

# HIT Policy Committee Transcript March 11, 2014

## Attendance

Members present:

- Christine Bechtel
- Neil Calman
- Terry Cullen for Madhulika Agarwal
- Arthur Davidson
- Karen DeSalvo
- Paul Egerman
- Judith Faulkner
- Scott Gottlieb
- Gayle Harrell
- David Kotz
- David Lansky
- Devin Mann
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Joshua Sharfstein
- Robert Tagalicod
- Paul Tang

Members absent:

- David Bates
- Patrick Conway
- Thomas Greig
- Charles Kennedy
- Aury Nagy
- Alicia Staley

## Presentation

### Operator

All lines are bridged.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is the meeting of the Health IT Policy Committee and it is the 57<sup>th</sup> meeting of the Health IT Policy Committee. There will be time for public comment twice today, once before lunch and once after lunch. As reminder to those making a public comment, it will be limited to 3 minutes. This meeting is being transcribed and recorded so just a reminder to all our participants, if you could please state your name before speaking, we would appreciate it. If you are planning on tweeting today, the hashtag for today's meeting is #HITPC. And with that, we'll take roll, but we'll do it by going around the room, so we'll start with Jodi.

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

Jodi Daniel, ONC.

**Judy Murphy RN, FACMI, FHIMSS, FAAN – Deputy National Coordinator for Programs & Policy – Office of the National Coordinator for Health Information Technology**

Judy Murphy, ONC.

**Doug Fridsma, MD, PhD, FACP, FACMI – Chief Science Officer & Director, Office of Science & Technology – Office of the National Coordinator for Health Information Technology**

Doug Fridsma, ONC

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

Devin Mann, Boston University.

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

Marc Probst, Intermountain Healthcare.

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

David Kotz, Dartmouth College.

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

Judy Faulkner, EPIC.

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

Paul Tang, Palo Alto Medical Foundation.

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

Karen DeSalvo, ONC.

**Paul Egerman – Businessman/Software Entrepreneur**

Paul Egerman, software entrepreneur.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Art Davidson, Denver Public Health.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Terry Cullen, VA.

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

David Lansky, Pacific Business Group on Health.

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

Deven McGraw, CDT.

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

Troy Seagondollar, Kaiser Permanente and Labor Representative.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Elise Sweeney Anthony, ONC.

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

And is there anyone on the phone?

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

Robert Tagalicod, CMS.

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

Scott Gottlieb –

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

I heard Robert Tagalicod, was there somebody else?

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

Scott Gottlieb, sorry.

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

Thank you.

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

And Josh Sharfstein.

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

Josh Sharfstein?

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

Right.

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

Anyone else? Okay, with that we'll turn it over to you, Paul and Karen.

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

Over to Karen.

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

Great. Well good morning everybody and welcome back to Policy Committee. We have – as you can see, a really full and exciting agenda today, lots of good things to discuss and talk about. I just have a couple of comments I wanted to make. First is to apologize, I have to leave at around 11:00 to go take care of some things that is beyond my control, and then I will be back, as soon as that is finished. So, I apologize for missing a part of the meeting, but I'll be back as soon as I can get here.

So the second thing is, we had a couple of organizational changes at ONC last week that – since many of you interface with us, I just wanted to make sure that you're informed about. We had – I have asked Dr. Jacob Reider to serve as the Acting Principal Deputy. So Jacob will be – as you all know, he was the Acting National Coordinator for a time. He has a great visibility across the organization and is helping to – for some continuation of that work. I've also asked Josh Brammer, who was the Special Assistant to the prior National Coordinator to take on a role as the Acting Chief of Staff. So Josh is still with us, but he's going to be working on coordinating – there's Josh there...across our efforts at the ONC to make sure that we are aligned in everything we do and easier for you all to interface the work that's happening across our various programs.

And then I have a new number of the team, Ayame Dinkler, who will be my Special Assistant, so I'm sure everybody will want to get her card. And she – most people know Josh; he's been with us for some time. Ayame's new to Washington, again, she came from California, then she was in DC on the Hill, then she was in New Orleans and for a time was my Chief of Staff when I was Health Commissioner, and she has agreed to relocate to join us on the ONC team. So just a few changes there I wanted to make you all aware of. And Dr. Reider is on vacation this week, that's why he's not with us, which is very well earned and deserved on his part. Great, thank you all very much.

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

Thank you Karen, and welcome Ayame. Okay, so we'll go over the agenda. So today, we'll start out with Meaningful Use Workgroup hopefully final presentation of the Stage 3 recommendations. There's still more feedback to go. Then CMS and ONC will update us on their data and Jennifer is responding to the Committee's request for more information about the participants in the EHR Incentive Program. We'll have an update on the Health IT Workforce, it has to do with coding, occupation codes so that we can track the workforce and it's – the supply and demand there. We'll then be having public comments, go to lunch, come back and talk about the voluntary – begin the discussion about the voluntary certification program in long-term and post-acute care, as well as behavioral health. So this will be some draft recommendations. If we pass this here today, that's fine; otherwise, they'll come back in April for final approval.

