



Collaboration of the Health IT Policy and Standards Committees

Draft Transcript

September 13, 2016

Presentation

Operator

All lines are now bridged with the public.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a joint meeting of the Health IT Policy and Health IT Standards Committee, and I want to welcome everyone back. We took a little bit of break over the summer, so hopefully everyone had a wonderful summer. Just a reminder, this is a public call and there will be time for public comment at the end of today's call. Also as a reminder, if you could please mute your line if you are not speaking and I will now take roll. Arien Malec?

Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation

I'm here.

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

Hi Arien. Kathy Blake?

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

Here.

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

Hi Kathleen. Paul Tang?

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Here.

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

Hi Paul. Did we get Lisa Gallagher? Not yet. Aaron Miri?

Aaron Miri, MBA, PMP, CHCIO – Chief Information Officer & VP Government Relations – Imprivata

Good morning, Michelle.

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

Hi Aaron. Andy Wiesenthal? I know Andy's on. Angela Kennedy?

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

It's me, it's Andy; I'm sorry.

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

Hey, good morning Michelle.

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

Hi Andy and hi Angela. Anjum Khurshid?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Good morning.

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

Hi Anjum. Anne LeMaistre?

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

Good morning.

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

Hi Anne. Aury Nagy? Brent Snyder? Carolyn Peterson?

Carolyn Peterson, MBI, MS – Senior Editor – Mayo Clinic Global Business Solutions

Good morning.

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

Good morning. Chesley Richards? Chris Lehmann?

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

Good morning again Michelle.

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

Hi Chris. Dale Nordenberg? David Kotz?

Dale Nordenberg, MD – Chief Executive Officer – Novasano Health & Science

Dale's here.

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

Devin Mann? Hi Dale.

Devin M. Mann, MD, MS – School of Medicine – New York University

Hey Michelle.

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

Hi Devin.

Devin M. Mann, MD, MS – School of Medicine – New York University

Hi Michelle.

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

Is David there, too? No. Donna Cryer?

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Here.

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

Hi Donna. Eric Rose? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Hi, I'm here.

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

Hi Floyd. Gayle Harrell?

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

Here from sunny Florida.

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

Hi Gayle.

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

Hi.

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

Jamie Ferguson?

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

Good morning.

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

Hi Jamie. Jitin Asnaani?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Good morning.

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

Hi Jitin. John Scott?

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

Good morning.

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

Hi John. Jon White?

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

Here.

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

Thanks Jon. I think Elaine is in for Jonathan Nebeker; is Elaine on yet? No. Josh Mandel?

Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Hello.

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

Hi Josh. Karen van Caulil?

Karen van Caulil, PhD – President and Chief Executive Officer – Florida Health Care Coalition

It's van Caulil, hi.

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

Thank you. It's been a while; I'm sorry I forgot.

Karen van Caulil, PhD – President and Chief Executive Officer – Florida Health Care Coalition

That's okay.

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

Van Caulil? I just want to say it right; van Caulil.

Karen van Caulil, PhD – President and Chief Executive Officer – Florida Health Care Coalition

Yes.

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

Okay. Kay Eron?

Kay Eron, MBA – General Manager Health IT & Medical Device – Intel Corporation

Hi, this is Kay.

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

Hi Kay. Kevin Johnson? Kim Nolen? Kim Schofield?

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

Good morning.

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

Hi Kim. Kyle Meedors...Meadors, sorry?

Kyle Meadors – President – Chart Lux Consulting

Good morning here.

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

Hi Kyle. Larry Wolf?

Larry Wolf, MS – Principal – Strategic Health Network

I'm on, thanks.

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

Hi Larry. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Good morning.

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

Hi Leslie. Lorraine Doo? Nancy Orvis? Neal Patterson? Patty Sengstack? Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here from sunny Massachusetts.

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

Hi Paul. Peter Johnson?

Peter Johnson, MBA – Senior Vice President & Chief Information Officer – Dartmouth Hitchcock Health Care System

Here.

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

Hi Peter. Raj Dash?

Rajesh C. Dash, MD, FCAP – Director of Laboratory Informatics Strategy, Office of CIO – Duke University Health System

Here.

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

Hi Raj. Ram Sriram?

Ram Sriram, PhD – Chief, Software & Systems Division – National Institute of Standards and Technology

Hi, yes I'm here.

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

Hi Ram.

Ram Sriram, PhD – Chief, Software & Systems Division – National Institute of Standards and Technology

How are you doing?

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

Rich Elmore? Scott Gottlieb?

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

Here.

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

Hi Scott. Steven Brown?

Steven H. Brown, MD, MS – Director, Compensation and Pension Exam Program (CPEP) – Veterans Health Administration

Present.

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

Hi Steve. Terry O'Malley?

Terrence “Terry” O’Malley, MD – Medical Director for Non-Acute Care Services, Partners HealthCare System – Massachusetts General Hospital

Good morning, Michelle.

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

Hi Terry. Troy Seagondollar?

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

I’m here.

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

Hi Troy. And Wanmei Ou?

Wanmei Ou, PhD – Director, Product Strategy in Precision Medicine – Oracle

I’m here.

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

Hi Wanmei. Did anyone else join as we went through that long roll?

Lisa Gallagher, BSEE, CISM, CPHIMS – Managing Director – Pricewaterhouse Coopers (PwC)

Hi this is Lisa Gallagher.

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

Hello...

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

Hi Lisa.

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

Eric Rose is here.

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

Hi Eric. Okay, with that I’m going to turn it over to Vindell, hopefully Vindell is on to make a few opening comments.

Jordan Grossman, JD – Chief of Staff – Office of the National Coordinator for Health Information Technology

Vindell’s getting on right now, this is Jordan.

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

He’s not on yet, is that what you said, Jordan?

Jordan Grossman, JD – Chief of Staff – Office of the National Coordinator for Health Information Technology

Yeah, he’s literally just hitting the pound button.

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

Okay well we'll have Arien go through...make some remarks and go over the agenda and then we'll go back to Vindell once he joins.

B. Vindell Washington, MD, MHCM, FACEP – National Coordinator – Office of the National Coordinator for Health Information Technology

I'm on.

Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation

Good morning, Oh. Vindell, why don't you go ahead and then I will do the agenda review after your opening remarks.

B. Vindell Washington, MD, MHCM, FACEP – National Coordinator – Office of the National Coordinator for Health Information Technology

I will make this very short and I apologize for working my way through the pushbutton sign-on. But I, you know I'm just excited to welcome folks and I feel like it's always important to give a thanks to our colleagues for their time; it's an important part of what guides the work at ONC to have the input. Arien's going to talk to us really about what the details of the day we'll entertain, but I want to underscore just two things.

One is the...interoperability still remains the core of our activity because we think that information sharing is going to be critical to the changes we want to make in delivery system reform, that's number one and number two is, we're pushing relatively hard on the empowered individual, the empowered consumer because it's my view that the...a consumer or an individual with their health information is not just a good use case, I think it's the use case that's most likely to push us to where we want to go, so I'm particularly excited about those two.

And so again, I appreciate your time and your effort and look forward to the presentations of those two as kind of underscores. Thanks Arien.

Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation

Thank you and thanks for that intro to the joint committee meeting. I'll give a brief overview of the agenda. You know, the mission of ONC was described by Farzad Mostashari as eyes on the prize and feet on the street and you know most of what we do, we're looking forward, looking at where we're going. This is an important meeting where we're looking at where we are right now and it's hard to know where you're going if you don't know where you're standing.

So we're going to start off with a data update really focusing on the state of patient engagement and view, download and transit, just giving us a look at how we're doing in terms of exposing health data to patients. That's going to be followed up with an update from the Consumer Task Force looking at Blue Button, the state of the Blue Button ecosystem and how to better drive patient engagement and better drive notification to patients on privacy both for view, download and transmit, but also for the wider world at health IT and mobile health.

Then we're going to roll right into the Interoperability Experience Task Force; they're going to report out their findings on how we're doing in terms of taking the important work of interoperability and plugging it into clinical practice. And we'll end up with Steve Posnack giving us an update that's partly in the present day and partly in the future. In the present day there's a pretty remarkable update to the Interoperability Standards Advisory that answers the important question, "do we have standards yet?" And the answer is yes, and many pages.

And then an update on the Block Chain Challenge, which is a little bit forward looking to see if there's a role for some of the new technology that we have out in the ecosystem. So mostly focused on how we're doing so that we can get a really good lay of the land, a really good assessment as we move forward to the next generation of interoperability driven by MACRA and value-based care.

With that as the overview of the agenda, we've got a little bit of business to take care of. There were minutes that were published from the last meeting; I assume that everybody has had a chance to read and review those minutes. They seem to me to be a very adequate reflection of the deliberation; it's a really important service that we make available to make all of the discussion summarized through the minutes. So I'd like to see if there is a motion to approve the minutes that we can entertain?

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

So moved.

W

So moved.

Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation

All right, we have a motion...

W

Second.

Arien Malec – Vice President, Clinical Solutions Strategy – RelayHealth Corporation

...do we have a second? We've got a second. And any objection to publishing the minutes as they stand?

Hearing no objection, let the minutes be approved. And back to you, Michelle.

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

Thanks Arien. So I think we'll just get right to it today and I think Vaishali was on the line, I thought I heard her earlier, Vaishali, can you confirm?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Yes, I'm here.

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

Thanks. Okay, thank you. So we'll turn it over to you to do the ONC Data Update.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Great. So today's presentation, I will be focusing on looking at hospitals adoption of patient engagement functionalities, and specifically I'll be describing trends in hospital adoption of patient engagement functionalities and describing how hospitals adoption of view, down, transmit capabilities varies by hospital and by state. The results presented here today are based on the 2015 American Hospital Association Health IT Supplement Survey, which is a nationally representative survey of hospital CIOs and the estimates are weighted to adjust for nonresponse. Next slide, please. Can we go back a slide? Okay.

So the patient engagement functionality that we focused on related to either regulation, so Medicare and Medicaid EHR Incentive Program, the view, download, transmit, secure messaging, submitting patient-generated data, or HIPAA, so assessing whether patients have the capability to request amendments to their medical records. In addition, we sought to assess whether patients had the capability to engage in functions that enabled them to engage in paying their bills online, requesting refills for their prescription online and scheduling appointments online. So, allowed them to you know, engage with their...and allowed them to do things that they needed to do to improve their patient experience and make things easier for them, what I'll call convenience functions. Next slide, please.

So what we found was that since 2012, there have been quite a bit of an increase in view, download, transmit capabilities, as well, you know as you look at the individual capabilities. So you can see that about...as of 2015, 95% of hospitals have the capability to provide patients with viewing their electronic health information and about seven in 10 have the capability to transmit their information. And overall since 2013, there's been sevenfold increase in hospital adoption of both view, download and transmit capabilities. Next slide, please.

So there have been significant increases also in hospital adoption of other electronic patient engagement capabilities, particularly those that are related to regulations. So if you looked at requesting amendments, about 77% of hospitals provide that capability to hos...to their patients, paying...sorry, secure messaging, about 63% provide that capability. And then amongst the more convenience functions, paying bills online not surprisingly is a capability that is...has been the most adopted by hospitals. And also interestingly enough, with regards to submitting patient-generated data, 37% of hospitals are providing that capability, which has increased about threefold since 2013 when about 13% of hospitals were providing that capability. Next slide, please.

