going to get to us to interoperability? Letting 1000 flowers bloom is probably not the right approach so I think the notion of trying to identify some easy to identify standards and moving things along are very good. So I actually don't have really a question, I just wanted to say that I'm very appreciative of what you are doing.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Thank you.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

You were referring to Jon White, not me John; I would never reprimand anybody. Jamie and then Andy.

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy – Kaiser Permanente, Institute for Health Policy

I'd like to focus on how progress is measured. And it's kind of striking we just had a conversation earlier today about in some cases moving towards outcomes-based measures in the systemic reform efforts. And yet here, in interoperability we're still looking at process measures, essentially counting the number of emails. Well counting the number of emails does not measure interoperability.

And so I would urge you again to focus on developing measures that can measure achievement of the objective of interoperability, which is the availability and usability and comprehensiveness of patient-centered information that's available for patient and provider decision making. And so I would urge you to work with NIST, I am looking at Kevin over there to see if measures can be developed that are objective measures of the comprehensiveness and usability of information that's available to the decision-maker and use those essentially outcomes, look at the outcomes of interoperability and achievement of the objective rather than counting widgets or emails or transactions.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

You're jumping ahead of us. We will talk a little bit about measurement. We'll talk a little bit about the outcomes piece of the roadmap. I think we're generally in violent agreement on that that we need to focus on measurement of outcomes. There are some process pieces that I think we will want to continue to measure simply because we will want to be able to make correlations and do some analysis over the long term. But it's a point well taken and it is a piece of public comment that came back resounding.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Yeah and just to echo, it's kind of sobering as we're working on the outcome section, which Erica will talk on...about a little bit more. But we're equally unsatisfied with where we are industrywide with how we can measure interoperability. And as we tried to lay out in the outcomes section, although I'm stealing thunder from the slides, there's a spectrum, right? The best we might be able to do as a proxy is counting some of these things at the moment. But that is certainly not where we want to stay.

And so as we can work together with everyone to get exactly to those points, Jamie, is really where we've been trying to lay out in working with our other colleagues in ONC to structure across the next 10 years' worth of work, how we can best position our work, as well as industry work, to get to some of those outcome measurements. Which could require us to figure out new ways to capture some of the information that we need, right? And that's where as we look at some outcomes that we'd really love to measure right now, we're like, I have no idea how to get the data to figure out what the numerator and denominator would be.

Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy – Kaiser Permanente, Institute for Health Policy

So if I can just jump in with a response. So, I think that's some of the point of some of the other comments that you've gotten about allowing national standards or things that are not regulatory standards to be used and so allow some of that innovation to fill those gaps to make the more comprehensive, patient-centered information available and usable.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

It looks...and I will go to Andy next, but is that Wes who's on the phone?

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

Yes.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Okay, so Andy and then Paul and then Wes.

Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP; International Health Terminology Standards Development (SNOMED)

I have a comment that links together what Chris and Jamie were saying. There are really two fundamental questions to answer. From the patient perspective, it's the old IHE dictum, nothing about me without me. If you were to survey patients and ask if something happened to them and they didn't know about it that would be a failure of interoperability. And from the clinician standpoint is, how many times today did you have to make a clinical decision missing information that you knew was there but you couldn't find it?

And to the extent that that can be answered in some automated way, I suppose that would be most desirable, but it may be that you simply just have to ask people and do surveys and dispense with all the other measures and all the sort of burdensome data collection that happens inside and in the periphery of EHRs and find out how many times today, because you're a doctor, did you do stuff not knowing something important or worried that you didn't know something important.

The other comment I would make is that, this is going to sound heretical, but I use that word advisedly. To me for a long time a lot of the arguments about the correctness or appropriateness of one standard versus another has not been scientific or objective but theological. So it's heresy, but you know, just forget it; pick one. And as Chris said, you know if it's lousy, like ICD, we'll make the best of it and do what we can to use it for a variety of purposes, even those which it was never intended for. Okay?

You've got a bunch of target standards out there; we spent a lot of time arguing about this in different task forces. We can argue about it in perpetuity but we'll never get to the action that you want unless you establish right in the front, let's do this one, let's stop arguing and if it's wrong we'll fix it.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I'm going to just riff on the comments that both Jamie and Andy have made. As we met on Thursday and Friday and we talked through measuring interoperability we said, well, on the one hand you could have NIST count the number of transactions that went across a network. Here is a bag of garbage, I have delivered it to you. It is a lovely bag of garbage, what are you going to do with it? I'm going to immediately throw it away, it is a tag of garbage. Versus the, oh you know, you and I agreed on what I need to coordinate care and it was available to me at the point when I needed it, which is more experiential than a count. And you probably need both, but you can't really interpret interoperability without having, as you point out, both of you, the utility and the experience of that transaction.

Any comments?

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Just maybe two thoughts, because I've heard this come up a couple of times that I would like to reflect on, given the process and experience of working with a number of folks to develop the roadmap. The first is, there is a real tension between getting standards right and implemented consistently and innovating new standards. And because implementing standards consistently and getting them right takes a little bit of time. And there's constant desire to innovate.

And so I don't think we've got the exact right answer in this particular roadmap. I will say, given the public comment that we received on the roadmap, I don't think there's agreement. There just is not agreement across industry on what particular standard is the exact right standard for our particular function. And so we have to be willing to be unpopular in saying, this is the path forward and recognize that that has certain implications or allow the community to continue to do what it does now, which I agree with you, tends to be sometimes more religious than not.

The second thing I would note is about use cases, use cases or at least allusion to use cases has come up a couple of times. The roadmap does not include use cases, in fact we say explicitly in the roadmap that use cases should be determined by things like payment policy, right? What you get paid for as providers should certainly influence the use cases that you prioritize. Consumers should be part of the prioritization of use cases and certainly local needs.

To determine of core set of use cases as we did actually try to do this, remember you saw the list of 56 use cases in the draft. To determine those at the federal and national level and then dictate those through a shared roadmap to the community we decided was not prudent. And instead it was more prudent to think about how do we piece together infrastructure, but from both a policy and technology perspective that allows a number of different use cases, recognizing that there may be additional work to be done for a particular use case; but at least create a foundation and some common playing ground.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, just to point out we are running about 15 minutes behind on the agenda, so I think you got the privilege of skipping a break, I think I get the privilege of skipping a break but we will of course go to Paul, Wes and then I think Stan, is that your card up? Okay. So Paul?