Any other changes to the agenda? And any changes to the minutes that were distributed previously? If not, I entertain a motion to approve the minutes.

**Paul Egerman – Businessman/Software Entrepreneur**

So moved.

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

Thank you, Paul. A second?

**W**

– a second.

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

Okay. And any other changes? All approve?

**Multiple speakers**

Aye.

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

And any opposed or abstain? Thank you. And so – did you have something else Michelle? It looked like – okay. Then, we'll begin with a Meaningful Use update and I'll switch chairs.

So Madame Chair, first I want to point out that it is probably more than coincidence that we're going to have 70 degree weather in Washington, and I can't do anything about tomorrow's weather, storm coming in. While this is the 57<sup>th</sup> meeting of the Committee, it only feels like the 50<sup>th</sup> presentation of Meaningful Use Workgroup presentation of recommendations. So, we're back and I hope you'll see that we've been very responsive to your feedback. This – as a reminder, this is a list of a very hard working group, the Meaningful Use Workgroup, many of which have been here from the start and have a long history of dedicating service to the agenda and to the country. So, I want to thank them. So we're going to talk about the feedback we heard from you, as well as the public. We went through and thoroughly re-vetted all of the recommendations and you'll see significant changes and present those revised recommendations to you, hopefully for your approval today.

So some of what we heard last time was that interoperability is the top priority. Interoperability is the technical term, really the top priority is the exchange of information to improve care, and we want to not lose sight of that. For that reason, the four emphasis areas, which you saw and approved of last time, were clinical decision support, patient engagement, care coordination and population management. And then I'll go into a little bit more detail on the next slide. We want to be careful that in the balancing act we weigh the impact to providers, the impact on their workflow. Because they, in fact, obviously do the

Work on the professional side and we can't burden them unnecessarily. Want to be as flexible as we can be, consider the needs of specialists.

At Paul Eggerman's request, we have – we did reconsider the certification only requirements. And he was a part of that discussion and we only have one to present to you today. We wanted to avoid requirements where the standards were not mature and we did act on your advice back in terms of consuming external knowledge, although that's an important concept, it's not ready for prime time now. So we've reduced that or restricted that one domain only, and that's immunization. And always cognizant of the importance of usability in the usefulness and the efficiency with which these systems are used. So the process, we basically took your word of saying we want to reduce the number, we want to tighten the focus, we want to reduce the burden on the providers and rely on more mature standards.

With that what we did, one is to tighten the focus. Clinical decision support is probably the most studied and the most written about function of an EHR, so that's really the biggest tool we have to improve outcomes in patient health. Patient engagement is so important and now that we – and thinking a lot the Meaningful Use Program, now that we have health data available to patients, we want to make sure they have the tools to make use of that health data, along with their professional team. Care coordination is a hard thing, but it's one of the most important things that we have to do and that this technology can help with. And population management is important as we focus on the population's health, not just taking care of each person at a time.

So, we put together the matrix and we used Judy's suggestion, although we had worked on each of these areas separately, we wanted to put them all in one place. So we created a matrix that had additional columns to make sure we looked at the burden on the providers, that we looked at the development effort, that we looked at specialist's needs and that we look at the maturity of standards, all in one place. So, we put that matrix together, or Michelle put that matrix together and we – each of us voted individually. And then so we tallied the votes and then had a group discussion thinking about each one of these attributes. And of course, it's not going to be a clean slate – clean – all the things line up all the time. There's always a balancing act that has to go on and we discussed that in the workgroup to achieve the recommendations we're going to percent.

So to start off, we looked at things that didn't necessarily fit the bill for as much of those things we talked about as possible. Did they concentrate on the four emphasis areas? Did they have mature standards, etcetera? And so we were able to eliminate, and this is a tough thing, we've been through this for many years and a lot of people have vested interest in some of these – some features. But, we were able to agree to remove from our recommendations that we're presenting to you, 8 of them, 8 out of 26, so 30%. So that's a significant reduction in the number. So that leaves us with 19, the math doesn't quite work out because there's one of them where we split, so there are 19 and actually, that's down from 20 in Stage 1 and Stage 2, and actually there are some menu in here, too. So we believe we have reduced – significantly reduced the total number in an effort to one, focus and two, reduce the burden.

We're going to go through these with you today and we're going to focus – now the color's not coming out very well on this projector, but we're going to focus on the ones where there is a high – one of the three main categories, the effort required by the provider to use, the development effort or the maturity of the standards. Where one of those were unfavorable, then we're going to discuss that in more detail with you and then talk about the others as well. So, in this first category, the things that are still have some high level of effort required by some party is clinical decision support, order tracking and some demographics. So let's go through those. Clinical decision support – and take it away George.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Let Paul save his voice for a little bit of the rest of the presentation. Hello all, thank you. And by the way, I feel good about this recommendation, I mean, when we started two years ago, this is where I felt we should be. It's actually fewer objectives, trying to reduce as much as possible without going backwards, yet still focusing on the areas that we really care about, we think have to be pushed forward. So we'll see, but with your help, I think that we've gotten to a good place in the total recommendations.