There's been a significant increase in hospitals adopting a greater number of patient engagement capabilities between 2014 and 2015. As you can see here, this includes view, download, transmit as well as the hospital...the capabilities in the previous slide. So hospitals are shifting; there's been a significant decline in hospitals only offering very few capabilities, so between zero and three whereas there's been a significant increase in hospitals offering more capabilities, between seven and nine. And overall, about nine in 10, almost nine in 10 hospitals are offering more than four...at least four patient engagement capabilities as of 2015. Next slide, please.

And so we looked also at how view, download, transmit varies at the state level and what we found was that the percent of hospitals with view, download, transmit capability has really spread nationwide between 2013 and 2015. There's been, as you can see from the map, on the left map in 2013, there were very few hospitals offering a significant number of patient engagement capabilities, whereas in 2015, most states were offering...a majority of hospitals in most states rather were offering patient engagement capabilities. Next slide, please.

And with regards to variation as well what we looked at was by type of hospital, and what you can see here is that compared to larger hospitals, critical access hospitals and small hospitals lag behind in the adoption of view, download, transmit capabilities. Hospitals...excuse me, sorry. About nine in 10 hospital...overall for viewing, over nine in 10 hospitals, you can see 93% of critical access hospitals and small hospitals have view, download, transmit capabilities; however, 98% of larger hospitals have these capabilities. So there's a gap there, although it's relatively small.

The gap is much larger as you look at the transmit portion of it. So about 65% of critical access hospitals and small hospitals have transmit capabilities as compared to the larger hospitals and 79% of those have transmit capabilities. And another point to make here is that with regards to transmit, that is significant, you know, that is lower in comparison to the view and download, and that's consistent across the board,

that all types of hospitals have lower levels of adoption of that functionality compared to view and download. Next slide, please.

So the key takeaways are that nationally the hospital adoption of patient engagement capabilities significantly increased; that was true for view, download and transmit as well as for the other patient capabilities that related either to HIPAA or were more convenience functions. You know, the percent of hospitals that enable patients to electronically view, download transmit overall has grown almost sevenfold between 2013 and 2015 and almost nine in 10 hospitals possess four or more electronic patient engagement capabilities besides view...including view, download and transmit rather.

And at the state level, the number of states where a majority of hospitals possess view, download and transmit capabilities dramatically increased since 2013. However, critical access hospitals and small hospitals lag behind larger hospitals in possessing capabilities that enable patients to view, download or transmit their electronic health information. Next slide, please.

So overall in terms of the policy implications, there's been tremendous growth in a very...relatively short period of time in hospital's adoption of patient engagement capabilities, particularly view, download, transmit and that is likely associated with the CMS EHR Incentive Programs and adoption of certified EHR technology that enabled that capability. Rural and smaller hospitals, however, have lower rates of view, download and transmit capabilities, likely reflecting lower rates of certified EHR adoption, and that will require continued monitoring.

And overall in order to increase usage of these capabilities that hospitals are offering, and that we've seen an increase of, it will be important to make it easier for individuals to access, aggregate, and subsequently use their health information. Examples of initiatives that support these efforts include the Patient Engagement Playbook, which enables clinicians to...and staff to implement and use patient portals; the Consumer Health Data Aggregator Challenge that ONC recently put out which seeks to foster the development of third party consumer-facing Apps that use open APIs to help consumers aggregate their data in one place and under their control. And the Blue Button Connector is another example of an initiative that ONC has helped support, which enables access to Apps and other tools for individuals to use and share their data.

And I would be happy to take any questions related to the data that I presented today. Thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Thank you, Vaishali. As always, it's very useful to look at the progression over time and this comparison from...in just a two-year period, 2013 to 2015 and seeing a sevenfold increase in the VDT in hospitals is quite dramatic. It's close to an iPhone take off in a sense, if you think of how many small and large organizations had to implement the system and make that available to consumers all over the country; it's really quite an accomplishment. I'll open it up for questions from the committee please.

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

Paul Egerman had a question.

Paul Egerman – Businessman/Software Entrepreneur

Yes. First thank you Charlene, excellent presentation and very useful information, very interesting. When you spoke about the smaller and rural hospitals having lower rates and said they also have a lower rate of adoption of certified technology, it might be helpful as a suggestion, to dig a little bit deeper to understand wh...if there's other reasons why the smaller and rural hospitals have issues. So one possibility could be like digital divide access in rural areas to broadband and another possibility that

I think is...personally think is likely, is whenever you have some computer technology application that is sort of consumer-facing or in this case, patient-facing, there is a need for some IT support structure and many of these smaller hospitals and rural hospitals simply do not have any kind of IT support that can answer questions from patients about, you know why they can't log on for example. So anyway, that's just a suggestion; good presentation.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Thank you.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

No, I think those are great points. Obviously, there's more than just certified EHR technology that may relate to patient engagement and some of the suggestions you offered a really good ones, related to broadband access, access to IT resources and the like. So, and these are things that we'll be looking into further.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Next is Kathy Blake.

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

Yes thanks, Paul and again thank you for a terrific presentation; I'd certainly agree that the progression over time is very encouraging. My comment has to do with saying now that we have such widespread adoption, particularly in the large hospitals and seeing that patient data is being entered in, I think it becomes important for us to forecast the need to examine the value of that data and I have sort of a couple of thoughts about that.

So a lot of unfiltered data that might be all of the downloads from someone's consumer product may not be the kind of information that is of great value or of unquestioned value, whereas there may be information of other types such as symptom information or information about or filling out of patient-reported outcomes scoring templates, it might be very, very valuable. So I'd urge us to think over time about how we can really change or pivot towards looking at valuable information as opposed to just information at large. Thanks.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Raj Dash?

Rajesh C. Dash, MD, FCAP – Director of Laboratory Informatics Strategy, Office of CIO – Duke University Health System

Yes, so actually following on that, I think it's a very important concept to think about the value of information and to think about a follow-up study that actually looks at the amount of discrete data being sent to patients as opposed to documents that you know might just be charted or scanned, which is really no different than what we've been doing for the past 30 years with faxing documents. Just sending it through the internet over TCP/IP doesn't really increase the value of it.

Certainly the ability to aggregate discrete information, to have patients that have discrete information coming over multiple patient portals and to have their own ability to manage that information, for example, pull out all medicines that affect hypertension and show them to me is extremely difficult if we're not taking a look at the actual content as opposed to just the capabilities reported by vendors for the ability to send information or for organizations to send information electronically. The actual data really needs to be scrutinized, but I think this is a great first step. Thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Let me just piggyback on these two comments. There was some national work; I think KLAS led about trying to assess the importance of the data, as pointed out by these two past comments, and I wonder if that's something we might want to get an update on to see from the clinicians or frankly even from the individuals whether the data that's being passed is both important and usable, to the last comment, structured data is always more computable.

Next is Chris Lehmann, please.

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

Thank you. This was an excellent presentation and I'm excited about the trends, as others have said before. But I have a question about how this layers out based on patient populations? So I'm wondering whether you have any data available for what these numbers are for pediatric hospitals compared to adult hospitals. I have a strong suspicion that pediatric hospitals are lagging behind and I think it's important to look at these differences so I was wondering if there is any data available?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Yes, I think you know that's a good point and when we looked at the certified EHR adoption, we did look at...broke it out like specialty hospitals...children's hospitals and found that you know children's hospitals did have significantly lower rates certified EHR adoption. And my guess is you know given that the linkage between certified EHR adoption and the adoption of these functionalities that it would be lower, but we could take a look at that, we have the data and we could take a look at that. So I can follow up on you with you Chris on that front.

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

That would be great.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Thank you for bringing that up, yeah.

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

That would be wonderful.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

That was something that we looked at at your suggestion I believe for the certified EHR adoption one, so, we can do that.

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

That would be wonderful. Thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

And Vaishali, I didn't give you a chance to address the question about some way of assessing the importance of the data that's being exchanged; is there anything you can say about that or something perhaps we can get more information on at another meeting?

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Sure. I mean, you know in terms of the importance of the data being exchanged on the consumer side, we do have a consumer survey that we are...that we've done in the past and actually that we're partnering with the National Cancer Institute, NCI with for this coming year. And in the survey we do ask about the usefulness of the information that is in their online medical record; so, and that's something that you know, I don't have the number, the exact numbers on the top of my head, but you know, a majority of individuals found, you know the information within their online medical record useful. That might be, I mean I don't know if it exactly gets at the point you know that was raised, but it does point to the fact that individuals do value you know access to and finding information that's in their online medical record useful.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

I think what people were asking here was also the provider to provider that'll come up in...

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Oh, provider to provider, okay, yeah. You know, in the...yeah, the provider to provider, on the hospital side, just thinking back to...for the presentation that I had done on interoperability, one of the barriers that we had asked about was, was...it was whether the recipient of the data had found the information...the summary of care record specifically, useful? And I can pull that up if you'll give me a minute, I can pull up the exact numbers. But we did ask that and I know that there was a significant number that said that basically that was a barrier, that you know the summary of care record wasn't valued by the recipient that they were sending the data to; and this is on the hospital side.

We've just gotten the data on the physician side from the National Center for Health Statistics; we're analyzing that and plan to report out on that within the next couple of months and we'll have some information on perceptions related to health information exchange. So, umm...

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

That would be helpful. Next is Larry Wolf, please?

Larry Wolf, MS – Principal – Strategic Health Network

Hi. So this is really great, it's good to see the mix of information you're bringing forward and the increase in adoption and, you know I'm glad we're acknowledging the power that the incentive program seems to have had. That's a good thing. I'm wondering though if in addition to surveys, which seem to be a huge preference for collecting data, if there's any information you've got either through surveys or through information supplied directly from the systems, on the use of the capabilities. So it's one thing to have something installed and another thing to actually see where the activity is, where it's being used, and I'm wondering if there's any system-reported data that you're getting, maybe not you know uniformly across all providers, but maybe we're beginning to see some pockets of things that could be...

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

You know, in terms of system-generated data, you know that's something that we don't have access to, so log audit data, you know and the like, you know that's something that we don't have. We are reliant on survey data; however, with the CMS EHR Incentive Program, we were able to capture, you know some level of patient usage in terms of you know, the proportion of patients that were logging in, you know based on you know, but that's also in some ways was self, you know this is self-reported, it's not...

Larry Wolf, MS – Principal – Strategic Health Network

Right.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

...you know, it's not system generated in the way that you know, we're thinking of in terms of log audit. You know, we don't have access to log audit data; that's something that you know, we might be able to encourage. You know, those who do have access to that data to, you know share how folks are using that, but that is not something that we have, you know the government has access to.

Larry Wolf, MS – Principal – Strategic Health Network

Right, so I understand there's no mandated reporting of that, it's what people are...

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

It would have to be voluntary and, you know there are researchers who are working with you know either local provider organizations and things like that to report out on that and that is something that we could look in to and share with this group, but the government itself doesn't have access to that because of what you just, the reasons you mentioned.

Larry Wolf, MS – Principal – Strategic Health Network

Right, thanks.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

All right, thank you. Next is Carolyn Peterson, please.