Paul Egerman – Businessman/Software Entrepreneur

So first I want to say thank you Steve and Erica, it was a great presentation and you presented very clearly something that's very complicated, so I appreciate that. And I also want to echo a lot of the other statements that what you're doing here with interoperability is really, really hard to do. I mean, it's just a very, very difficult thing and it's made more difficult with all the different people who have views and different constituencies and also different...difficult because of the expectation of what interoperability means.

And so one of the things that I...strikes me as I listen to you is one of the challenges you have is, we don't really have a definition, a succe...a definition of what a success would look like. I mean, I'm not sure I know what it would like if we didn't have an interoperability problem and I don't think that...and I look at some of the things you talk about like syntax and semantics. I think those have always been problems and they always will be problems. We'll always just have issues with those going forward and we're always going to make progress. Where we are now is a lot better than where we were 5 years or 10 years ago. And the concept I want to...the question I'm going to ask, and partly answer is, what does success look like? And then I partly answer that by saying, well maybe consistent progress is what success looks like. Maybe this is something we never like completely win it; I don't know what you think.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

That's an interesting idea and depending on how it's framed, could be miserable, right, consistent progress. I will say we tried to be fairly explicit in painting a picture of what success would look like both in terms of functionality and in this notion that, and I think Andy picked up on it, that the right person has the right information at the right time; that's a subjective assessment of success. It's dependent upon the person that you ask. How you measure that then, I think, becomes a very challenging question and one that we've already spoken about today, we don't have perfect approaches for.

Paul Egerman – Businessman/Software Entrepreneur

But even Andy's criteria, the right person has the right data at the right time, I mean we've made huge progress on that compared to where we were 5 or 10 years ago. But it seems like that's something that is always an issue and it's not necessarily even an interoperability issue.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Right.

Paul Egerman – Businessman/Software Entrepreneur

It's hard to get the right information when you have the entire record right in front of you and where there's not any issue about communicating, it's just how do you find the data you need in what appears to be 5000 pages of data on that patient.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Yeah, I like the idea of defining success in terms of making progress. At least we're moving in the right direction; it's a great idea.

Paul Egerman – Businessman/Software Entrepreneur

I really also like Paul's construct. When I was a resident in emergency medicine over 20 years ago, I had a fax machine and a phone and I worked magic because I was able to get outside EKGs in almost 12 hours. Can you imagine? Whereas today, I can get an outside EKG from 2 million patients in under a second by clicking a button in the middle of my workflow; ah, okay, that is a measure of progress. Is it every data element for every purpose and every person, well not quite yet, but it's a whole lot better than a fax machine and a phone.

Paul Egerman – Businessman/Software Entrepreneur

Right and, it's nice to see a young person like you involved in healthcare. There was a time before we had fax machines, so that by itself is huge progress.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So yes, but that Morse code was really helpful back in the day. Wes?

Wes Rishel – Independent Consultant

Hello?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Go ahead.

Wes Rishel – Independent Consultant

Okay. So first of all, I want to say that we're all very fortunate to work in healthcare because we all still know what a fax machine is, whereas in other fields it's kind of gone away. I want to celebrate the fact that two different groups with different purposes and points of view that is the developers...ONC developing the current document and FHIR both have contributed to the un-deification of the use case. I think we have learned that it caused a lot of hardening of the information arteries.

I want to emphasize we are being hopeful about innovation in two radically different ways. One is, we're being hopeful about innovation in actually how care is delivered by healthcare delivery organizations that are somehow set free from constraints caused by the payment system or constraints caused by information requirements for billing or quality measurements. And at the same time, we're talking about innovation in how we share data among healthcare organizations.

The...if we were to get the desired blooming of innovation in delivering care, I think experience with, for example organizations that carry their own risk shows that they do a lot of innovating at the IT level, they do a lot of ad hoc interoperation and they do a lot more of that within their organization than across. But they find solutions to across organization sharing of information when they need to. Put it another way, if we innovate in healthcare we will get natural innovation within fault lines that is within areas of exchange that directly profit or make better the parties that are participating.

On the other hand, we have a tacit goal at least, of getting better interoperation across fault lines; making sure that competing hospitals in the same region have equal access to the patient's data , making sure that public health has access to data and we are going to have to set our goals and measure our process...measure our progress based on an understanding of which problem we're trying to solve.

Finally, it's been my experience in standards, and this goes to the Internet standard suite or it goes to HL7 version 2 that we do best at making standards when we are compiling and assembling best practices rather than creating a de novo idea of how to solve information problem. And that we should definitely...and furthermore, the idea that Andy suggests of just pick one. We've picked a lot of standards and we have found flaws largely because we picked the standard before they had really been well-demonstrated within fault lines.

And I think we need to do what we've been saying we'll do all along which is find standards that demonstrated maturity, enable all kinds of programs for demonstrating maturity, but don't compromise on the maturity levels, even if it means slowing down the apparent progress and the number of items that we crossed off the list. Thanks.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Steve or Erica, any comment? Okay. Well Stan, you have the last word then we turn it back to these folds because they have 20 more slides before we break.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

This has been a wonderful discussion. Again, I guess to quote Mark Twain, if I'd had more time I'd say less. But there are some really interesting themes and I, I mean could let's extend and go all night because there's...I'll just say a few things. I mean in terms of testing, I think we've gotten into the idea of certification testing and what we ought to be thinking about more is the lifecycle. I mean what we want to have is a place where somebody who's developing interoperable software can go and they can test their software while they're doing the development and they can test it again after they've been certified and they can continue to test it, and so it's that sort of thing.

The...we talked some about particular standards and I would say a couple of things. One is that we...you never want to state specific standards, especially in legislation. And then we talked about which standard to choose and I think the first thing to recognize is that interoperability isn't one thing; interoperability has different...in situations is different. So if I'm moving data from a laboratory information system into an EHR, HL7 version 2 might be great; but if I'm trying to integrate data on the screen from two EHRs, then FHIR or a service-based thing is going to be...so people think about it as if it's one thing and it's not one thing, its different things and if we're going to get to it, we're going to have to think about those situations.

The other part is that creating the interfaces, the easiest part of the interfaces is changing syntax, saying you're going to do XML or you're going to do a JSON object or you're going to do some...the hard part of creating interfaces is the logical structure of the data and the codes. So when we make interfaces, if you're just changing format from the V 2 to something else; to CDA, you can have a programmer write that and they can write it in a couple of weeks, if they're slow. But you start lining up the terminology and that takes six months, because you take clinical experts who have to decide what this concept means and decide what the representation is in somebody else's system. And so I think we need to focus on that.