So first, clinical decision support, we have to include clinical decision support, we can't do Meaningful Use and not have clinical decision support, it's part of the – this is the lever we have on the whole quality initiative. I agree with reducing the number of quality objectives, but I think clinical decision support is important. However, based on your recommendations, we have pared down this objective; most notably the part about consuming external rules. I think the most difficult and controversial one is not in this part right now and I'm going to explain a little bit more about that later – when we get to public health. So what we have is, to produce a CDS intervention, so we're being more general, it doesn't have to be a reminder or an alert, but any kind of intervention, has to belong to four of six categories.

And then we just asked, on the right side and we clarify this because I think there was a misunderstanding about the difficulty of that first certify – what's listed as a certification criteria. We simply ask that the system be able to track when they sent a recommendation and if it offered an option to perform an action as part of the recommendation that it logs, whether the provider did it, clicked on the button or did not. We are not asking for any indirect evidence that the person is following the advice, because that would be too difficult. We really just want a mechanical thing here, so that's number one and two, the age-appropriate maximum daily dose that we discussed in the past. So – and that's the one kind of new thing and I believe that's probably the reason why development is high, you see in the lower right, is in red. So this is basically the recommendation you've seen several times before, but pared down under – on that right hand side.

Order tracking. Again, this is a new menu objective, which you've seen many times before about tracking orders, that is being able to close the loop. And what's changed from what we presented last time is there was concern that under the certify – what's listed as certification criteria that the EHR should figure out if this is an abnormal result. That is not what we intended, we simply meant, if a result comes in under the HL7 standard, is flagged as abnormal, be able to represent that to the user. We're not asking for any decision support or to be able to figure anything out, we just want to transfer the information that was transferred in the HL7 message to the user and otherwise, this recommendation remains the same. The difficult part of this one is matching the results that is matching the order that goes out to the result that comes back. But that is one of the big thing – reasons we're doing electronic health records, is to do that matchup because that's how we have many – publication after publication of results getting lost and patient's getting hurt. And so that's why we've left this one in.

And last, this is the one certification only objective that Paul referred to and it comes forward from the demographics, reducing disparities is one of our most important objectives. And we can't do it if we don't know what those disparities are; so this is the ability to capture the method of communication. We've already had that in the past for our patient engagement, to capture occupation and industry codes, sexual orientation and gender identity and disability status. And these are ones that were presented in the past. We really literally just mean the ability for some place in the EHR to capture these fields, we're using standards as defined by the Standards Committee.

And again, the reason it's in here still is because we can't track disparities without this. This does not mean – privacy issues were raised in the past, this does not mean that the provider is forcing the patient to answer these questions, nor are we forcing the provider to ask them in the first place. We simply want for a provider for whom these questions are important to their practice, that they have a place in the electronic health record to record the answer to these questions.

And then these are the four objectives that were deemed less – did not have high difficulty or emerging standards and the care planning, the advance directive. Accor – similar to our previous objective, although now having the ability to link to a document or store a copy. Electronic notes, we've eliminated the revision or track changes example. We simply suggest now that there be the opportunity to see – what's the phrase – what's new –

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

We actually just eliminated it.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– oh, we eliminated it totally. So we've eliminated the objective and we leave it up to the vendor to decide what's best in terms of tracking changes or watching the evolution of a note over time. And then hospital labs, just using LOINC is highlighted there. And then the new one that we presented in the past, unique device identifiers for devices. This is not certification only, this is a use objective to enter when you insert a device into the patient that you enter the device into the record and that has strong safety considerations.

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

Thanks George. So in Category 2, engaging patients and families in their care. The three areas to highlight that have some level of effort required are the view, download and transmit, the patient-generated health data and secure messaging. So we'll go over those in more detail.

VDT really – actually the change here is not a change in the functionality, it's only a change in the timeliness of it and that is from four business days down to 24 hours. That is – that does require a level of effort on the provider's behalf, but you can recognize the benefit. So, whether it is the person, the patient him or herself coming home and having the spousal inquisition, what did the doctor say? Or, there's some acute situation going on and you really do want to know what my instructions are, what are the changes, that kind of information. Or you're coming out of the hospital and everyone knows that the timeliness of getting information, the timeliness of changing the management is really important.

So that – we thought that that deserves as quick a turnaround as possible. It's in actually the provider's best interest to turn that around and what we call "close the chart" within that 24 hours anyway, it contributes to efficiency. So, this is one of those things where we did highlight an important use of the HER in contributing to patient health and patient outcomes.