Carolyn Peterson, MBI, MS – Senior Editor – Mayo Clinic Global Business Solutions

Yes, thank you. I want to commend you on the excellent presentation. I had a question with regard to slide five. I'm wondering if in the expansion of ability to submit patient-generated data, I'm wondering if we have any information about what that involves. Is that related specifically to things like entering demographic data, you know names and addresses and phone numbers and that kind of thing, or is it the capacity to submit things like wearable data or data from remote sensors or other kinds of medical information the patients might be transmitting to a facility at the request of their physician.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

So that's a good question, I mean we...on the survey we don't specifically...we didn't specifically ask about what types of data patients are able to submit. However, we are in the process of updating, working with the American Hospital Association to update the survey, which will go out this fall. So I think that's a really good suggestion to ask, you know to drill down a little bit more and to find out what types of data patients are able to submit.

Carolyn Peterson, MBI, MS – Senior Editor – Mayo Clinic Global Business Solutions

Great, that sounds...

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Please excuse me, this is Donna Cryer. I just wanted to perhaps rescue a little bit because these excellent questions are many of the things that we have been wrestling with on the Consumer Task Force. So I just wanted to put that forward so wait, there's more and to speak to the power of the data update, as it's been given, but that there is additional work and I think everybody is thinking in exactly the right track.

Carolyn Peterson, MBI, MS – Senior Editor – Mayo Clinic Global Business Solutions

Great, thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Great. Thanks Donna. Next is Floyd Eisenberg, please.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So my question is really a follow-on to Carolyn Peterson's and it's basically the...any information about the type and quality of data that patients are entering as patient-generated would be very helpful in comparing that actually in rural hospitals and critical access, even though less critical access hospitals may have the ability, what...whether the quality of the data is better because patients are doing more care from home, would be actually very interesting to know.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Agreed. We don't capture that right now, but, good point.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Next is Angela Kennedy, please?

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

Yes, I was just wondering if you noted any patterns or correlation between geographical region and the size and the classification of the organization, based on some of the questions that you asked about rural and critical access facilities.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Sure, just to make sure I understand, you're wondering whether there was a significant association between like the rural critical access and the adoption of patient engagement functionalities or are you talking about...a little bit more broader...like regions of where they're located like South or North or Southeast, you know, that kind of thing? So I just want to make sure I understand.

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

Exactly; right, the regions where they're located.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Okay, that is not something that we looked at with this, but that is something that we could look at is to look at the regional variation and to see if there are any regional variations with regards to adoption.

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

I think that might be helpful and also if you could capture any affiliations that these rural organizations may be aligned with, given that some may have affiliations with other or larger facilities; you might see a different pattern, so I think that information would be very helpful.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

Right, so looking at whether they're part of a larger system or not is something that we could look at, that's something that's in our data.

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

Yes, thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Thank you, and then finally, John Scott.

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

Thank you. Great presentation; my comment echoes those of the previous that talked about the ability of a patient to be able to aggregate information once they download. And in the DoD experience, we have good access for our patients but to download their information even from Blue Button on CCD, but we don't have something for them to do with it. So I think there needs to be some emphasis and attention on a personal health record such as the VA and US Postal Service are deploying that enable a patient to take downloaded information, store it, aggregate it, and view it.

And I wonder what the Consumer Task Force and others think about the idea of looking at the population of patients who have versatile PHRs from the VA and USPS and their experience in being able to download information from other care providers to be viewed in that PHR. Thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Well, I want to thank Vaishali ...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Paul, this is Leslie and I've had my arm raised, but I don't think it's shown up. May I ask one, or make a couple of comments?

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Sure, absolutely.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you. So first of all, there's a lot to celebrate here and we should be very uplifted by this information. I remember when this...these events or these ideas were first brought forward and there was mixed response as to well how well hospitals would respond and I think this is a dramatic report to show that those hospitals have adopted and patients have benefited. There is also another area of patient engagement in patient specific education materials and in the same dashboard that's referenced in the slides here with 94% adoption and that is dramatic to know that 94% of the hospitals and the patients who are leaving the hospitals are receiving educational materials to help support them in their health so, that's another item for celebration.

And then one other comment is that as we think about value of information, the value of information is in the receiver and we may or may not be privy to what the patient believes is valuable and useful. And as we adopt the open API and the patient's ability to choose the App of their desire and attach to the medical record, we'll see use cases we've never even dreamed of and the value will be how the patient uses and appreciates and help themselves with that information. So I think we're just beginning and to see this. It would be important as we evolve and add more functionality, like the open API, think about how we can track or gain the knowledge about the information shared. But, those are my comments and most of all just thank you and it's great to hear and to celebrate this good news.

Vaishali Patel, MPH, PhD – Senior Advisor, Office of Planning, Evaluation and Analysis – Office of the National Coordinator for Health Information Technology

So Leslie thank you for bringing up those points and you're right, the...on the dashboard there is more data on, you know hospital adoption of patient engagement functionalities that you know I wasn't able to present here. And the other important point is, I think you know when thinking about measurement more broadly, right now you know, this is focused on looking at hospitals adoption of functionalities, but we really do want to, you know now that that's beginning to reach a critical mass, we really do want to focus on you know, looking at the usage of those functionalities and what individuals are able to do with it and how that ultimately improves their health, so, I think great points Leslie, and thank you for bringing them up.

One last point Paul before I sign off here, just from an earlier point that asked about the usage and utility of information that's exchange, I was able to dig up, you know the interoperability data brief that I presented on a few months ago and what we had reported on was that about half of hospitals used information that they received from out...but about half of those hospitals had necessary information available for providers at the point of care and that about half of those hospitals reported that providers used patient health information received electronically from outside providers. However, that about one...about three in 10 hospitals in 2015 reported that many recipients of care summaries that they sent reported that the information was not useful. So, I just wanted to share that based on the earlier question.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Oh good, thank you very much; I think that was half of a half too, as far as right, so half were getting it and half were finding them useful. So it's probably lower than we would like and so understanding that better and tracking that would be helpful.

So to echo Leslie's concluding comment, we're all just very appreciative of one, seeing the data and two, celebrating how much has been accomplished in the two years, not that anybody's giving up, but now we can...that data is starting to flow, if we can make sure that it's impo...it's useful both to, in this case to people and patients and in the exchange amongst providers to them as well.

So thanks again for the update and we'll turn it over to Lisa to conduct...and also thank you for setting us up for the next report, which is from the Consumer Task Force, as Donna mentioned. So Lisa?

Lisa Gallagher, BSEE, CISM, CPHIMS – Managing Director – Pricewaterhouse Coopers (PwC)

Thank you, Paul and as Paul mentioned, what a nice segue into the Joint Committee Consumer Task Force update on the work they did to provide feedback on some very important consumer connecting technologies and initiatives, Blue Button Connector Site and the Patient Engagement Playbook. So we have Donna Cryer and Patty Sengstack, who are Co-Chairs of the committee. Not sure who's going to kick it off, but I'll turn it over to you.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Thank you so much and this is Donna; I will start and then turn it over to my very capable and fabulous Co-Chair, Patty Sengstack. I will not, this is probably no surprise to those of you who have served with me on the committee for some while; I will not be reading directly from the slides because as you all know death by PowerPoint is the third leading cause of workplace fatalities. But I will in this first part of the presentation, give you a sense of the charge and composition of the committee and then describe our early effort.

So for those of you who are familiar with past iterations of a Consumer or Patient Committee, this is a little different. This is more of a SWAT team, if you will, of patients, consumers and also hospital and

practice provider leaders of various sizes. So to the many excellent points and questions that were raised for the last presentation, this task force was purposely com...and excuse me, if there's any background noise of confusion on my part because I'm in the infusion lab right now.

So the committee was put together purposely with a diversity of patient and consumer leaders, and those with direct experience, as well as folks like Patty with...who's a Chief Nursing Informatics Officer, so that we would be able to answer the types of questions that have been raised by providers seeking greater engagement with their patients; one so we'd be able to answer those questions from a patient and consumer perspective, but also that the feedback we were given, we would have the members of the committee present to be able to give us direct feedback immediately as to rather that feedback and advice was practicable and workable within their system.

We also took great care to try to ensure that there was diversity of sizes and types of practice. So to the point about layering of different types of data and adoption in rural or community, children's hospitals, academic medical centers, we tried to have that diversity of practice settings represented on the committee membership itself. So next slide, please.

So again to the charge; this is a task force that is convened as an as needed basis as ONC presents to us the really frankly fantastic products and I cannot commend the work of the ONC and all of the team involved in creating the different products that have been presented to us. So on an as needed basis, the task force has been providing very, very detailed feedback and suggestions and recommendations for improvement as well as dissemination on engaging the experience of patients and providers.

And so although it's been labeled a Consumer Task Force, I really cannot emphasize enough the diversity of the membership and the diversity of thinking and background and experience that has been demonstrated in the calls and hopefully that is reflected. I also have been taking copious notes on the questions that we're asked, because many of those issues have been raised in the course of the call and I think they do follow along the lines of the thinking that we've had that there are some several opportunities for additional evidence generation and additional dicing of the data if you will, to give additional...set additional light on what has been presented. So, next slide.

Thank you. So I'll just spend a moment or two on Blue Button Connector. And for those of us who all wear our Blue Button pins, Blue Button Connector pins at conferences and know what a truly revolutionary initiative and product this has been from the start, initiating from a challenge which in and of itself is a, as we think through this administration and the evolution and history of the office, I think the connector is a fantastic example of the effect of challenges and prizes and a push towards innovation. And so if you all haven't looked at Blue Button Connector today, I would encourage you all to do so because it has evolved several steps forward. Next slide, please.

Thank you so much. So, first the compliment, I think that's always a great way to start. The members of the committee felt that the connector was very easy to navigate; the design was commended many times across the membership. I think the main message is one of the last questions that was raised in the prior section, does this solve the problem for patients of having a one-stop shop to aggregate their data and to...which we all know is very hard to collect in a useful format to be able to send where it needs to go? And the...just the honest answer is, it's not quite there yet. So that is the bottom line of the committee.

That said, the...there are opportunities beyond consumers for the Blue Button Connector that were identified by the committee for where it is today. Certainly the information for developers for how to build into Blue Button Connector products, there is an opportunity for setting expectations for patients

for what the Blue Button Connector can do today and its value today; and there is significant value today, the committee did agree.

And lastly, there is an incredible opportunity through Blue Button Connector as a key point of entry for education and health literacy and specifically data health literacy as it evolves into that sort of one-stop shop aggregation point that we all aspire to. So I would say the Blue Button Connector today is a...it has been moving at warp speed in terms of its evolution and value from where it first began, but there are significant ways where it can be improved. So, I'll leave it there. Next slide.

And this I can hand this over to my very capable Co-Chair, Patty Sengstack and I will be available on the...I'll mute myself, but I will be available for questions after Patty's portion of the presentation.

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

So hey Donna, thanks for your commending me like that, you make me feel so important. So hi everybody, I'm Patty Sengstack; I'm the Chief Nursing Informatics Officer for the Bon Secours Health System and serving as a Co-Chair with Donna on the task force. And what ONC asked us to do for both the Blue Button Connector and for the Patient Engagement Playbook, they gave us homework, we felt like we were back in school.

So we had to answer a set of questions related to the tools and so we had to go home, go through it, surf through it, click on the link, see if they worked or they didn't work and you know, really do that deep dive into the tools, and then answer a set of questions. So I commend our task force that, you know they were all wonderful at providing very detailed feedback to answer all the question about the two tools.