And then there's just a kind of a word of wisdom in that in that when you talk about those kind of syntaxes and other things, your new great idea about that has to be really dang good to compensate for being different. There's so much value in just being the same and being able to move stuff that if we keep looking for just one little bit better, we're going to be in big trouble because the value really isn't being the same, at least for a given point in time.

And that comes to the next theme, which has been mentioned and Erica has mentioned a couple of times, the ability to evolve because we don't want to stay static. And there's this...there's just this contradiction between getting better and saying the same and somehow I don't know how to apply it in what we're doing. But how many of you guys track daily anything to do with which version of Wi-Fi you're using? Somehow, that migrates behind the scenes and my old clunky PC still sort of works backwards from whatever, you know and so I think, and that's, I think a thing that Wes has told us a bunch of times is, you know how you cross the boundaries, but.

The other thing, maybe the last thing I'll say is that, I think we want to think about the difference between how we measure interoperability and how we implement interoperability. And what I mean by that is that ultimately the measurement of interoperability has nothing to do with a particular standard you're doing and probably not much to do with the number of transactions. It has to do with the things that others have said about whether I have the information I need at a point in time to make a decision. And so you measure that almost at a sort of a Turing machine level of whether you're having the impact and outcome that you want to nothing to do with the standards.

But at any given point in time, you have to say we are going to use HL7 version 2 and here's the exact set of LOINC codes we're going to use because that's...if that part is just left to everybody, then it's just chaos. So we've got to, in terms of stipulating at a point in time interoperability, we have to say those things. In terms of measuring the effectiveness of what we're doing, it has nothing to do with the technology. But at a given point in time in achieving it, it's all about being very specific and explicit about it and so it's that yin and yang between specific and the other.

I lied; one last thing. I mean it's implied in everything that we've said but, the paradigm shouldn't be that we're returning data to clinicians to process; I mean that's one important thing. But we're never going to have the impact on medicine if we leave it to us foolish physicians to make the decisions without real interoperability. I mean, you can take any given situation you want and we now have the capability to make decision-support programs that are as good or better than any expert panel and individual physicians are not that good.

And so we've got to remember that one of the use cases is not just getting this data in, if you will discrete data that I can now display to a clinician. Because if that's the end of everything, the clinician's still going to make the wrong decision 30% of the time or 40% of the time. We've got to have that data so that I can compete against it and it can tell me when I'm making a stupid mistake. And so we've got to remember that use case for decision-support. So I'm sorry, I'm almost yelling at you but...

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

...passionate.

Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare

I'm passionate about this stuff.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So all of these are very valid points; and so Karen, please.

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

I both appreciate and I respect your passion and frankly that of this whole group. I want to push back on one little thing you said and then I want to get to the broader place where we have agreement, that the thing that computers can't do that doctors, I'm just...sorry Patty, I'm going to say doctors because that's what I know. But doctors can...do have is instinct, smell, emotion. There's more, there's a human element to this, so the computer can't completely replace the care piece, but I think you mean that also but we do need a better support clinicians so that the evidence is at our fingertips and we can make those nuanced decisions with the person in the room about what's the right diagnostic or therapeutic intervention for them.

The place where we agree with you and I suspect it was said is, so I was over here passing a paper note to Jon White, which is one form of communication and it was useful at the time, more useful than a text or e-mail and I think it just depends on the use case which kind of vehicle for communication that we're going to want to use. So we do have to have sufficient flexibility; just, you know, you might call, text, whatever on the device. So you're right, we can't be stuffing everything into one box, it has to be a lot more nuanced and flexible than that.

And you are also right that there has to be sufficient specificity that it's not chaos when you get into the environment. Getting that correct, getting that balance between specificity and flexibility is what you all have to help us with going forward. And I know and sometimes it frustrates people when we talk about iterating standards lists and living documents as roadmaps but the reality is, is that the market is dynamic, people are dynamic and we have to keep making this better. Every time we know something we turn the crank again and we get it better. So this is a guide path, this is a roadmap, this is a way to go and we're going to push...use all of our incentives and our opportunities to protect the American people as we're going on this journey. That's what we see our responsibilities as; where we should lead, we will and where we need to step back, we will and you all are going to help us understand where that is.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

...thanks. And of course by the way, the way the semantic interoperability worked between these two since I was their gateway is, it was addressed as Jon, which I was able to interpret from a vocabulary control standpoint, that wasn't me. And he addressed it back as National Coordinator and I knew the equivalency mapping it was Karen. Neal did you have a final comment?

Multiple speakers

(Indiscernible)

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

No, I think it's appropriate Stan had the final comment.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Thank you very much. So Erica and Steve, please take us home. And we will, of course, get the public comment done in time by 3:45, I promise.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

You know, you took your break...nah.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Okay.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

We're not having fun yet, right?

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

We still have a lot to get through. I will try to move quickly. So next up is individual data matching; just a couple of notes, I mentioned this already on feedback from the public. There was a clear and consistent call in the public comment, which by the way all of the public comment is posted on HealthIT.gov, so if anyone is interested in seeing what came back to us and validating what we're telling you, you can.

A clear call though for a unique identifier, I don't think that's surprising to anyone, some suggestions for modifications to the attribute list that we put forward in the draft roadmap. What you'll see in this updated version of the roadmap is the best strategy that we could put forward absent a unique identifier, which is really grounded in and focused on tightly standardizing a core set of attributes about a person and then exchanging those consistently when exchange transactions occur, so that they can actually be used for matching purposes.

Another piece of feedback we've heard from the field is, yeah that's a great list of attributes for matching, but the fact of the matter is, I don't get half of them when I get information from other systems. And so in order to put those to good use, I actually have to receive them. So that's basically the crux of the strategy that you see in the roadmap. You'll also see some pieces, calls to action around measurement, so that we're effectively measuring matching activity.

The milestones in this particular section are focused on duplicate record rates. I do just want to mention that setting those thresholds came as a result of a good deal of feedback, including a community of practice of folks in the field. I think we all know that a good assessment of matching accuracy looks at both false positives and false negatives. It's very difficult though to have a systematic approach, as we've learned from feedback, to assessing false positives.

So those things, usually when something is falsely matched, it usually...you do not know it ahead of time otherwise you wouldn't match it. It generally tends to come up when there's a patient safety incident when someone sees their own record and says, hey, I need a correction here, this isn't my...this isn't accurate information. And so the milestones for this particular section of the roadmap focus on duplicate record rates, because that's what we understand folks can assess and it at least tells us a little something about matching accuracy.