The second one is patient-generated health data. You've heard us talk about this many times. It was our lifelong dream to have this available by Stage 3. You see because of the immature standards, or certainly the immature adoption of standards in the device space, we're not able to make a recommendation in that area. But we do want to include more and more information about what's happening outside our four walls, whether it's in the ambulatory care setting or the hospital setting, and getting input from the patient is one of those important things to do. So, even though there is some development work and there is work in the provider accepting and – this information and acting on that information, we thought it's really important as we bring patients onto their healthcare team.

And finally, secure messaging. The change here is to be able to help providers track the timeliness and the reliability of responding to messages. So, one, it's really to say, is there way to report on how – are we making sure that we don't overlook messages and are we making sure we're getting back to patients in a timely way? And bullet one under certification criteria is one of the ways to help with that tracking. Because you don't want to have to say that oh, just because you didn't respond to something when the patient wasn't expecting a response, would count against you. So that's one effort of trying to make the reports you get back more useful. It's sort of a QA and watching out for things falling through the cracks kind of report.

The other two, the visit summary really was just a clarification or you might even consider it correction. What we heard from testimony is that sometimes vendors are writing these reports, these visit summaries as a full dump and that's not helpful for a patient to get eight page summaries after each visit. So we specified it so that you could only include the things that are relevant at that particular visit, that's what that change is about. Patient education is a new item here is to have at least one different language, other than English. So you can start making that transition to becoming more and more – taking advantage as the technology becomes more and more useful to individuals, particularly those who don't speak English as a first language.

In improving care coordination, which as you know is one of our highlights in terms of areas of emphasis for Stage 3, certainly it was part of Stage 2. Summary of care at transitions and notifications are the two areas that are still challenging. So one, summary care, we tried to do a better job at describing transitions, there are three kinds, we got down to. One is you're transferring site, the other is you're consulting, you're sending out a referral request or, in closing the loop, you're returning a consult request note. And we heard from testimony from both primary care providers and specialists, they each want to know what the other is thinking. So the specialists are saying, please tell me why you're sending this patient? The primary care provider is saying, please let me know what you found.

So that narrative, the synopsis, what are you sending the patient for or what had I, as a specialist found is required, we're suggesting, in each one of these transfer documents. So there are only four requirements, the only – only the first one, this narrative synopsis is required for all transitions. The others, your – the provider decides what's appropriate and those include the patient goals, patient instructions and information about the care team that's known to you. So, there is some development effort required, there's some provider use effort required, but this really is central to both Stage 2 and Stage 3 if we're going to have care better coordinated, and that's one of the key things that leads to improved outcomes.

The second piece is a new requirement, it's notification; it still goes with care coordination. It's pretty hard to take care of someone as part of the professional team if you don't know they've gone to the ED or you don't know they've been in the hospital or when they're discharged and with what instructions and new meds and new problems. Or certainly, if they've died. So these are significant events that we'd like to have better coordination across the whole care team. And it's unusual that one organization has all of that data available in their EHR, so, we're trying to – we understand that it's hard to match patients, etcetera, but it's one of those things that's really important to care. And it's one of the things that EHRs should be a part of making better.

So here we've also defined timely. If you leave a word like that open to interpretation, you get all kinds of interpretations. So, in our RFC that we sent out quite a while ago, we had proposed two hours, people thought that was too long. You certainly don't want to make it two days then – otherwise you've lost the impact, so we're recommending here four hours. So we're moving now into population and public health.

#### **George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So in this area there are four objectives, the first two had higher development, the second two are objectives that we might otherwise have eliminated; however, there's a difference because they already exist from Stage 2 and even 1. However, these two particular objectives, there's a waiver if your local health department, say the state or at a local level, can't do it. So therefore we can't sit here and say that all providers have already been given the opportunity, or have been – anyone who's in the program has already done these, because they may not have. So therefore we're continuing them forward from before, but – without changing them, so no undue stress on the vendors, just to make sure that we fully cover the nation. Now, I'll discuss those first two that are higher development.

Immunization history, we've been working hard for two years to get immunization information to the health department, we can't improve the health of the public unless we get it back in the hands of the professionals. So this objective that you've seen before is to return the immunization information to the professional. The important thing here, compared to our last presentation, is that we not just clarified, we actually reduced the objective. As you see in red there, ability to receive results of external CDS pertaining to patient's immunization. So it no longer says to consume external rules, it's simply to receive a recommendation, that is, it's like receiving a laboratory result, not very different in difficulty than receiving the immunization history is to also receive the recommendation of what's the next immunization.