So this is wri...this particular tool, and I don't know if you've seen this one or not, or the Patient Engagement Playbook. Wonderful tool geared towards...it's a tool that's intended for care providers on the implementation essentially of patient portals. And I think the intent is to expand beyond that at some point, at this phase of the playbook, it the primarily focuses on the patient portal and its implementation. So there on the screen, you've got the URL so you can take a look at it yourself and see what you think of it. But it essentially has a nice introduction that speaks a little bit to the why, and we can go ahead and go to the next slide, so you can be kind of looking over some of the feedback as I ramble.

So there's an introduction that's broken into four chapters with an introduction. The introduction essentially talks about you know, why it's important to have a patient portal and to connect with the patient in that way. And you know we all thought that it could be a little stronger in that you know why is it important? We know these things are important, we know that they have the potential to be real game changers and we think that that could be a little stronger in that introduction, but nonetheless, the why was in there.

There were four chapters in there and they were nicely laid out, good usability of this tool. The chapters; so the first one was about facilitating easy enrollment, you know how to get your patients enrolled and I thought, this is so timely for me because we here at Bon Secours have had a big campaign recently of getting our patients signed on, I mean just activated into the...their patient portals. So I found the tool really helpful and we used it recently to get our campaign going.

So there's a chapter on facilitating easy enrollment, and actually some great data in there that shows clearly that when the patient is in front of you, it is the best time to get them signed up because once they go home, it was a study by athenahealth that's embedded into the tool, you know showed that

once they go home that the chance that they'll go ahead and sign up is pretty low. So there's that chapter on facilitating easy enrollment, a chapter about activating features that meet patient needs, about setting up appointments, improving communication, providing the notes, prescription refills, all various features that are available were covered in the second chapter.

And then third chapter was about allowing caregiver proxy access, so a little bit more information about that, and then integrating, fourth chapter, integrating patient-generated health data. So the importance of putting in things like the health his...patient's health history, allowing patients to do this themselves and symptom trackers, you know Fitbits and other you know exercise collecting data devices. So we looked through all this and provided feedback and what you're seeing on your screen now is just the summary, kind of the highlights of what our group gave to ONC regarding this particular tool.

So we found it very user-friendly, very easy to navigate and I think if you're listening to me now and have Googled it or you know, gone to the URL, you're seeing what I mean. Several examples from the field, and I mentioned one earlier with the data on when to get a patient signed up; so several examples and lots of content that's engaging. There's interactive media in there that's very helpful. So we like that, we thought you know, put more in there, the more interaction the better.

We thought that it was appropriate and at an appropriate level for providers. We thought maybe that with a little bit of tweaking, it might be good for the audience of our patients; you know they could benefit from something like this. So we asked members from ONC to consider a patient audience in the future in a tool such as this.

Another suggestion was to, could you create it so that we could print out a PDF or generate some kind of a printable form of a PDF? You know, there's that myth of going paperless, but some people still like that paper and that that might be helpful to share as a resource with their care teams and/or their patients if it could be printed out on paper.

We thought about the title, you know, it's called the Patient Engagement Playbook, but it really is focusing on the patient portal. So should the title or a subtitle be included, and I believe the ONC is considering that, that says you know, something about, you know empowering the patient portal or something about the portal use.

And then the last thing that I'll mention is that several people mentioned that maybe there's an opportunity to add more granular steps for the care providers on how to implement some of the tasks and features that are in a portal. So you know in the second chapter I mentioned that the...there's information about setting up appointments, communicating, putting in notes, prescription refills; in reality, in our practices, I know where I work anyway, our providers are not IT staff.

So sometimes you need to work with the IT staff to set these things up and sometimes they need guidance on what to implement first, what to implement second you know how do you kind of ease yourself into some of these features and functions. Some are pretty easy to set up, some a little more complex; so we thought maybe there should be guidelines on how to set those features up and in what order and the resources that you need to do that.

So I will stop there on those...on discussions about the playbook and I think the next slide is about our continued work plan, but maybe Donna we should st...should we stop here and...well, let me go...let me just go o...I'll go over the work plan; I'm sorry, I'm confusing the slide changer. Let me go over the work plan and then we'll take questions.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Okay.

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

Is that okay?

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Yes, yes.

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

Okay, so we met on the eighth and we talked about the feedback that we were providing today to make sure we kind of had our ducks in the row to present today and ONC introduced our next bit of homework to review and provide feedback on the Model Privacy Notice. So they shared that as just kind of as an introduction and we got an e-mail from them just I guess it was a day or two ago on the homework again that we have on providing feedback on the Model Privacy Notice. So we'll be meeting again in September to talk about that in more detail.

Then they'll be presenting another tool on patient-generated health data that we've not seen yet and then I'll just going to let you guys read the rest of the work plan for us as we go through to the end of the year. So, I will stop there and I guess turn it back over to see if we have some questions.

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

And this is Elise, maybe before we do that, I did want to just say thank you to all the work that the Consumer Task Force has done so far and the upcoming agenda. As many folks know, when we release the Federal Register notice on the Model Privacy Notice, our goal was really to kind of start the conversation again and move the notice into kind of more present day, in terms of making sure that it's considering things like API and where information sits and really to make sure that it's helpful to the patient that would ultimately be using it. So to have the Consumer Task Force take a look at it I think this is really crucial.

And then similarly for the PGHD Policy Framework, this is something that we've been working on internally for some time and we're getting to a point where we're going to have a draft that we would love to share. And when that happens, we really look forward to receiving the input from the Consumer Task Force, particularly given, you know obviously the positions and the engagement that you hold within the stakeholder community. But also we think for us to have a good, strong product and a framework that will be helpful across the health IT community that having your input will be invaluable. So thank you in again advance.

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

You're welcome.

Lisa Gallagher, BSEE, CISM, CPHIMS – Managing Director – Pricewaterhouse Coopers (PwC)

Okay thank you, this is Lisa. I want to just thank both Donna and Patty for a very insightful presentation and thank Elise as well for helping with some additional detail on the work plan. I think at this point, we'll turn over to some questions and Michelle, I'll ask you to help me moderate the order of the questioners. I believe Paul Tang has a question and he would be first, so Paul?

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Great, thanks Lisa. Like Donna and Patty, I wanted to commend the ONC staff on really beautiful work here in this playbook. I think both what's already there and then the excellent suggestions that the task force made in its review will really make this an outstanding piece of work. I hope we can distribute it literally in the whatever material that EHR vendors distribute to their customers to make sure that people don't have to come to our website to find this. I'm sure you have other plans, but really almost want to make sure that you talk to the vendors and see if they'll just distribute it as well, just to put it in front of the faces of the people who actually work on this stuff.

I thought the comment about whether it really is an engagement tool book it's really how to implement a PHR, which is extraordinarily impor...I mean a patient portal which is extraordinarily important. But then there's the piece, the person-facing side of like how do I...what do I get out of this and how do I engage and that seems like a useful contribution as well. But at any rate, thank you for the great work, thanks to the task force for the wonderful feedback and detailed feedback that are very constructive. Thanks.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Thank you Paul, this is Donna. I wanted to respond to both of those comments. Yes, EHR vendors were identified by the committee as a very important potential distribution method and I thank you for underscoring that. This is really something that we wanted to make sure as it is, as Patty mentioned, really a playbook for providers to be able to engage with their patients not only on the portal, but in other ways through technology. And so the vendors I think will play a very important role with that as well as other organizations and systems themselves, of course.

One of the questions we specifically asked and kept asking were, would your colleague use this, to the provider members, and so dissemination was an important part of this. And the second part as well as this is...it was designed so beautifully, much more than just how to get greater adoption of a patient portal. This really was built so richly with so many great opportunities for both providers at various levels, as well as hospital administrators to understand why engaging with their patients through technology was something that would benefit them as well as benefit the patients. And our recommendations are very strongly that the examples and the language around that should be expanded to ensure the success of this wonderful piece of work.

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

So, and I echo all that Donna; this is Patty. I can tel...let me give you a specific example. You know I shared earlier that you know we just had this big campaign to get our patients signed up on their portal. So we...I used this playbook, you know and it was thanks to this task force that I'm on that I even knew it existed. And I mentioned that they included several examples and some evidence from the field.

And they have in there there's a beautiful graphic on a study that athenahealth conducted amongst 973,000 patients who visited their practices and were offered their patient portal. They found that 57% of them, given the opportunity to sign up, 57% of them used a kiosk or a tablet and signed up right there while they were in the practice. And it's got such a great graphic and it shows that if you let them go home, then maybe you get anywhere from a 4% maybe up to 12%; so not so much.

Because we were in the midst of figuring out how to do a bulk e-mail to all of our patients who did not have an active account and send it out to them, to their homes. And when I showed the group this graphic, we said never mind. And I can't even tell you how much work that avoided. And that's just one example of some of the tools that are out there. So you know you say it's for providers, but you know it

is geared towards providers, but I can tell you, you know organizations and informatics specialists in organizations will find it useful as well.

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

This is Michelle; we have a number of folks in the queue so if we could try to go through the questions fairly quickly, just looking at the time, we're already a little bit over. So, the first question is Wanmei.

Lisa Gallagher, BSEE, CISM, CPHIMS – Managing Director – Pricewaterhouse Coopers (PwC)

Sure.

Wanmei Ou, PhD – Director, Product Strategy in Precision Medicine – Oracle

Hi, it's Wanmei here; thank you Patty and Donna for the presentation. I have a quick question regarding the Blue Button Connector. Do you have any statistics about how many hospitals, clinics or providers have been connected via the Blue Button Connector?

Donna R. Cryer, JD – Founder and President – Global Liver Institute

We do have number of those who have pledged and connected; may I look to ONC staff to give that specific number?

Wanmei Ou, PhD – Director, Product Strategy in Precision Medicine – Oracle

Okay, I mean it would be very interesting to see that the group that has not been connected and how to outreach to those groups.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

It's a diverse group that includes both...that includes hospitals, payers and a number of different types of entities. The Blue Button pledge process has been ongoing for a number of years and so...that also is reflected in the diversity of types of data that are connected through Blue Button, which is both the challenge and the promise of the product. But we do have that number and I'm sure the ONC staff will be happy to send that around in follow-up to this call.

Wanmei Ou, PhD – Director, Product Strategy in Precision Medicine – Oracle

Thank you.

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

Thank you and thanks Donna. Gayle Harrell?

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

Thank you so much and I really appreciated the presentation. For me patient engagement is absolutely a key component and ONC's role in making...in assisting in doing that. Part of that, of course, is something I am particularly concerned about is the privacy information and privacy notice and I see that you are going to be meeting on the 27th to discuss the Model Privacy Notice and get some feedback on that.

I would very much want to emphasize to you as you go into that meeting is how important that is and that it is really how to disseminate that and make sure that patients understand exactly what their rights are and how that they can interact through in this patient engagement, to make sure that they understand and what role ONC might play in getting that information directly to patients.

So a key component of the whole patient engagement is privacy. And I really like, you know maybe we'll have another update on this next time, after you've had that meeting, but as you go into it, please I

really want to emphasize that patient engagement in that aspect is so important and thank you for all you're doing.

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

Thank you.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Oh, thank you so much. We certainly agree that point is noted not only in the conversations around the Model Privacy Notice, but even in the Engagement Playbook we saw opportunities to discuss privacy, giving your password to others, use of proxy for caregivers and so thoughts about privacy in the process of sharing has been a thread throughout all of our discussions. So we take that very seriously, but thank you for bringing it up.

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

We'll keep it at the front of our brains. Thank you.