Calls to action I mentioned focus on standardization of attributes, oh, I've skipped a slide. Attributes for matching, working together to identify best practices, document and disseminate those and some things around reporting; the ability to report, for example, duplication in matching rates out of products. ONC commits to coming up with a core set of metrics that can be used by a number of different health IT stakeholders to assess matching algorithms, both their performance and...performance across different data sets and different settings.

Next up is resource location; this has to do with the ability to find the information or the person or organization you happen to be looking for. A great deal of feedback has come back to ONC as a result of Stage 2 Meaningful Use requirements around transition of care about the need to be able to find, in that particular case, another organization or individuals Direct address. But this is a much larger concept you'll see in the milestones a much broader trajectory; and in fact, the way we've defined this component of the roadmap is much broader than just finding individuals.

Some of the feedback that we heard through public comment indicated that we had frontloaded this a bit. I think this was one of the areas where we heard from folks that we were perhaps a bit too aggressive in our expectations and so you'll see some adjustment to calls to actions and milestones that reflect that. We also heard from folks, as I mentioned, I think in part as a result of Stage 2 Meaningful Use that there's just significant need in the directory and resource location space in the real world.

In terms of calls to action, these focused on looking at emerging RESTful approaches to resource location as well as leaning on the Interoperability Standards Advisory and the standards that are identified for provider directories there. By the way, this section is called healthcare directories and resource location for a reason; it addresses both. They are not the same thing although directories certainly help with resource location for some particular technical approaches and some architectures.

In terms of commitments for this section, ONC commits to working with stakeholders to encourage current provider directory activities; there are a number of activities underway with states, for example, as they look to leverage funding to support their local needs for provider directories; also commitment to work with certification bodies to determine how best to support provider directories through ONCs certification process. And I suppose I'll skip the FA...should I skip the FACA discussion on this and just plow through?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, and so...

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Do you want me to pause?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And so let me just ask if there are pressing comments on this section? We are moving faster now. I think you've tired everybody out. No? Okay, well go for it.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

All right. The next several sections relate to privacy and security, they reflect the privacy and security component of the roadmap. Our Chief Privacy Officer's office has really taken a lead on these sections and so as I mentioned at the beginning, if you have specific questions I'll talk to them at a high level. If you have specific questions about...then Lucia is on the phone to field those.

So first up is ubiquitous secure network infrastructure; this is where we address issues of cyber security and encryption. Certainly need secure network infrastructure to be ubiquitously available if we are going to the scale of interoperability that the roadmap contemplates; there was some concern through public feedback that there's too much focus on encryption as an answer to cybersecurity issues. And also some concern raised about the inclusion of data at rest in the encryption calls to action in the roadmap. You'll see some updates to this section of the roadmap.

In terms of calls to action, we're talking about organizations deploying health IT should ensure that it's deployed and maintained in a secure manner. That includes regular penetration testing; you'll see penetration testing in a couple of places in this section of the roadmap, as well as an emphasis on security risk assessments and appropriate responses based on security risk assessments. A push for stakeholders to implement the NIST Cybersecurity Framework as part of the risk management and incident management programs and encouragement to participate in information sharing environments such as ISAOs, which is Information Sharing and Analysis Organizations or ISACs, Information Sharing and Analysis Centers.

You'll see commitments in this section of the roadmap, a number of commitments; I don't have them all on this slide. To...continuing to support and promote those information sharing arrangements, the ISAOs and ISACs. ONC also commits to identifying best practices for implementing encryption policies for existing at rest and in transit encryption standards and a commitment to work with NIST and OCR to finalize and publish the NIST Critical Infrastructure Cybersecurity Framework and HIPPA Security Rule crosswalk.

Next up is identity...verifiable identity and authentication of all participants; this is so important as we think about information moving across systems as well as individuals accessing information from systems. In the roadmap we break out verifiable identity and authentication in one section, authorization in a separate section and to have further discussion of permission in a separate section.

I recognize that all of those concepts are related, and in fact to a certain extent we talk a little bit about authentication in the authorization section of the roadmap. Can't get away from how interrelated these things are; nonetheless, they are distinct concepts and distinct parts of processes and so we felt the need to keep these separate in the roadmap.

Some of the feedback from the public on verifiable identity and authentication of all participants relates to a push in the roadmap toward multifactor authentication. We did hear concerns that this may inadvertently make it difficult to access information; I think that came up also in some of the workgroups within the Federal Advisory Committee and that it also may create some workflow issues for providers.

Examples of calls to action; in this section focus on technology developers adopting innovative solutions, such as mobile technologies and RESTful approaches to provide efficient, effective paths for individual and provider identity authentication. For stakeholders to begin leveraging FICAM, the Federal Identity Credential and Access Management roadmap and for collaboration between NIST, OCR, CMS, CDC, FDA and other stakeholders on approaches for identity management including HIPPA guidance for remote identity authentication and access management.

In terms of commitments here, ONC commits to working with stakeholders to establish and adopt best practices for provider and individual consumer identity proofing and authentication. I won't read the rest of that to you, you can pick it up but it's, we think, a strong commitment.

In terms of authorization, consistent representation of authorization to access electronic health information; as I mentioned, this is closely related to authentication but is, in fact, a distinct concept and a distinct activity. The feedback from the field in terms of what we put forward for the draft roadmap was generally supportive for this section, not a lot of criticism here. I will say this involves roles and attributes about individuals or systems and access controls. And so what you'll see in this section of the roadmap relates, in many cases, to roles or role-based access, access and system controls.

In terms of examples of calls to action, by the way, I recognize there are way too many words on these slides for proper PowerPoint etiquette. We did include all...the exact verbiage, in most cases, from the roadmap simply because teams gave a lot of thought to exactly how these are written out and so we wanted to provide that as it is written. So please forgive us for too many words. I see John across from me raising his glasses to try to read it.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

You know, when you get to your mid-50s PowerPoint like this gets really hard.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Please forgive us.

So in terms of example calls to action, healthcare organizations and other organizations with access to electronic individually identifiable health information should ensure that their access control rules and organizational policies are aligned to leverage permitted uses and disclosure under HIPAA to advance interoperable exchange of information and to help us advance a learning health system; a few other calls to action there that I won't go in to explicit detail on.

In terms of commitments, ONC does commit to working with stakeholders to identify the technical standards and means by which a user's authority can be clearly represented among the exchange partners. OCR commits to considering where additional guidance may be needed to help stakeholders understand how HIPAA Privacy and Security Rules apply in an environment where ACOs and other multi-stakeholder entities permeate the landscape in support of value-based purchasing.