Registries, you've seen this objective before. This reduces us from the previous two registries, that is the cancer registry and the public health related one to this one. We clarify – we reworded, electronically transmit data from certified electronic health record technology in standardized form to one registry. In discussing this, our workgroup didn't really come to a complete consensus of whether this was too hard, or whether we continue with it. Some put forward that we went from one registry – two registries to one and therefore it's not greater difficulty. Others, I believe, and during the discussion period perhaps Paul, you could speak up. I believe it was the part about moving to C-CDA. The previous objective was CDA, but it was the cancer template CDA and not C-CDA, so that may be the more difficult part. But we believe that registries are important to population management, they're already part of Meaningful Use and that having this one is a reasonable step forward for population management.

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

Okay. And another one of our priorities is reducing health disparities. You'll recall from our discussion about deeming, and you'll notice that that is not part of our recommendations for Stage 3, it's still a good idea, but it's not included in our Stage 3 recommendations for timing reasons that we discussed previously. But we didn't want to lose the way we proposed, in terms of both reporting on and reducing healthcare disparities.

One of the things we proposed were – what we proposed was to have for the provider to select a CQM and stratify it by a disparity variable that's important in their locale. And that helps at least stratify your performance in an important – let's say diabetes is important in your catchment area and stratifying it by a disparity variable, let's say ethnicity, so you can better understand how your populations are being cared for and what the outcomes are so that you can target improvements to a specific group. That's still important, and we want to begin that process of using the disparity variables, as George mentioned, that we're now collecting, and to report on them so that you can both understand your current performance and improve upon that.

So in summary, we've taken very seriously yours – the feedback from you and the feedback from the public and reduced the total number by about 30%. We've focused, as you recommended, on 3 – 4 areas that we all agree on and we are relying on more mature standards. There are some things that we want to push, but some of the standards aren't ready, but we've carefully selected which ones are going to be the biggest “bang for the buck.” We're in this process of – we would like to have your feedback and approval of these recommendations that are going to ONC and CMS. This is just the start of yet another review process. The NPRM is due to come out this fall, from ONC and CMS, and then there's another comment period, which we will vigorously participate in, and then the Final Rule is expected in the first half of 2015. So with that, Madam Chair, we'll turn it over back to you.

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

Thank you Paul and thank you George. For those on the phone, this is Karen DeSalvo and we're going to go ahead and move into a discussion phase. I would just like to make a couple of broad comments. This being my third month in the role and having been now to the third Policy Committee, just want to nod to the workgroup and people who are not necessarily on the workgroup, but who also participated in this process to make sure that the voices of everyone were heard. And that we were as thoughtful as possible in balancing those voices and perspectives and I really appreciate the approach that you all took, trying to be as systematic and data-driven as possible, and I thank everybody for their ideas around that.

My framing comments are these. Meaningful Use is one of the many tools that we have to advance the agenda of seeing that we get health information in the hands of the nation so that it can be put to good use. It is a fifth of our economy, it's an enormous amount of data and that doesn't even include all the new data that patients and caregivers and others want to enter so that can be part of the care continuum and the voice that's being heard. So, Meaningful Use 3 is the next chapter, it's an important one, but it's not going to be the final chapter, nor is it our only tool.

And I want everyone to keep that in mind that we have so many other ways that we want to move this forward and major goal, as you all have been talking about, is to balance the need to drive standardization and the way that we capture information. To balance that in such a way such that we don't interfere with the practice of medicine, with the experience of medicine, with the opportunity for patients to have a voice and a vote. And for there to be sufficient market innovation so that we can drive the products and the continuum of care, information capturing and sharing to such a place that it is advancing quickly.

And so I think that you all have striven – been striving to do that. And so, that's just a general comment about the way we're thinking about it at ONC. And so with that, I'm going to close and just ask the Policy Committee if they have some questions for you all and let you all answer. And I'll start with Paul Egerman, who has his card up. And he's the only one, can that be possible? Of course not, there you go, Judy, Deven, Marc – Michelle, can you help me keep track of this. Judy, Deven, Marc, Christine, David, Troy – you got that, Judy, Deven, Marc, Christine, David, Troy. Paul first.

**Paul Egerman – Businessman/Software Entrepreneur**

Great –

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

By section that we went over rather than –

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

Ah, the systematic mathematician asks us to do it by section. You all want to do it that way, by section? If you have a broad comment, I'll let you go, if not, then we could back it up and maybe go by section that works for me. Thanks Judy. Yours is a broad comment?

**Paul Egerman – Businessman/Software Entrepreneur**

Well, I have a couple of broad comments before we go by sections, and one is, I look at the presentation – I mean first I want to say I agree with what Dr. DeSalvo said, that George and Paul, you've done a terrific job of running this group. And the group has worked with members who feel very, very passionately on a lot of the issues. This has not been an easy process and they feel passionately for a good reason, people are trying to do very good things. I was very pleased that Dr. DeSalvo said that this is not our final approach to the entire process. There are many things we can do so – because I sometimes fear that people were afraid if we didn't get into Stage 3, we're not going to see it, and that's not necessarily the case.