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

Thank you. Eric Rose? Eric, are you on mute?

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

Hi, yeah sorry, I had to take myself off mute. So the...one thing that has shown itself at least in my own city of Seattle is that healthcare providers have basically adopted patient portals universally, except for children because they're concerned for the issue of confidentiality and the fact that like in many states and Washington State, certain types of healthcare for adolescents are not to be disclosed to parents.

And I'm wondering if the playbook had any guidance to providers on navigating those treacherous waters of segmenting out things like reproductive health care and mental health care that remain confidential from other types of healthcare that don't remain confidential to parents and how to make this information available to parents of children through portals.

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

It's interesting that you...

Donna R. Cryer, JD – Founder and President – Global Liver Institute

We did...oh, go ahead Patty.

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

Okay. I was just going to say it's interesting that you mentioned that because there are two examples in the...I'm looking at it right now, in chapter 3 there's the section on the chapter caregiver proxy access. The two examples in there are both about adolescent situations.

So, you know with parents needing to see adolescent's data and what can be you know parsed out in terms of even there's one example, you can take a look at it where the University of California at San Francisco provides access...varying levels of access based on the age of the patient. So you know, you can take a look at that; so there are examples out there and it is addressed, but you know perhaps there are, you know perhaps there are other things they can add to it so, you know you can provide that feedback to us after you take a look.

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

Great, thanks; I'll take a look.

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

Yeah, thank you.

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

I think Lucia might have had a comment to make as well.

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

Yeah, so I really appreciate that question because it helps us remind you that there are obviously a lot of different facets to how health IT gets deployed in each particular environment and we...the complexities of individualized state laws are not...nobody on this call, on our FACAs are surprised by those and it's a complicated issue we've been working on for a really long time.

I will say that our work with the NGA that we launched last year has been pretty productive and we expect to have some more public information to tell you about that, possibly in October. But again it's one of those beings where the UCSF example is unique to the State of California rules environment; Kansas might have a different deployment. Michigan one that's different from that and so there's kind of only so far we can go in a playbook that's meant to support all the markets, because then the providers and their communities have to look at exactly how they want to accomplish their deployment in their own unique rules environment. And so we just...we have limits to how far we can go.

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

Thanks Lucia. Kyle?

Kyle Meadors – President – Chart Lux Consulting

Yeah, this is Kyle; two quick things. First of all, just on Paul's comment, I thought about getting it in the hands of vendors and I would suggest one thing to consider along those lines is maybe working with the ONC ACBs who do the certification in terms of if there's a way they can provide a packet so to speak, you know because they always have to after certification, have to send out certificates and other things, maybe there's just a packet that we send like this is from the ONC, just information tutorial, whatever it could be packaged as, just to kind of help distribute that. I just want to throw that out because I think it's a really good point. This has been really well done and I would really encourage to get this in the hands of the people who need to see it.

And then, just secondly, this is I think a minor point; it's not even a really big deal. I was looking on the introduction, it still makes reference to the providing the clinical summaries as a measure, even though that's actually been deprecated now in the Meaningful Use Program. I don't know if we want to keep it in there or not or if there's a right way to go about suggesting that obviously clinical summaries are still a good thing, it's just not in reference to the Meaningful Use measure anymore.

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

Good point thank you.

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

Thanks Kyle. And last question to Leslie Kelly Hall.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Sorry about that. I just really wanted to say thank you to the Co-Chairs, to Patty and to Donna. This is some great...I would also like to thank the ONC staff for really listening critically to all the feedback and taking it in. This was an excellent piece of work and I can see it expanding to having as said, the patient-facing tool in the future. It was well researched, well thought out. Back to Arien's beginning comment of use for the future and keep feet on the ground; I think this was a great example of that so thank you.

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

Thanks Leslie and thank you both to Donna and Patty, we greatly appreciate you presenting today. And so now we're going to move on to have Kathy Blake walk us through the next part of the presentation from Jitin and Anjum.

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

Sure, and thank you Michelle and I think that we're seeing a common theme or thread throughout all of the presentations today. And so next we'll be hearing from the Co-Chairs, Jitin Asnaani and Anjum Khurshid for the Joint Committee's Interoperability Experience Task Force. And I'll remind the committee members that we will be asked to approve the findings that the committee co-chairs present us at the close of our discussion and also there will be, associated with the slide deck, a transmittal letter that will come as a...and be finalized based on our discussion. So I'll turn it over now to our co-chairs.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Thank you Kathleen. This is Anjum Khurshid, thank you for this opportunity and let me start by thanking my Co-Chair, Jitin Asnaani who was just outstanding in moderating some of the calls with the task force and providing a lot of thought into the discussions that we had. Also want to thank the task force members who during the early part of the summer, spent a lot of time with us in terms of addressing these issues, the chairs of the joint task...joint committees have been involved in guiding us through this process as well, so wanted to thank them. And finally I do want to thank ONC staff, Vindell was on some of our calls as well, but the staff was very helpful in helping us through this process. So thank you to all of them.

The task force, remember was formed just before summer, and comprised of a fairly diverse group that you see here. It represented practicing physicians; it represented some of the very senior experts from the industry. It also had some consumer representatives and some members from other federal agencies as well. And they worked very hard in terms of coming up with specific findings from this process. Next slide.

Yeah, so just to remind that the charge of the task force for the Interoperability Experience was to provide...to look at the most impactful approaches that could help in improving the interoperability experience for providers and patients. And in taking up this question actually early on, the task force members realized that the scope of this task is fairly broad and we had to somehow narrow this in terms of understanding and make it doable within the time period and the expertise that we had. So one of the things was to consider interoperability and the stakeholders in the context where interoperability was already taking place, so we were not necessarily looking outside that spectrum where

interoperability is not happening, and then focusing how we can improve the experience of the interoperability for the end users, in this case specifically providers and patients.

The other question which was also in terms of how best to use our time together as a task force, I think again we realized that while there has been a lot of work done I think on parts of interoperability experience, this was in a way a very concerted effort by the FACAs and ONC to shine light on what would be the approaches that would, in any systematic way or comprehensive way, continue to improve the experience of patients and providers. And given that I think a lot of the effort that was initially spent was mainly to identify what those needs would be that if those are addressed, they will help improve the interoperability experience.

And the task force members I think also realized that in the time that we had, our best option was to prioritize those needs that will improve the interoperability experience going forward, and we may not have the time or the expertise again on the task force specifically to come up with specific solutions to those needs as well. So our first step was really to identify and prioritize the needs that if addressed properly would improve the interoperability experience.

And then we did spend some time in talking about what can be done, but again I think the task force members realized that we needed to do a much more detailed kind of root cause analysis for some of these aspects that had been identified, and there was a longer process required to come up with the best solutions because there were solutions.

So what you will see is that I think as a result of our discussions, we have come up with the findings and with the potential opportunities that we have suggested should be presented to the federal government and ONC as a menu of options in terms of what are things that need to be address. And then the specific solutions I think still need to be built on that and so that work should continue in that respect. Next slide.

And so in coming up with the criteria for how do we prioritize these needs, we not only had discussions with experts on our panel on the task force, but we also had virtual hearings with invited experts from different stakeholders that represented healthcare providers, that represented health IT vendors, also represented both state and federal agencies so that we get as much information as we could from outside the task force membership as well to understand the criteria on which we can identify those needs and what those needs may be.

And through this process, as we were discussing these, we came up with this criteria which we described it as a formula of how do we...what effects interoperability experience. And we realized that it is proportional to what is considered as a user delight in terms of getting the right information at the right time, to be able to get the, you know relevant data to improve care versus...inversely proportional to perceived friction. And we used the term "perceived" specifically because there are sometimes you know solutions there but if users don't know that, then it causes the interoperability experience to not be that good, which could be the number of clicks needed to get to that information or deviations from workflow that are needed in order to get to that information. So this was one of the kind of criteria that was used by the task force in terms of prioritizing the...among the various needs that were identified which could improve the interoperability experience. Next slide.

So as we discussed the various aspects of the experience both for providers and for patients and consumers, we came up with almost a set of about 35 sub-needs, each one of which was important and had further discussions that were taking place, but we bucketed them in terms of groups that came together well. Now this was based on a process where we started off with concrete use cases that we could understand what are the needs in the various scenarios starting from like transitions of care to

patient-initiated data to you know quality improvement efforts. And then across these use cases we identified what are the various granular needs will improve the experience of stakeholders within those use cases.

And those sub-needs were then grouped into these eight categories, which you see on the slide. Some of them are grayed out, but in total, these included ability to identify patients nationwide, ability to locate relevant patient records, ability to locate and identify providers, ability to access and interpret consent and authorization, ability to exchange health information, ability to encode data, ability to effectively utilize health information and then a category that was governance, which had some components...but even these, you know each one of these had further details which are actually attached to the appendix of the letter that was...that will be transmitted.

But we also realized that we needed to further prioritize these...among these eight. And so after our discussions, the three that you see highlighted here, the ability to effectively use health information, ability to encode data that is syntactically and semantically interoperable and ability to exchange health information were identified as the top three priority needs that if addressed, would improve the interoperability experience for patients and providers.

And with that...next slide, I will hand it over to Jitin to walk through some of the details within each of these categories.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Great, thank you Anjum. So before I jump into some of the detail here that's outlined in the next couple slides, what I would like to do is again underscore a point that Anjum made a moment ago which is, the focus on these three buckets at the top of the screen really came down to the factors which the task force considered to be the biggest drivers of interoperability demand; and so we really focused there on the demand.

And within each of these buckets, there were several points at the first time we presented this deck to...here to the joint committee two months ago, there were several more points and we just went through a process of winnowing down with the workgroup, particularly based on the feedback we received from this joint committee, as well as the feedback that we...then back to the workgroup and as we kind of tried to winnow down the number of key takeaways that we wanted to share with the workgroup so that they could be a little bit more focused.

So without any further ado, there were three elements here under the ability to effectively utilize health information that really sort of bubbled to the top as drivers of the interoperability experience. Number one was we found that clinical information reconciliation and curation is a key aspect. And we captured it here in a very simple, single line; it's the shortest line on this page, but it's actually probably one of the deepest topics. Certainly none of us here is unfamiliar with reconciliation, but what we wanted to underscore here was that it's not just about what data elements are to be reconciled, but what is the behavior expected of those data elements as they're reconciled? What is the expected behavior of the providers or the users as they want to engage in reconciliation? And what about that other data that's non-reconcilable data that's actually critical for being able to understand what sense to make of the reconcilable data.

So there's actually a fair depth of information and discovery that needs to happen here and we realized that no matter whether within the context of just the task force or virtually every single one of our panels, that topic came up again and again. So we wanted it to capture it here as one of the key issues driving the ability to effectively utilize health information.

A second aspect that came up in several contexts was the work needed to improve user-centered design and usability and the usability of systems. It...the...and the point that we really wanted to bring out over here that was certainly brought out several times to us was that interoperability is clearly more than sharing data, its ability to allow the providers to act on the data and the ability for that data to be consumed in a usable way; and so that was the second point.

And then thirdly, the burden of, and this is really more a finding than a specific kind of recommendation here, the finding was that the burden of clinical data entry faced by clinicians has an impact on the demand. And the...on the surface of it that doesn't necessarily make sense, right, it's...we're talking about clinical data entry as opposed to interoperability.