I do have to say you'll note in both the authorization section and the permission section of the roadmap, what is hopefully a very clean focus on understanding how HIPAA helps support exchange and interoperability as opposed to thinking of HIPAA Privacy and Security Rules as barriers to interoperability and exchange. We have heard from many stakeholders that there are misunderstandings or myths about how HIPAA and its associated rules prevent exchange and interoperability. And so we've taken the tact, our Chief Privacy Officer in particular has taken the tact of really helping empathize how those rules help advance exchange and interoperability and encouraging stakeholders to understand those properly.

In terms of consistent understanding and technical representation of permission to collect, share and use identifiable electronic health information. As I mentioned earlier, this is often referred to as consent by many folks. In terms of public feedback, I also mentioned this earlier on in the day, there was confusion about the concepts of basic versus granular choice. You'll find that discussion in the supplementary material of the document; hopefully that is a bit clearer this time around.

Despite the confusion about those two concepts, basic choice and granular choice, there was great deal of support in the public comment for addressing this topic in general, doing something about it and really addressing permission, often times referred to as consent in the public comments.

So by way of examples of calls to action, the majority of states should conduct an assessment of their health privacy laws, to determine alignment with permitted uses of electronic health information regulated by HIPAA. Professional associations of health lawyers should help educate the members about how the current HIPAA rules support interoperable exchange and patient access as important supports for national policy. I'll let you read what's remaining on that slide.

In terms of commitments, ONC is committed to launching a project to better understand the complexity of the rules environment, especially the diversity among more restrictive privacy laws at the state level and their impact on computable privacy. ONC also commits to identifying a definition of basic choice and providing policy guidance regarding if and or when basic choice should be offered, even when not required by law based by recommendations from the HIT Policy Committee. And ONC commits to doing that by the end of calendar year 2016.

ONC also commits to convening a group of industry stakeholders to determine if it's possible to create an open-source mapping of the codes that capture clinical care to sensitive health conditions such as mental health. This has to do with the notion of granular choice and being able to automate some of the protections around particular conditions by looking at codes.

The next section is shared decision-making. So the privacy and security sections and the shared decision-making section as a grouping really reflect the policy components in the technical and policy components of the roadmap. The shared decision-making rules of engagement and accountability section was formally referred to as governance. And we have decided to use that term very sparingly in this version of the roadmap back, in part because the term itself much like the term interoperability means different things to different people. It tends to have some baggage, tends to be a little bit loaded.

And so instead you'll find in this section of the roadmap we talk about what we think comprises governance; things like shared decision-making. There was concern; I think I also mentioned this earlier, in terms of public feedback, mixed feedback on what was put forward in terms of governance. Concern about a single entity being established to govern inoperable health IT and, I think, a clear sense from a number of folks that there needs to be a number of diverse networks to meet local needs. And the fact that there needs to be a number of different and diverse networks means it may be very challenging to have a single entity govern all of those.

There are several changes to this section of the roadmap. I will say, in thinking about what Stan mentioned a minute ago about changes in Wi-Fi versions and users being generally oblivious to what version they're using and that's generally a good thing. That depends often times on shared decision-making and that's what we really tried to dig into in this section of the roadmap, getting to a point where interoperability not only exists, but endures over time as the technology evolves, as standards change, requires some way of making shared decisions.

So in the calls to action in this section, you'll see a call to action that was in the draft; it remains here, to public and private sector stakeholders to establish a shared decision-making process. That doesn't necessarily mean a single entity, but a process to address operational issues related to standards, services, policies and practices that enable interoperability. Including agreement on technical architecture and establishing clear consistent feedback between SDOs.

Another topic that we wrestled with in this section of the roadmap I think came in the previous discussion is a holistic lifecycle around standards and the need for in the field experience with standards to then inform development organizations and improvements to standards. And there's a proper lifecycle that includes testing and implementation and so we called for some of that in this shared decision-making section of the roadmap.

We ask that existing and future data sharing arrangements between organizations align with ONCs policy guidance. You'll see on the next slide that ONC commits to issuing some policy guidance around policies and business practices. And that...the shared decision-making process that ideally would be established again process not entity, would select standards for specific use cases and functions from ONCs most recent finalized Interoperability Standards Advisory when that advisory contains standards that are relevant to the use cases that are being contemplated.

As I mentioned, ONC commits to publishing an advisory similar to the standards advisory, but on the policy side that addresses policies and business practices that advance trust and interoperability. And the second commitment in this section is a commitment you're all aware of and that is to continually produce the Interoperability Standards Advisory to guide the field on the best available standards. Let me pause there for discussion on the policy pieces.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Discussions, thoughts; privacy and security, Dixie, you've got to have some.

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I'm eager to see ONC get the states to agree on privacy and security policies; I'll be really impressed.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Dixie this is Lucia, you know I have a magic wand.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Someone on the phone?

Dixie Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

I think Lucia's...

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

Oh, this is Lucia, I just got of mute so if you have questions, I can answer them.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Very good.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

John?

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Yes. So we have a couple of comments over, let's just...going around the room here. So why don't we go now clockwise around the room, Lisa Gallagher.

Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society

Hi, thanks Erica and thanks Steve; wonderful work. I have a couple of comments; the first is on the patient matching area. I'm a little dismayed to see that we only have guidance on duplication rates as opposed to matching rates. As you know, we're working on projects with you all to look into measurement of the accuracy of algorithms and that's in terms of matching. I know our work on that will continue and I'd like to delve into that with you all offline little bit more.

On the privacy and security side, I wanted to comment a little bit about the notion of basic and granular consent. That's something that you all have brought out since Lucia's been on board as Chief Privacy Officer. I'm finding that there one, isn't a clear understanding of those concepts and also that it really hasn't permeated far enough into the sector, I mean, we sort of heard about it, but none of our members are really understanding that it's even out there as guidance.

So I know that you've committed to doing a guidance document by the end of FY16 to provide a definition of basic content and granular consent. I would also say that you might want to treat the topic of the legal basis for those two concepts because I know that Lucia has spent some time looking at that. And I think it's going to be important for us to understand the legal basis...legal and regulatory basis for those terms and that framework for information sharing so that we can sort of educate everyone on that and, because that question is going to come up. Fine there's a definition, but what is the legal basis for this and are we safe in assuming that we can use these definitions, these terms and this methodology to interact with patients? Thank you.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And Lisa brings up a point, you know I've read things about being a Co-Chair is that half the conversation is occurring electronically behind the scenes and coordination here that...there's a lot you've just presented and I think Lisa, Dixie and other have run workgroups than the past where they've dived down deep into the stuff. And so I think Michelle, to the extent that our next meeting is going to be telephonic, if we maybe have an opportunity for further reflection that would be very helpful. For what?