I do want to remind everybody that for – because of timing, Stage 3 will be implemented in 2017, so that means, on the Medicare side, it's on the penalty phase. In other words, there will no longer be incentive payments to help you pay for the system or to help you with the cost of deployment, it's more of an issue of you either deploy it or you take a haircut, is the basic message. And I think that should impact the recommendations, because these recommendations are in the same ballpark as Stage 1 and Stage 2 and I think they should be smaller if we're in the penalty phase.

I also want to make the recommendation – the observation that when we said we were going to delay Stage 3, there was an announcement made by Robert from CMS and from our Acting National Coordinator three months ago. And the reason to delay Stage 3 was to review the results of Stage 2 and to incorporate that into our recommendations. But, I have to say, we haven't done that and so in a lot of these areas, we haven't done that and we really should have. Because I think that those recommendations, like the last one you mentioned about registries, there should have been, for example, a discussion about well, what really was the impact of what we did in registries in Stage 1 and 2, was that good or not good? And that could help drive that.

And patient engagement, some things that we've done in patient engagement have worked extremely well and we should be proud of it. Some things are more questionable. And so we should understand that, because that could help us make better recommendations. So, those are my general comments.

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

Thank you Paul.

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

I'll respond, just to talk a little bit about the timing. One, the Final Rule, as we mentioned, won't come out until the – next year, basically. And so there's time that both ONC and CMS have to hear some of what's going on with Stage 2.

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

Um hmm.

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

That was by design. We're acting on the timeline given to us because the other side of the bridge is, people want as much time as possible to prepare. So we're trying to act in both ways. We want to give indication of where we are headed, for feedback there, and for signaling. As well – knowing that as the experience comes in, both ONC and CMS are going to take advan – take that into account as they prepare their final – work towards their Final Rule.

**Paul Egerman – Businessman/Software Entrepreneur**

If we actually had fewer objectives, they would need less time, is my observation. I still think for a penalty phase, there should be less here.

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

Thank you, Paul. So, if you want, Paul Tang and George, if you want to scroll back maybe in your slides –

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

Sure.

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

– and we could just take them in – if that's okay, unless other people who have their cards up have general comments. Do you have a general comment Deven?

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

This is Deven. I think that the only thing I wanted to say is that I know this was hard work from the couple of meetings that I was able to participate in. At one point I got off the phone and I described it as a scrum. Because people have their sort of sacred cows in this fight, right, and people gave some of those up in the service of coming to a good overall conclusion. So my own view is that we, as a Committee, should spend less time debating the merits of what got cut and what's still on the table and instead, if there are incremental things we need to fix, then we can fix them. But otherwise, I just want to say, really hard work and excellent job.

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

Thanks Deven.

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

Thank you, Deven. Marc?

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

Again, I think it's amazing work that you guys have done, but one of the comments is very similar to what Paul was saying around just learning. And, we've had zero opportunity to learn from 2 and I'm wondering, are we self-imposing the time frames that need to be out there. I mean, I don't think they're by statute that these things have to happen at the pace they're doing, I think they were created by some goals that we set. But that ought to be part of our learning too, is if we are doing things too quickly. And if I look at the numbers on Stage 2, which are just early, but they're single digits, so we know people are struggling to get into Stage 2, do we have to put all these things out here at the pace that we're putting it out there? Or could we do some very meaningful things that actually fit within what we're already doing. So, that was my general require – comment.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Just one comment to Marc and Paul; so, I appreciate those comments. The one thing is given the timing, it's a lot harder to put things in than take them out for ONC and CMS so if we eliminate something, it's going to be very hard for them to override – let's say it goes very well in Stage 2, it is much harder to put it in. If it goes slowly in Stage 2, they could throttle back more easily. So we're – and remember, if you look at the number of menu plus the number of core, we actually did reduce the number of objectives compared to Stages 1 and 2, 19 of the total including the menus, if you take half of those, the total was a smaller number. So like – well, that's the comment.

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

No, I appreciate that and I think that as they said at the outset, this is the beginning of a conversation. The sooner that we have this, the sooner the Standards Committee, for example, can really begin to give us some more concrete feedback about what's feasible and we can begin to work that process. But, don't want to see that we have any further delay, so I want to make sure we continue that pushing ourselves, and as he said, we can still have plenty of opportunity to continue to rethink if we need to, if it's not feasible. All right, any other general comments? Christine, then Neil, then David, everyone – okay, and so and then Judy's going to have the floor for all of them, apparently, she's got her spreadsheet out. So, Christine and Neil.

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

And I'm totally sure that going section by section is going to work as well as we might hope, because we're going to keep having to do this and take new names, so, maybe I'll make a general comment and we'll go back to the name queue –

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

Okay.