But again what we found was that the...if you had a poor experience in trying to conduct clinical data entry, then the concomitant effect on the interoperability experience was high as well. It co...you know some things as simple as just the time availability of using...of engaging in interoperability if you are, as an example, if you're 15 minutes with the patient were consumed in entering data, then you're probably not going to be spending a whole lot of time interoperability to get more data.

Certainly if frustration or on the flip side, user satisfaction of the system that they're using has impact on the involvement in interoperability, as well as of course the effectiveness of the user and so on and so forth. So despite the fact that it seems orthogonal, the clinical data entry actually turns out to be a critical demand driver in our minds of interoperability. Let's go to the next slide.

In terms of the ability to encode data that is syntactically and semantically interoperable; I know this is certainly a ground that has been sort of plowed over several times over the years by ONC and by the FACAs. So really we wanted to focus on a couple of aspects which have been...certainly been mentioned in the past, but we think there's actually a time now where it's starting to be one of the factors that impacts demand of interoperability.

The first one was the ability to use, you know, actually I'll just read it off here; improve the usefulness and the usability of non-clinical data, particularly things like the behavioral and social determinants of health. Again, have been mentioned here before, but there seems to be now an opportunity to start thinking about how this actually does really affect today the interoperability demand from providers and others. There needs to be more work to understand how to achieve interoperability with unstructured data.

Is somebody ticking a clock for me or is that just something on my phone? All right, here we go. The third part over here called out is C-CDA standards. This is...this was certainly a place where, you know that we spent a significant work on in terms of the FACAs themselves, ONC and you know the private sector, and it's just an acknowledgement that there is still more work to be done to support better integration and patient matching.

The fourth part was continued collaboration on terminology with ONC and its stakeholders. And this again was an acknowledgement that actually in this case, a lot of great work has been done, we have made a lot of progress as an industry, but there are still things that need to be addressed and improved upon, so there is still more work to be done, particularly, you know, for exam...actually one of several examples we came up with was to the use of LOINC for ordering codes and so on.

And there are certainly organizations out there, like the National Libraries of Medicine, who are...who can be tasked with or collaborated with to achieve that kind of work. And we wanted to call that out as another place where the work needs to continue for us to get to a better place in terms of the value of interoperability. Next slide.

Finally, there was this bucket called ability to exchange health information. Certainly there are a couple of points in here which was...which are well known, you know there's obviously been an API Task Force and there was an acknowledgement that wider...widespread use of APIs is still needed out there. There was a lot of discussion, however, on the various aspects around costs of interoperability as barriers to the ability to exchange.

So the costs of owning EHRs specifically and a refresh of ONCs work...report to Congress on the feasibility of mechanisms to assist providers in comparing and selecting certified EHR technology products, aka the report that was one of the prime justifications for the Meaningful Use Program. Patient-generated health data, this...probably this is the only other non-cost related point here, but the use and exchange of heal...patient-generated health data needs to be more prevalent and more well understood. And actually I'll speak a little bit more about that on the next slide.

And then like I said, on the other aspects around cost; there's a cost of data exchange and understanding what those are in a consumer me...in the context of consumer-mediated exchange, you know the cost of obtaining Direct addresses, etcetera, as well as costs around interoperating in a particular region. There was...it was brought up several times across our panels and with our task force that there's work needed around the discrepancies in HIE costs. HIE here was really the capital HIE centered around, you know regions and territories and municipalities, etcetera, and the interoperability policies among states; so the cost of exchange as well as things like consent, privacy and security. Let's go to the next slide.

As Anjum mentioned when he started describing the...sort of the buckets that we were able to kind of identify where interoperability demand can be generated, we came up with more than 35 needs. And through a process that bordered on strenuous, we narrowed it down to the three slides I just presented to you. But as we presented these at the last FACA joint meeting, a slightly expanded version of these at the last meeting, one of the clear pieces of feedback we heard was, this is still a lot, can we focus a little bit more on sort of surfacing up just the top few that are extremely, you know the other ones which we thought were the most important?

The workgroup had more or less said, disband it at that point, so we didn't go through an overly rigorous scientific process, rather the Chairs went back and looked to see where the deter...where the most effort and discussion and energy had been placed in the discussion along those dimensions which we already articulated, and realized that there are probably three findings that were particularly of high priority.

One is around the reconciliation and curation, as I actually mentioned earlier. And again to underscore this, there's...I'm sorry, is somebody trying to say...oh, okay no worries. The first one is around the clinical information reconciliation and curation and the burden that places on the clinical data import on the...on providers particularly. And the feeling was that a...and the feeling sort of in a nutshell in sort of plain English was that there is no viable floor here for what we should expect in behaving and reconciliation and an ability to view other types of data that go alongside reconciliation here.

There's obviously a balance here between being overly prescriptive and not, but there was definitely a feeling that there is a lot more that can be done due to the...just the wide variety of negative, primarily negative responses that our study showed in terms of provider engagement through reconciliation of the data.

The second aspect that we...that was...that clearly came up to the top was around the nonclinical and being able to incorporate nonclinical and unstructured data, particularly behavioral and social determinants of health, which are obviously a critical part of being able to actually treat and manage the

care and health of patients. The emphasis here was we've spent a lot of time focused on EHR-to-EHR data, including for example the reconciliation data discussed above, but that nonclinical information is again, a critical part of care.

Finally, the third bucket that we realized that our discussion really focused on, primarily because it's time is certainly germane, is around the patient-generated health data, as interoperability continues to include that. So it's...in some sense, it's the subset of the nonclinical data that I described just a bullet point ago around that unstructured data that's nonclinical. But in some...in another way it's sort of broader than that because there is a lot of opportunity to bring in a variety of different types of data that can be germane to the treatment of the patient.

And there are...there's very little as yet around the methods and standards for inclusion of that data. Of course while acknowledging that there are task forces that have spent some time on this and that are spending time on this, to expound upon it. Nonetheless, we found that that was, particularly for patients, an important determinant of the interoperability experience.

And I think that's it, that's where we wanted to leave it off for the FACAs. Anjum, is there anything else you'd like to add before we turn it over completely back to the FACAs?

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

No, that is fine; thank you.

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

So this is Kathy and first of all, thank you for accepting our request after the initial presentation to go back and to come before us now with these three prioritized findings. Just a couple of items that I'd like to comment on and to share with the two committees; and I'll point to first to an article from the Annals of Internal Medicine, Allocation of Physician Time in ambulatory practice.

A time and motion study that was funded by the American Medical Association, which is where I work, but basically showing how serious a problem this is in terms of reducing the burden of clinical data import, which is the first your prioritized findings and basically showing that for every hour that physicians are providing direct, clinical face-time with patients, nearly two hours are spent on EHR and desk work within the clinic day. So this is...there is no question that this is an issue that seriously impacts the experience of care that patients have, but also the experience of care being delivered by providers.

And then secondly, just reinforcing your emphasis on being able to get behavioral and social determinants of health, I'd point people to an article in JAMA from September 6, senior author, Abraham Verghese and looking at how critical this is because it can so frequently influence someone's ability to implement the care recommendations that have been offered by the healthcare system and it so often really significantly affects their level of satisfaction with the care that they receive.

So congratulations to the task force for presenting these recommendations to us. And Michelle, I think I'll turn it over to you in terms of going through the queue for members of the committee to ask questions and to comment.

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

Thanks Kathy. First question is from Floyd Eisenberg.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Thank you. First of all, I think this is a really very well done synopsis of the three critical issues and I agree with the last set of comments. I would just add as far as cost, to add in the cost to the provider in terms of workflow time and effort.

My main comment is about reconciliation. I've been involved in a project looking at immunization data and EHRs and managing clinical workflow and one of the key components of bidirectional exchange with the registry is reconciling the information that comes back from the registry. This project included usability experts evaluating a user-centered design process and what they found is a number of key issues that make it a little bit different than just medication reconciliation. They also looked at reconciliation of easier they also found that reconciliation of inventory, of dealing with information concerning forecasting.

And what we learned from this project is reconciliation of data is not the same for every kind of data. So it really needs some input concerning usability to make this work for almost every kind of data that you're trying to reconcile. I think that's important; I'm not trying to over-complicate it, but I think what really helped in the immunization work was we published two those, the other two will be published shortly, and we've gotten a lot of good feedback from some vendors and also the immunization community about how that helps understand the data that's being sent and received.

One thing that I think is important that most people tend to forget is, I may reconcile what's coming in with what I have locally, but when I find that what I have locally is more correct, do I also send back to the sender that you might want to correct your data? So it's something to consider. But, this was a great presentation.

One other issue about terminology; if you remember the committee has looked at the Transitional Vocabulary Task Force and that had recommended that the ONC they should set a point in time when terminology is standardized, some point in the future. And I would consider addressing that as we look at the terminology. But thank you very much, this was great.

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

Thanks Floyd. Andy Wiesenthal?

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

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.

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

Because I got a message from the tech people that they had muted me. Anyway, I have two points to make; first of all, just to...I now will add to Floyd's point. The National Library of Medicine is actually recognized everywhere else in the world as the national relief center for all terminologies and vocabularies in the United States. We ought to recognize it and as Floyd mentioned, set a date certain for when these vocabularies will no longer be optional but...and that will make the process of reconciliation that is the burden you described today, much less of a burden.

The second thing I would urge is that whenever we have commentary on the costs of health information exchange and interoperability, we at least pay some obeisance to the fact that the costs of not being interoperable, which we fail to mention most of the time, are enormous. So yes, we all have to pay for this, yes, I'm the first in line to say there has to be a business model that will make it possible for us to interoperate and to build the infrastructure necessary for that and maintain it. But when we don't, we harm people every day and that costs a lot.

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

Thank you, Andy. Raj?

Rajesh C. Dash, MD, FCAP – Director of Laboratory Informatics Strategy, Office of CIO – Duke University Health System

Yes, thank you. So I really enjoyed the presentation, I think it's a great start to address a very complex challenging problem. You know, as I look at number one I see the criticality of it, it's super important, but I also see it as kind of symptomatic to a root issue of a lack of technical interoperability that we haven't address. And as you stated, we're just kind of starting on that and not presenting technical solutions, but there's many aspects of, you know that involve not just solving the technical pieces of interoperability, but also how the vendors implement that in EHR workflow design.

I kind of see the issue as a newcomer to this committee, you know medical documents in this country as books in a library each having multiple authors written about individual characters or patients that are written, you know at different points in time with various inconsistent titles and multiple indexing systems, so we have no Dewey Decimal system to tie everything together, and that's not even looking into the content of the documents.

And terminologies can certainly help with that, but we really need, I think, to think about the next steps and a systematic technical plan to close gaps. It's not an intractable problem; it's just a large one, but I think we can make some progress if we start looking at this, you know at a very broad level across the country and figure out how to make some sense of these documents within individual institutions that each makes sense.

But when you look at them as a whole, when you look at it across the planet, it becomes an almost inconceivable problem to solve. But we just need to take it a step at a time and one of the pieces is establishing that index, that central registry. And I think some folks have attempted it in limited scopes, but we've never attempted it in a larger scope to bring documents together in that way and I think hopefully that this committee will tackle it at some point in time. Thank you.

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

Thanks Raj. Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Thank you and thanks for the presentation. I have a few comments. The...first of all, I really appreciate all the work that's gone in on this, one of the items mentioned has to do with patients. But I still see a tone in the presentation of what the clinician needs and what the patients need rather than the what being something larger that all stakeholders need. I would argue that the physician has to know as much as they can about the patient in order to be effective and the patient needs to know as much about what the doctors thinking in order for them to be participating.