M

(indiscernible)

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So I see Karen has left the room and so the press, of course, is constantly asking me, so is the fact that the agenda was delayed the sign that MU2 will be released at four? Is the fact that Karen left the room a sign that MU2 will be released at four? Is the phase of the moon a sign that MU2 will be released at four? ...the MU2 rules could be released at four. Leslie?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So thank you for this and I appreciated your calling out the consumer with regard to authentication and identity matching for purposes of logon to portals but felt that the rest of the discussion around privacy and security was largely provider-focused or industry-focused and not necessarily, at least in the tone of the slides, inclusive of the patient as an active stakeholder and participant both in receiving data that...sharing, finding, using and contributing data throughout. Is there more detail in the actual guide or are we silent on this topic ?

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So Leslie Kelly Hall, this is Lucia; if you don't mind if I answer that, I would be delighted to. Obviously we were aiming for a document without getting into the...that most people could actually read and get through and I'll break that...to answer, I'll break that down into three parts. If you go back to the original commitments Karen made and some of the things themes that Erica has brought out, what we're really trying to drive home is that we actually have a pretty good environment in support of interoperability, at least in HIPAA itself.

And you know that has not only what are providers and their business associates required to do by law or permitted to do by law, but also within that it is what are the rights of the patient to access their own data. And although that is not specifically called out as a task in this roadmap, it's obviously something we're working very hard on as you and everyone who's working with us on the Consumer Workgroup knows. So that has not been forgotten, but it's not a...that task is so important that actually we're pursuing it independent of the roadmap, we'll just put it that way.

The second thing I would say is I think we see it as over a course of time, our first immediate goal is to get the data moving where it needs for the patient for care. We think that there's an environment that supports interoperability for that right now, but if you look at the 10-year span, that's in fact what granular choice is really about, it's about empowering the consumer to make those directions in a computable environment without it causing the providers, as Lisa stated, to fail to move the data because they're afraid of not following the directions properly. So we have a very long way to go to get there, but we have a plan for it.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

All right, just thank you. Just one follow up, there was a study that was released by Surescripts just in the last week and they talk about that 40% of the time patients are the ones taking the results from one place to the other, so they're actually already the data exchange of one. And so being left out just means they're possibility of forgetting to bring something because they assume the interoperability is there, because they're not in the chain, tells them something's there; so, I would be cautious and appreciate the continued work. Thank you.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

You're welcome. Thank you for your comment.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Arien and then Lorraine.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

So thank you. Yeah, a very meaty section of this and it would be useful, at some point, when we aren't distracted by other topics to dive deep on this. I would note that...just a couple of areas; one is you've proposed implementing the NIST Cybersecurity Framework and the FICAM Roadmap and my observation is for most healthcare organizations both of those are going to come as an extreme shock to the system. And so, I'll leave that comment as it is.

One comment or suggestion that I have with regard to the topic of computable consent, one thing that we can make significant progress in in the short term is an interoperable representation of purpose for use. Because choice isn't an open-ended activity that's actually enshrined in HIPAA and there are a set of permitted uses that are outlined in HIPAA, each of which has somewhat different privacy implications.

And if all we had in the short term was an interoperable representation of purposes for use and context for use, we'd actually go a long way toward solving some of the computable consent activities. So, a request for maybe a friendly amendment or an ONC-focused activity to take some of the work that's already been done in defining that and putting together a good vocabulary for purpose reuse.

Lucia C. Savage, JD – Chief Privacy Officer – Office of the National Coordinator for Health Information Technology

So this is Lucia, I would like nothing better than to work in collaboration with Steve's team to do that for you. I think that we have to recognize that there are two pieces of that; one is, recognizing the purpose and the second is within the HIPAA rules it stops, of course, with purposes of permission. And that's kind of what we are driving at behavior-wise is we want people to take advantage of the permission they have and that has almost nothing to do with the data itself, it has much to do with many other things including confusion, business practices and things identified in other documents ONC has issued. The idea is to do both at the same time.

Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation

Lucia, you know that I'm in utter agreement with you and to the extent that we can define, for example that the purpose of use is HIPAA...treatment is defined by HIPAA and the target of the query is an adult...competent adult and no request for sensitive data? You know, 99.9% of the request for data fall in that category and it's a pretty trivial application of HIPAA. We get ourselves confused often by defining consent and authorization in this open-ended way that can serve any purpose. When we start to narrow these things down, we start to fall more and more into the permissive framework that you described.

Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services – Health & Human Services

Two things, I think you handled this section on the...in the one area on the standards commitment really beautifully and the idea of bringing all of the groups together to talk about which ones are ready to be adopted but then also bringing together who's missing from the table, particularly with respect to the maturity of the standards and making the decision about which ones can actually be then leveraged and the policy guidance. Because there's a whole range of them, the gamut and so that commitment that you were talking, I think is on page 56, I really can resonate with, and particularly the data sharing arrangements and the data transfer arrangements I thought was really well done and that we'd definitely like to work with you more on that because the time it takes to develop and adopt standards is really different in each of the organizations, very different.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Great; I think we are now down to our final section, outcomes and I think we're are roughly back on schedule, so please, go ahead .

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Sweet. Okay, I will try to go these as quickly, also I think we're looking at maybe about eight more slides. So as we mentioned, the last section of the roadmap is focus on outcomes. It's not a comprehensive review of outcomes that we achieve when we advance interoperability, but two very important components, consumers and providers. First for consumers or individuals, I think I've mentioned this in the past, I'll mention it again; we use the term individuals in the roadmap to refer to people, consumers. We tried not to use the term patient unless we're really talking about patients; just a clarifying point.

So feedback on this section of the roadmap originally it wasn't framed as an outcomes section, so that's one thing that has changed in this version, in part in response to public comment. One other piece of public feedback from a number of consumer groups was that patient-generated health data, this notion of information created by the, or curated by the consumer then being pushed into clinical processes needed to be of greater focus early on in the timeframe. It was pushed out a little bit in the draft roadmap; the request from public feedback was that we move that to more aggressive timeframe. This section of the roadmap is really about empowering consumers not only to access their own health information but, as I mentioned, to contribute to it and to direct it wherever they want it to go.

Calls to action that support this include calls to the health IT purchasers and developers to include individuals and caregivers in the co-creation of electronic tools that can securely exchange electronic health information. And I'll also note, a call to individuals and providers to work together to define a reconciliation process for electronic health information from multiple data sources to ensure accuracy, completeness and comprehensiveness.