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

– would be my suggestion. I think I want to respond to what Paul Egerman was raising and I think we all agree that want to see people succeed in this program, but I think it's not as simple as what you're characterizing. If ONC and CMS follow the pattern they have previously, when Stage 3 goes live, the penalties won't be tied to meeting Stage 3 criteria. So right now they're only tied to Stage 1 and we don't know how that will progress, but I would imagine that it'll be either Stage 1 or Stage 2. So, I also think that by the time Stage 3 goes live, people will have received a lot of money to do this important work, if they got on the escalator – we used to call it the escalator, early, they will have, in the case of hospitals, received millions of dollars for this program. And providers will have, as well, received not maybe millions, but significant sums of money.

So, I think – and we were very – we were very explicit about trying to make Stage 1 and Stage 2 achievable, we backed them off as well. I think we've been reasonable this whole time, but part of the deal was that we knew we would get to more advanced uses of the technology given that we would see full incentive payments. And I'm not sure we have really gotten there yet until Stage 3. So, I think conceptually we've landed in a generally good place with respect to the focus of these criteria, so...

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

Thank you. Neil?

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

So, I'd like to say that in my opinion, we're going too slow, not too fast. I think that there's enormous innovation taking place all over the country using electronic health records and the longer we wait to push the standards and to push people to be doing the same thing across the country, the less value we will get out of all of this innovation. We know when people innovate in a million different directions that it takes a while for that stuff to consolidate and for standards to appear.

So for example, we're talking about being able to look at quality measures using some disparities criteria, but if we don't push the fact that we need to collect more different types of information in people's demographics, we're never going to be able to look at disparities information. And the more different ways that people collect that information, the less we'll be able to move forward as a country and be able to understand which popula – which parts of our population are really being underserved and are not achieving the same outcomes.

You know public health, we've been listening for years to how different places are developing different ways of processing and sharing the same information and that we don't really have national standards. And the faster we push for that to happen, the easier it will be for us to be able to collect that information from across the country. So, I think that having been part of this process, a lot of things have been withdrawn, but if we just keep slowing this down, I think we will have wasted billions of dollars of money and I think that this is not something we're asking people to do on a voluntary basis. We're basically putting incentives in place for people to help move this forward and although those incentives are for providers, they surely have benefited the vendor community as well.

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

Thank you, Neil. David?

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

Yeah, I'll echo the last couple of comments. I think, we will have already put in \$20 billion in public money and by 2017, its eight years into the program that we've been working on. So – and I think our goal has always been in Stage 3 to get to outcomes and now emphasizing interoperability, I think is exactly right. I know inside this forest there are lots of individual trees and bushes we've been whacking at, and I think the Committee has done phenomenal work at the individual detail analysis of the elements.

I'm really concerned that the aggregate doesn't achieve the goal of either documenting outcomes, enabling longitudinal care, enabling interoperability across the continuum and really, as Neil suggested, leveraging the emerging technologies by 2017. I feel like it's a rearview mirror process and I think we need to create some stage for much more aggressive forward movement in this model. And I'm particularly concerned about the external perceptions. I understand that the detail work is really important, but if the aggregate story doesn't say, we have a dynamic, modern, comprehensive, longitudinal healthcare management system that captures and manages information and allows people to be fully engaged in their care, we will have sent the wrong message after this very substantial public investment of everyone's time and energy.

So I think registries, the quality measures, longitudinal care management are really important domains that I don't think are adequately supported by the framework yet. And – we're talking 2017, that's really far out.

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

Any co – any feedback from you?

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

Let me – I'll – we're going to talk about our work plan next month and I think some of the things that at least Karen and I have been discussing, are along those lines. This is sort of preparing the land for – the landscape for what – the division you are trying to describe. I think more work for sure has to be done on the quality measures side, as an example, and we're trying to tee up – tee that up as an important area for 2014. So hopefully, weigh in when we discuss that next month.

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

Troy?

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

Are we on general comments or – questions?

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

If you want to do specific, then I'll – Judy has the specifics, so –

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

Okay, let's go to Judy.

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

And she has general, so and Christine has specific and so, if you have –

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

Yeah, but I have a couple of questions on – but there are always accolades to be handed out, but –

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

Well, not always, sometimes there's the opposite.

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

True.

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

Okay, then you're going to defer? Marc has a general, non-accolade. Accolades are welcome.

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

So, I appreciate the comments about going faster and I would suggest if you want to go faster, please do. Are we listening at all to what CHIME has to say, to what HIMSS has to say, what actual providers are doing out there? I mean, it sounds to me like our assumptions are, vendors are just sitting around taking the money and the providers are out there just taking their time off. And that is exactly not the message that's coming through, they're working incredibly hard and they're not making Stage 2, and now we're going to outline a whole bunch of things for Stage 3, without even looking at any of the data that exists from Stage 2, because there isn't any. And I think that was the point Paul was getting to, yeah, I think that's problematic and it's not Paul and George's problem. I love the list for Stage 3, I think those are exactly the kind of things we need to be doing, but we also need to pay attention to the fact that we have an industry out there that right now is pretty much hurting to try and get done what we've already put on the table for them to do. So, that was general, not an accolade.