So I would encourage that we look at two things; one is, the vocabulary that's mentioned, we should also start getting ahead of the game with the consumer vocabulary and think how that this we can translate consumer ideas and cross into medicine. And I would be happy to be involved in any task force that looks at that.

Also, on the usability, it's really important to consider usability and user-centered design for patients, not just providers and making sure that all stakeholders have equal emphasis as we make these recommendations. And I would also submit that when patients enter data it is very much clinically relevant, it is not non-clinical data; it might be non-dictated, not generated in a clinic, but patient-generated data is all the data we have, it's either a finding, an observation, an interview or now the ability for patients to add information.

So it is clinical data, there's demographic data, there's data about person's values and goals and beliefs that are all material to care, so let's think about things more holistically and specifically on your page 7 and 8 and 10, let's make sure that all of this is not just around clinicians, but also useful to individual patients and family caregivers.

One other item, Andy mentioned about cost and benefits; we need to look at what would efficiency do to healthcare and if efficiency included the patients interacting with the ecosystem, the caregivers interacting, then we would be able to collectively improve...system and bring efficiency there. It's not the cost of doing the task; it's eliminating the task that could be the most profit...Thank you.

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

Thanks Leslie. Rich Elmore?

Richard Elmore, MA – President, Strategic Initiatives – Allscripts

Great presentation, very thoughtfully done. I had a question for the task force. There were some eight different priorities that you weeded down to three that are shown here and I was just wondering if you could explain how you got to those priorities? Some of the other ones seem like in a certain respect they might be prerequisites, you know in terms of you need to do those first before you can get to some of these, and so I was just wondering if there wasn't a drag-along effect to some of the others that weren't prioritized and how you arrived at this list, short list? Thank you.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Absolutely. This is Jitin; I'll respond to that. That is an excellent comment, Rich that's...that actually was a point of much discussion, that exact point that there seems to be in some senses a little bit of a chicken and egg between....sort of interplay between some of those buckets that we outlined, in the eight buckets we outlined. And what we...the way we thought about it, and then I'll separate the way we thought about it versus the process we got to, to actually us outlining the three.

But the way we thought about it was, there is...there are aspects which are directly the repercussion of demand, it's what the users are saying or the users are feeling is preventing them or discouraging them from interoperating. And then there are aspects which enable that interoperability to happen. And what we decided was yeah, the three buckets that we chose, or that our process led us to choose, focused on those things which were nearest to what that deman...what the demand issues were.

But we absolutely acknowledge that as you delve deeper into those demand issues, what you may uncover is that there are root causes, and I think that also goes to Raj's point earlier, that stem from those other buckets, that they're act...you know, you cannot do "X" unless you have done you know, "Y" and "Z" or maybe I should say that the other way around, you can't get to "Z" unless you've done "X"

and “Y” first. And...but we decided we were going to focus on that place where historically where there’s not...we think that...first of all we don’t think there’s been enough focus and second of all, that was closest to our mandate in thinking about the demand for interoperability.

And so when we...and the process we used to get to those three buckets was just straightforward vote and then discuss. And when we voted through it based on what the task force members themselves understood and what we learned from the virtual hearings, these three buckets actually came up to the top by a long mar...by quite a margin above the remaining five. So, we didn’t actually have a predetermined number of sort of buckets we were going to go after, but those three clearly bubbled all the way to the top and we realized it’s because those are the three that are closest to the issue of the user demand, even though as you just so articulately said, it actually you know, solving those issues may require you to think about some of those other buckets as well.

So it was more a mechanism for us to identify those issues which were closer to demand than they are to say that three were more important, per se than the other five.

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

Thanks for clarifying...

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Michelle?

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

...Jitin.

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

Yeah.

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

Jamie Ferguson?

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

Hi, thank you. So first of all I want to commend the group and thank you for a good report. My comment is, I want to recommend a small change to focus finding number three, and that is to add the words “relevant to a health condition.”

But I also, first I want to explain the context and the reason for the small change. And you know there are at least three distinct types of patient-generated health data that are commonly considered. First there are one time electronic questionnaires, then there’s data from consumer grade general wellness devices, and then third there are professional grade monitors for serious health conditions. But the recommendation is not specific as to the type of PGHD and the only evidence of clinical efficacy refers to professional grade monitors for people with conditions such as diabetes or congestive heart failure.

And so I think the recommendation should differentiate between PGHD which has been shown to be useful and that which is not. So our experience at Kaiser Permanente is that patient engagement occurs when the tools and the data are relevant to a particular patient need and not something that is thought to perhaps have a generalized potential benefit. And so I think a more reasonable recommendation would center on providing means for the collection and use of patient generated health data when

there's agreement between the patient and the provider that this is a good thing to do in a specific use case.

And another part of rationale for this is that there's a real problem physicians face dealing with the signal to noise ratio due to both excessive alerts and other noise in the EHR and so adding to the noise by receiving unsolicited patient-generated health data that's not relevant could actually result in poor patient care because attention would be given to information that's not relevant to the management of the patient care and would take away from a more focused approach to medicine.

So...and a last thing on this is that the liability for holding unsolicited data should also be considered. And so again, my recommendation is just to add a very few words to say so number three would read, "Work is needed to better understand how to deal with patient-generated health data, PGHD that is relevant to a health condition as interoperability includes PGHD. Thanks.

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

So this is Kathy and I'll take that as an offered amendment to the report and since these are recommendations that we will be voting on, to be able to consider that and to then have further discussion, do we have a second for that suggested amendment? And I'll read it, and please correct me if I didn't write it down fast enough; "Work is needed to better understand how to deal with patient-generated health data, PGHD, related to a particular health condition as interoperability includes PGHD and then the clause in parentheses.

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

Yeah I...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd, I'll second.

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

Yeah, I said relevant instead of related but I think either is okay.

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

Ah relevant is fine, so we'll say "that is relevant to a particular health condition.

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

Thank you.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie are we going to have discussion on this?

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

Yes. So Michelle is there a way...

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Okay.

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

...we will definitely have discussion of any amendment; especially this has now been seconded. So Michelle, is there a way to reset and have people speak only to this proposed amendment? And it would be reset the queue in terms of hand raising?

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

We certainly can. It was only Floyd and Leslie that were left based on the...

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

Okay, so Floyd do you second it, maybe...

Donna R. Cryer, JD – Founder and President – Global Liver Institute

This is Donna Cryer, I'd also like to...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Actually mine was directly related to this issue, so I wanted to support one Leslie's and two Jamie's comments. One thing that concerned me was the comment that patient-generated health data was nonclinical and I thought that that was problematic, even behavioral health information may be clinical and clinically related. I think the amendment is reasonable because it talks about research being done and getting more information, so I think that's valuable.

One thing that I know has been problematic especially in clinical quality measures that have been applied electronically is they're often looking for such information as exceptions, exclusions or even inclusions and that creates a real burden on providers to enter something that they're interpreting from a patient when it's the patient's information that should be driving that decision. So...and I understand research is needed to see the value, but if it's in a measure hopefully there's been some evaluation that that has value. So that's why I would support the amendment, especially to the extent where it removes the term nonclinical data from what's listed there. Thank you.

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

And so then you're act...so here we go, Robert's Rules of Order. So you are actually suggesting deletion of that clause in parentheses; is that correct Floyd?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Actually that's right; sorry, I...that would be an addition, right...an amendment.

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

Okay, so I'll ask then if the original proposer considers it as a friendly amendment.

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

Yeah, this is Jamie, I will accept that.

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

Okay. And then Leslie Kelly Hall?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yeah thank you very much. I guess that I have a very strong reaction to the idea that what's relevant is only in the eyes of the provider. The patient's voice, the patient's narrative that the patient wants the physician to know may actually provide additional information, new discussion, new findings that they wouldn't have otherwise. So although I don't...I agree with Jamie that we still don't know about what to do with all this data, but I think we will all be burdened...a patient, a provider to understand how to curate data because each data point is valuable, even if it's in...(indiscernible, background noise)

So I disagree with the idea that the only thing being added in patient-generated health data is what's relevant to that care because it's might be relative holistically to the patient, not just to that particular encounter or episode. So I don't believe we should be filtering as a form of policy what we think is right or what to include. So relevance is in the eyes of everyone, not just the provider...like if I just... (indiscernible)

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

Thank you, Michelle? Do we have others with comments and I can't see the list and so if you could go through them that would be great.

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

Yeah, there are two more people in the queue. I just want to see where...have we landed on this part yet...go ahead Paul.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health
And I'm commenting on the amendment.

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

Yes, that's all we're open for right now is comments on the amended recommendation.

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

So Elaine and Donna, are you making comments on the amendment?

Donna R. Cryer, JD – Founder and President – Global Liver Institute
Yes.

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

Is that Donna?

Donna R. Cryer, JD – Founder and President – Global Liver Institute
Yes.

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

Okay, go ahead Donna.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Thank you. So I do support the amendment because it does place an extra emphasis on patient-generated health data and I support Leslie Kelly Hall's very articulate defense of that and would go a point further, as someone who has been actively engaged in teaching clinicians the relevance of patient-generated health data.

So I think I support the amendment, but I think for reasons other than how it was originally proposed. I think we should not foreclose at this very early stage our imagination and our ability to understand how patient-generated health data, both coming from...directly from wearables and APIs and others as well as patient statements can in fact be used very effectively to make clinical decisions.

And so I do speak in favor of the earlier comment that would have restricted, and I thank you for the change in the amendment because I think there's a variety of data that can be relevant to clinical decision making and care and I think that we just have begun to embark and to teach providers the different types of information that patients can provide through various methodologies that are very relevant to the care process as well as to non-care processes.

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

So Mich...thank you Donna and Michelle, I want to be sure that the recommendation number three, if you could read it to us as it currently stands because it includes the addition suggested by Jamie, which has been seconded and the deletion of the last clause in parentheses, which was viewed as a friendly amendment. And so if you could read it, I want to be certain that...

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health
Kathy, could I propose that you...

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

...when people speak in support that they have it fully in front of them.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health
Kathy, I still have a...

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

I think Paul has a comment first.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health
...comment.

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

Sorry.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health
And maybe I can help with the wording.

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

But I will admit that from Donna's comments, I heard two messages; one was in support of Leslie Kelly Hall's comment, the other was in support of Jamie's amended or amendment.

W

And my understanding is the amendment was accepted, so that's how it's currently reading.

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

The amendment has not been voted on yet, and so we're still at the point of discussion.

W

Okay, thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

Kathy I...this is Paul Tang.

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

Yes.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

I've gotten lost with all of the...may I suggest something for your consideration as a rewording of the proposal that I hope is incorporating the different thoughts and that is, "That work is needed to better understand how to deal with patient-generated health data, clinical and nonclinical." Does that incorporate the proposals to change?

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

It certainly would to me, is that the view of Jamie?

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

No, that...I think Paul that frankly that kind of seems to have missed my main point which is that first and foremost work is needed to better understand how to deal with PGHD that is relevant to a health condition.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

And how is that different from clinical versus non...clinical and nonclinical?

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

Well, because if you only say clinical and nonclinical and not relevant then you get into the signal to noise problem and liability issues and the other things that I mentioned.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

But how does an individual...how do you...how does an individual filter themselves if they think it is relevant, then why isn't it?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Exactly.