In terms of commitment, I'm sure it's no surprise to folks to see commitments from ONC around Blue Button, the Blue Button Initiative and those standards. ONC also commits to continuing to work with health IT community to remove barriers and support consumers ability to access and electronically share their own health information with whomever they trust.

ONC will also promote consistent, easy and efficient methods for sharing health information with individuals by supporting existing and emerging standards for exchange including APIs and continuous iteration...excuse me, and development of those standards in partnership with health IT community. You'll start to see in many of these sections that there's a linkage, and in some cases dependencies with other sections of the roadmap.

On the provider front, this outcome section focuses on provider workflows and practices including consistent sharing and the use of patient information from all available and relevant resources. The feedback that I think that we consistently saw from a number of provider groups is that all clinicians, not just Meaningful Use eligible providers, but really all clinicians across the care continuum need access to longitudinal health information. There was a particular focus in some of the feedback on longitudinal care plans to support care coordination. And you'll see some of that reflected in this section of the roadmap.

In terms of calls to action, we call technology developers to develop technology platforms that allow providers and other users to perform key interoperability functions such as standardized exchange within their system with minimal effort and ease using clear instructions provided by the developers themselves that are made publicly available.

We call providers and their staff to proactively offer individuals timely access, electronic access to their own health information and ask that they encourage individuals to access it. We encourage providers to use not only the Blue Button specifications but also Blue Button and download my data logos so that consumers understand and start to consistently see some of the same branding around those functions. And that public and private stakeholders incorporate interoperability into training of new providers in professional education opportunities.

In terms of commitments, ONC and federal agencies commit to working to identify additional best practices for the incorporation of patient-generated health data in care delivery and research. ONC also commits to developing a Health IT Playbook that will contain tools and resources designed to assist providers working toward the adoption and optimization of health IT, including key interoperability workflow considerations and engaging consumers to access and use their electronic health information .

Tracking of progress and measuring success; this is the last section of the roadmap. We've already had a fair amount of discussion about this and I know, as I mentioned earlier, the health IT, at least the Policy Committee has had a presentation...more detailed presentation on our Interoperability Measurement Framework, so I won't spend time going into detail on that here. But will note that feedback from public comment was consistent with what we heard I think from our earlier discussion and is consistent with the values that many of us hold and that is that measurement should focus, to the extent possible, on outcomes unless on some of those process pieces.

ONC, in terms of calls the action calls to a number of different stakeholders to help in the measurement activity, both in terms of designing measures and thinking about data sources; how we gather data and how we have data for particular measures. We call out the behavioral health community in particular as partners, as well as the long-term post-acute care community. We don't have great data for either of those sectors of the healthcare ecosystem.

We also call to action stakeholders, federal partners and ONC to work together to identify measures related to individuals and determine ways to address measurement gaps. This really relates to consumer engagement, consumer use of data, contributions of data, etcetera.

And in terms of commitments, ONC commits to analyze and report on nationwide progress including our report to Congress on proposed measures mandated under MACRA. I think all of you know that that is a mandate that came to the Secretary under MACRA. ONC also commits to working with federal partners and stakeholders to address measurement gaps, identifying future measures resulting in the development of long-term...our long-term measurement framework. This will also, I think you'll find over the coming months, relate to measurements from MACRA. And that is it.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well done. Well...

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

That's all she wrote.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Comments, questions? Have we tired you out? Paul.

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

Thanks, that was a very comprehensive report out of a large project, some of which is because it is a collaboration amongst the various federal agencies. I wonder if to make it consumable by the people you want to reach, whether you can categorize some of the recommendations?

So for example, I would say the clarify HIPAA and responsibilities is probably one of the biggest things you could do to help, actually, to help interoperability. It has nothing to do with technology, right, yet it's so important. It's so easy to get confused about what you can and what you can't and then when you open it up to other organizations, some of which aren't even "healthcare providers," certainly not all covered entities. It's just...it's an unknown to a lot of people.

So that's an example of something where a few things would apply to a lot of folks and they would get out of this report...interoperability roadmap, which sounds very technical, but there's something that could really help the reason...to support the reason that we do have interoperability. So is there a way perhaps to just create sort of a stakeholder view of the roadmap report?

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Paul, you have a beautiful mind; this is underway. In fact, in the next couple of days on healthit.gov we will be posting the breakout of calls to action by stakeholder group. Hopefully that will make it easier for folks to digest. And as Steve mentioned, the commitments in the roadmap are all federal commitments and so we can also parse those, but if it's labeled a commitment that means it's something within our purview or control sphere of influence and so we are able to make a commitment on it.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

...the supplemental...

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Oh, I should also mention; in addition to the roadmap itself there is a supplemental material document. So one of the ways we reduced the length of the roadmap and made it a little more digestible was to take some of the background material, some of the in depth explanation of concepts of put those in a supplementary document. And so what you'll find on healthit.gov, in addition to the roadmap itself, is a supplementary material document that contains explanation of a number of different concepts, a number background components that...some of which were in the draft version of the roadmap, some of which we added just for clarity sake as we developed this next version of the roadmap. So just a heads up that that also exists and is a resource. And that is where the detailed discussion of basic and granular choice exists.

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

And also structurally, since you haven't seen the roadmap yet, there's an introductory component, then there's the roadmap itself, which is about 50 pages. And then for each of the milestones, calls to action and commitments, those are all tables in the back. So you can tear it out if you want to look at a particular subsection, it's all in one place and that's how we've restructured the roadmap as well to make it more accessible.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Good, but if there is a movie made of Paul's mind, hold out for Tom Hanks. Leslie, go?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So I am doing the happy dance, you can't see it, but I am doing a happy dance.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

So that's a happy dance...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah, I can do it, but...so thank you very much, I really appreciate the work. I only have one area of caution and that's on slide 61 when we talk about a reconciliation process. And I really caution against this, because you see, it's not about who is right, it's about...or what's right, it's about having multiple stakeholders participate in the discussion and sometimes the conflict is what brings the richest discussion in care. So this isn't whether the patient is right or the doctor is right, it's whether we now have everything at hand to have rich discussion and co-produce health for the patient. It is not a reconciliation process that says, if we have all the bits lined up, we're good. So, please be cautious.

Erica Galvez, MA – Interoperability Portfolio Manager – Office of the National Coordinator for Health Information Technology

Thank you.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

I think Siri had a comment. No? Okay. Any other comments? Well, I think that is the end of our agenda and work for today. Of course we have public comment, but I wanted to just give Jon White, because you are the ONC representative, I presume, was there anything wanted to add before public comment?