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

So Jamie, do you want to respond to that and I'm going to try and...?

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

Yeah, I'm not suggesting who filters or how but that the focus should be on PGHD that is relevant to a health condition.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

But there...it's person-generated, it doesn't...so I don't know where you're...how you're planning to filter or how applying a filter in this finding helps.

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

This is Colonel Scott, forgive me for breaking in but I think what is important is what becomes part of the health record for which the covered entity is responsible. The paradigm for...has always been to listen to everything the patient says, of course that's important, but clinicians and covered entity staff have determined what becomes part of the health record. The filtering is on what becomes part of the health record; it's always been the responsibility of the clinician to listen to the patient. Thank you.

Paul Tang, MD, MS – Vice President and Chief Health Transformation Officer – IBM Watson Health

I feel like you're...so I think that...

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

And this is Kathy and I'm going to pose a question to the group to see if this holds water which is to say that our discussion right now is actually reinforcing in whatever way we ultimately vote on it, item number three. Which is to say that work is needed to better understand how to deal with patient-generated health data, PGHD. And so...

M

Maybe you should just end it there.

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

And I...and that's what I would suggest. It's awkward for me as the Chair, but I think that our discussion is certainly pointing out how acute that need is.

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

I can support that.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Yeah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I can support that; this is Leslie.

Donna R. Cryer, JD – Founder and President – Global Liver Institute

Yes, this is Donna as well.

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

So then I'll take that as seconds to that revised shortened amendment, and then ask if there is any further discussion of it.

Elaine Hunolt, FACHE, PMP, CPHIMS – Co-Director, Interoperability Office – Veterans Health Administration

So this is Elaine, I'm from VA. I agree is that that's certainly the better topic is to end it with patient-generated health data period. But I also want to point out that the recommendation number one should also apply to patient-generated health data as we look, you know we just need got a narrow look into, we're focusing on how patient-generated health data's used for the clinical purpose.

But from the patient perspective, it is a huge problem, and I don't want to go down the too narrow path on this but, it is a huge problem now because patients have multiple portals and when they show up even at a visit, they're expected to have much of their homework as well. So there's actually, just as there's a burden of clinical data import, there's also now a burden on the patient with multiple sources of data, too. So some recognition that that topic also funnels into a huge expanse that we need to consider is the burden on the patient. But I agree with the shortening the statement here as far as the work that needs to be done; agree, lots of work needs to be done.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie, I agree with that, item number one should...the idea of curation, reconciliation should include all stakeholders.

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

And so other comments with regards to maybe we can finish up on item three and then we'll go back to the full set, one, two and three?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Just Floyd with a supporting comment; I think number one reconciliation should apply as well to patient-generated health data, not just what you might consider clinical, non-patient sourced. I would agree.

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

And so would it be acceptable to the committees if we said around clinical information and patient-generated health data? So to specifically call that out or say including patient-generated health data?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd; personally I would prefer including rather than calling patient-generated health data nonclinical, including sounds better.

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

Sure.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Yes, that sounds great.

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

Comfortable with that, and I'm going to circle back if I could before we then vote with these modifications and just ask the Co-Chairs of the Task Force if they're comfortable with these modifications to their report.

Anjum Khurshid, PhD, MPAff, MBBS – Senior Health Systems Strategist – Louisiana Public Health Institute

Yeah this is Anjum and yes we are, in fact it reminds us of a lot of discussions we had in the task force on each of these bullets, so thank you.

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

Testimony to your hard work and Jitin?

Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance

This is Jitin; I agree with Anjum's comment that yes, we are good to go.

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

Okay and are there any further comments on findings one through three before we vote on them with the modifications? I will take silence as saying that we are ready to vote. So Michelle if you could start the vote for us and do you want us to do it electronically for you?

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

Yes, thank you Kathy. If you all can see where you've been using to raise your hand, there's also a red and green. So if you're voting to agree, it's the green check; if you're voting to disagree, it's a red "X." And I'd actually like it if you could all give me time to tally up everyone's vote and while we do that, we'll turn it over to Steve to make a few...to share a few ONC updates and then we'll come back and make sure that everything was approved.

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

Michelle, this is Gayle; I can't vote electronically right now, could I just register a yes.

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

Okay, thank you.

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

Do we have any others who need to do a verbal vote? If not then we'll go ahead and vote electronically and turn things over to Steve.

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. I feel like I'm the commercial break as part of the voting. All right hi, I'm Steve Posnack, the Director of the Office of Standards and Technology at ONC to give you a brief ONC update today.

First I'll just touch on the Interoperability Standards Advisory 2017; we have published that for public comment, comments are due middle of October and I want to thank all of the continued efforts for that task forces work. Many of the early recommendations have been integrated into the recent publication that we put out. You'll notice that we are shifting from a PDF-oriented format to a more web-friendly oriented format, but for those of you that want to grab a piece of paper, there is a printable version. And as we continue to evolve to have this be more web-based and interactive over time, we'll still be

working on ensuring that there's a printer-friendly option for those that want to kind of print out the full compendium.

The other thing that we were able to do in this first release, really looking toward the end of the year as the full kind of web interactive approach is include links to the Interoperability Proving Ground, which as part of my other Public Service Announcement, you know it has over 310 entries, over 200 that are active project entries and close to 708 that are completed. That's really a new connection that the web approach enables for us, in terms of connecting the standards that are referenced in the ISA to real-world implementation work that's ongoing using those standards.

So that's about it right now for the Interoperability Standards Advisory, but real positive trajectory, a lot of work going forward to help integrate this and make it more accessible overall for the stakeholder community. So keep it up ISA Task Force.

The next thing that I wanted to briefly touch on is that many of you may be familiar that we put out a challenge related to blockchain and healthcare. We are cosponsoring with our colleagues at NIST a workshop, which is during Health IT Week, the 26th and 27th. We received a lot of papers, over 70, picked 15 winning papers; a number of those folks will be presenting at the workshop.

It covered a wide range of topics in the privacy and security realm, Medicare and Medicaid payment and programs, the health internet of things, precision medicine, research, records management. So a real diversity of opinions and thoughts around blockchain in healthcare and as Arien mentioned in the beginning, really an intersection of timing, topic and the kind of thought maturity around, you know like what is the relevance of this type of technology in healthcare?

And then the last thing that I wanted to touch base on which wasn't on the agenda, we recently closed and had submissions for the first phase of the Move Health Data Forward Challenge and I'm pleased to announce that there were over 2 dozen submissions. We are going through right now for our kind of completeness review. And this is the first phase so applicants needed to submit a description of the technical, operational, financial, business aspects; the participants that are part of their project.

This is really a preparatory phase and 10 winners will be selected out of this phase to continue on to phase two, and that we hope will be...we'll hope phase one will be concluded and those applicants will be notified by the end of October; so, lots to look forward to this fall and thank you very much for the time.

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

Thank you and I'll just keep going along. Michelle, do we have the results of the vote?

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

I'm still counting them up, but there's nobody that disagreed, so I mean it definitely has approved. There's a few folks what are either no longer on the line or have abstained, so I'll just follow-up with them, but otherwise it has been approved.

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

Then I think you can go ahead and open for public comment.

Public Comment

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

Thank you, Kathy. Operator, can you please open up the lines?

Jaclyn Fontanella, MPH – Digital Project Manager – Altarum Institute

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

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

So while we wait for public comment, I just want to thank you all. Again hope you all had a wonderful summer, welcome back. And we will have an in-person meeting on October 5, so I look forward to seeing you all then. Fall will be in full swing by then hopefully and I wish you all a wonderful rest of your day because there are no public comments. So thank you all and we'll see you in October.

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

Thank you Michelle.

Public Comment received during the meeting

1. **David Tao:** Regarding what patients regard to be "of value," I wish to call the committees attention to an article published in JAMIA on August 7, 2016, entitled "Patient and Clinician perspectives on the outpatient after-visit summary: a qualitative study to inform improvements in visit summary design." This deals with the exact question that the committee is asking about, and is based on interviews with patients using clinical summaries given them by providers.
2. **Thompson Boyd:** Thompson H. Boyd, III, MD, Hahnemann University Hospital in Philadelphia, PA. Comments regarding slide #10. PGHD also includes the Patient's Narrative: the patient's story, the patient's preferences, the patient's wishes - all part of Shared Decision Making.
3. **Donna Doneski:** NASL is pleased to hear that ONC outreach on the Patient Engagement Playbook will include vendors. As a national association representing the majority of health IT vendors serving the LTPAC community, NASL would be pleased to highlight ONC's outreach and share information with our members about the Patient Engagement Playbook. Please include us in whatever you do in terms of vendor outreach. Thank you. Donna Doneski, Director of Policy & Membership National Association for the Support of Long Term Care (NASL)

Joint Committee

Name	09/13/16	07/27/16	06/23/16	06/08/16	05/17/16	04/19/16	03/10/16	01/20/16
Aaron Miri	X	X	X					
Andrew M. Wiesenthal	X	X	X	X	X		X	X
Angela Kennedy	X	X		X	X			X
Anjum Khurshid	X	X	X	X	X	X	X	X
Anne LeMaistre	X	X	X	X	X	X	X	X
Arien Malec	X	X	X	X	X	X	X	X
Aury Nagy								
Brent Snyder		X	X	X		X		
Carolyn Petersen	X	X	X	X	X			
Chesley Richards			X					
Christoph U. Lehmann	X		X	X	X		X	X
Dale Nordenberg	X	X	X		X	X	X	
David F. Kotz		X			X		X	X
Devin M. Mann	X							
Donna Cryer	X	X			X	X	X	X
Eric Rose	X	X	X	X	X			X
Floyd Eisenberg	X	X	X	X	X	X	X	X
Gayle B. Harrell	X	X	X	X	X	X	X	

Name	09/13/16	07/27/16	06/23/16	06/08/16	05/17/16	04/19/16	03/10/16	01/20/16
James Ferguson	X	X	X	X				
Jitin Asnaani	X	X	X	X	X		X	X
John Scott	X		X	X	X		X	X
Jon White	X		X	X	X		X	X
Jonathan Nebeker	X	X	X					
Josh C. Mandel	X		X	X	X	X	X	X
Karen van Caulil	X	X	X	X	X			
Kathleen Blake	X	X	X	X	X	X	X	X
Kay Eron	X	X						
Kevin B. Johnson						X	X	
Kim Nolen		X	X		X	X	X	
Kim Schofield	X	X	X	X			X	X
Kyle Meadors	X	X	X					
Larry Wolf	X	X	X					
Leslie Kelly Hall	X	X	X		X	X	X	X
Lisa Gallagher	X	X	X	X		X	X	X
Lorraine Doo		X	X	X	X	X	X	X
Nancy J. Orvis		X	X	X		X	X	X
Neal Patterson		X	X			X	X	
Patricia P. Sengstack	X		X	X		X	X	X

Name	09/13/16	07/27/16	06/23/16	06/08/16	05/17/16	04/19/16	03/10/16	01/20/16
Paul Egerman	X			X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Peter Johnson	X	X	X					
Rajesh Dash	X	X						
Ram Sriram	X	X						
Richard Elmore	X	X	X	X			X	X
Scott Gottlieb	X	X	X		X		X	X
Steve H. Brown	X	X						
Terrence O'Malley	X	X	X					
Troy Seagondollar	X	X	X	X		X	X	X
Wanmei Ou	X	X	X					