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

Just a couple of things; really appreciate everybody taking their time to make the effort to come here to Washington. You know, this is a big deal for us, not just the framing that happened, which actually was really nice. A lot of the discussions that we've had, whether at the Policy Committee or the Standards Committee, in a lot of different ways hasn't necessarily benefited from that broader picture of where things are going. We bat it around a lot internally, but it is really helpful to have you all here at the same time and place. So, I'm grateful of course to my CMS colleagues for coming to this.

And then just really want to acknowledge Erica and Steve and the tremendous work and the team for the tremendous work to bring this to reality and finality, which is of course not final. This is going to move ahead. Just in case you're wondering about what happens with this, my job now as Deputy is to start tracking again, so I'm going to be like, okay Steve, commitments A, B and C, did you do them yet? And, right, so that's...so yeah, it does get tracked and acted on by us and we're hoping it will by...

Steven Posnack, MHS, MS, CISSP – Director, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

That's why my office is the farthest away from Jon's in the building.

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

Yeah, I know how to get to your office. So, it's a tremendous amount of effort and work and it's a real service to the nation again, thank you. The final thing I would like to do before we go to public comment is like that I would like to yield the balance of my time to my colleague, Jodi Daniel for the final, final word.

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

Thank you. It is, now I might need the tissues, yeah.

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

Tissues? Okay.

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

This is my last advis...thank you. This is my last advisory committee where I will be working directly with all of you and one, I wanted to say thank you to all of you for all of your service, for all of your hard work. I know you all do this on your free time and that you do this because you have the same commitment to public service and to helping us get the policies right as we all do at ONC and at CMS and the rest of HHS.

I have loved working with this group of amazing folks. As we've transitioned over the years in all of the workgroups and the like. I want to personally thank Michelle Consolazio for all of her hard work. She has made, see, I told you. She has made this job, for me, easy because she is doing all the hard work behind the scenes and making sure that Karen and I and Jon and Steve and all of us have everything we need when we need it and that we...so that we can best support you all and help advance our recommendations and policies.

I have to say this is very bittersweet for me, I feel like it's been 15 years at HHS, 10 years at ONC. We've made so much progress over the years. You know, just thinking back, we just had a moment before, we were on another call where Steve put a little note, Steve and I started together for those of you who don't know; he preceded me by a few weeks I think; where he wrote, déjà vu because some of the conversations we're having, we're having again, but this time we're actually making some more progress on them because we set the foundation and we've really seen a tipping point of adoption, of exchange of information, interoperability in pockets. And it's just amazing to see consumer engagement, you know, just there's so much to be proud of for all of us. I will, I think always look fondly at this time in my career as one of the most meaningful and important times in my professional career and I thank you all and the ONC staff for that.

And I won't be going far, I'll be in DC and I'm hoping I will get to work with many of you in my future endeavors. So, stay in touch; I'll make sure you all have my contact information.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well with that Michelle, shall we open it up to public comment?

Public Comment

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

...mic was on that whole time. If there's anyone in the room that would like to make public comment please come up to the table. As a reminder, public comment is limited to 3 minutes and I'll turn it over to Alan again to open up the lines.

Alan Merritt – Interactive Specialist – Altarum Institute

And if you'd like to make a public comment, and you're listening via your computer speakers, please dial 1-877-705-6006 and press *1. Or if you're listening via your telephone, you may press *1 at this time to be entered into the queue.

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

Well it looks like there's nobody in the room; we're waiting for the operator. And we have no public comment.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Well, we have, I think, three meeting Co-Chairs up here, so we'll offer that last closing comment to each of them today. Thanks very much for all that hard work on the interoperability roadmap. I know that Michelle, to the extent that our next meeting, we may or may not have additional agenda items to discuss regarding Meaningful Use, but certainly we want to do some deeper dives on some aspects of this to make sure the Standards Committee digests it. And I too will be leaving in January, so this is the second to the last meeting I will ever chair in person, after my 10 years, since we started at the same time.

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

Yes, back in AHIC and HISPC days.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Exactly, those glory days; so anyway, thanks to everybody and let me turn it over to Paul.

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

All right, well thank you everyone, it's been a long, very productive, we got a lot of information to us and shared great dialogue so thank you; safe travels. See you next time.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

And Jon White, any last words?

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

Yes, I hope you enjoy your reading material for the ride home.

John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center

Michelle, I guess we are adjourned.

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

Thank you.

HITPC Meeting Attendance

Name	10/06/15	09/09/15	08/11/15	06/30/15	05/22/15	05/12/15	04/07/15	03/10/15
Alicia Staley	X							X
Anjum Khurshid	X	X	X	X	X	X	X	X
Aury Nagy								
Brent Snyder		X	X	X	X	X		
Brian Burns	X							
Chesley Richards			X				X	X
Christoph U. Lehmann	X	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	
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 Seagondollar	X	X	X	X	X	X	X	X

HITSC Meeting Attendance

Name	10/06/15	09/22/15	08/26/15	06/24/15	05/20/15	04/22/15	03/18/15	01/27/15	12/10/14
Andrew Wiesenthal	X	X	X		X	X	X	X	X
Angela Kennedy	X	X							
Anne Castro	X			X	X		X	X	X
Anne LeMaistre	X	X	X	X	X	X	X	X	X
Arien Malec	X		X	X	X	X	X	X	X
Charles H. Romine					X	X	X	X	
Christopher Ross	X			X	X	X	X	X	
Dixie B. Baker	X	X	X	X	X	X	X	X	X
Elizabeth Johnson	X	X		X		X	X	X	X
Eric Rose	X	X	X		X	X	X	X	X

Floyd Eisenberg		X	X	X	X		X	X	X
James Ferguson	X	X	X		X	X	X	X	X
Jitin Asnaani		X							
John Halamka	X	X	X	X	X	X	X	X	X
John F. Derr	X	X		X		X	X	X	X
Jon White	X	X	X	X	X	X	X	X	X
Josh Mandel	X	X							
Keith J. Figlioli			X	X	X		X		X
Kim Nolen		X	X	X	X	X	X	X	X
Leslie Kelly Hall	X	X	X	X	X	X	X	X	X
Lisa Gallagher	X	X	X	X	X	X	X	X	X
Lorraine Doo	X	X		X		X	X	X	X
Nancy J. Orvis		X		X		X	X	X	
Patricia P. Sengstack	X	X							
Rebecca D. Kush	X	X	X		X			X	
Richard Elmore	X	X							
Steve Brown		X		X		X			X
Wes Rishel	X	X		X	X	X	X	X	X