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

Thank you.

**W**

(Indiscernible)

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

Is that Gayle? Gayle, are you trying to make a comment?

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

Yes, I'm trying to –

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

If you have the cards for the people who are on the phone, you could start to – to me.

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

Yeah, so Gayle, we'll put in the queue and if you can send me an email going forward if you have a comment, so we can make sure that you get in the queue.

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

Okay. I just want to follow-up on what Marc said quickly that I don't think we, as a Policy Committee have been saying that we don't hear what folks – that folks are having struggles and that they have concerns. I actually believe that this group has heard that and have been thinking about it. But back to this point of this is three years away, and we're thinking about what we might want to do with the specific Meaningful Use Program, as an opportunity to dir – to advance HIT in this space. It's not the only tool that we have nor the only place that any of us, I think want to go, predicated on the conversation we had last time.

So please don't – again say focused in this box is the work of this Policy Committee, the responsibility of the FACA is to think much more broadly and we will. But today's agenda is to give us something to begin to work with at ONC and CMS, so that we can move the process forward. I do believe that we need to learn from Meaningful Use 2 in a quantifiable way, not just a qualitative way, but the qualitative piece, I'll speak for myself, is not lost on me. Okay, Judy.

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

And I'll speak for the workgroup, it's not lost on the workgroup at all.

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

Okay, great. Thank you. Judy?

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

I want to talk about the criticality of what we're doing and I don't think it is slow or fast or whether it's – that's not the real question, I think it's whether it's right or wrong. And it's not the general topics that we have here, that's, I think, all right topics. It's when you get down to some of the specifics within them that you look at that you think, that's not right, that's not going to work, it's going to hurt instead of help. And I have heard several times the words, we're regulating healthcare IT here. And whether in fact you agree with it or don't agree with those words being said, I think that's really true. We are not only regulating healthcare IT, but because healthcare IT is your central nervous system. We are regulating healthcare and that's a huge, huge burden that we have.

And the biggest thing I have to say on this is, when I look at the people on the Meaningful Use Workgroup, what I'd really like to see is that a very large percentage of them were actually users 50% of the time or more. And I'd like to see that the other part on there were people who actually developed the systems and talked to users out there all the time, and found out what's going on. Not necessarily the marketing people, but the people who are the actual hands-on folks who when there's a problem, they're the one who shows up at the site. Without those right people on there, I think that there's too much of a danger of the details being mixed up in a way that in the end, we mess with that central nervous system and we get it wrong, and then the body doesn't work right after that.

And I've heard the analogy before of – in this meeting of a car that people can – when you go to get your driver's license, your car has to be certified and that's the same thing as this. But, everybody I think who makes up the rules for what makes a car certified or not, drives a car. The problem we have here is the people who are making up the rules on what the electronic health records do, are not a group of people who primarily drive the car. And I think we can see that the outcomes, the details aren't quite on and because of that, the whole thing is going to, I think, endanger healthcare more than help in some of these things.

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

Thanks, Judy. Do – so Gayle, on the phone?

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

Yes, I – first of all, I'm here from the users and thank you Judy for making that comment about listening to the users. As I've said many times, I tend to be the bottom of the puddle, people call me and really get the hands-on opinion and they tell me what's going on out there. And I can tell you, our providers are certainly struggling, and I don't know how many we're going to have that actually meet Stage 2. I was very pleased to see that there was a little bit of a back off on Stage 3. I think this is a long-term process and I couldn't agree more with Paul when he – Paul Egerman, when he says that we need to be very careful how we do this when we get into the penalty phase.

And I think we have a long way to go, there's going to be a Stage 4, there's going to be a Stage 5, I'm sure because fortunately electronic health records are only going to get better and we're moving down a road. The road is a long road and I think we have a long way to go and we do need to listen to the providers out there. We have ICD-10 coming down, we have – there's so much going on as we move to change healthcare in this country. The message needs to be, listen to the people on the ground, listen to what they are saying and we really need to be very aware. What good is Stage 3 if nobody gets there? Let's make sure that people can get there. Thanks.

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

Thank you, Gayle. Troy and then Christine.

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

Thank you, Karen. I appreciate it. I actually have, I think – I don't need to expound anymore on the comments that are in the room. But I do appreciate the polishing up of this. I mean, I had some concerns, as you all well know, in the last document. And I think for the most part, those concerns have been allayed and I appreciate that.

Just a comment from the nursing community in regards to the overarching goal of care coordination, enhanced care coordination. You talk about the population health and outcomes. Nursing – the nursing community is poised and ready to assist in those endeavors, okay. So, I just want to not really get it embedded into the document, although it would be nice if we could in some way, shape or form, but I just want to make a public announcement and assure that we are here, we're ready and we're able to help, okay. We've got processes already set up in play, waiting in queue and we can certainly move forward with that at any time.

In regards to this particular document, there are a couple of questions that I had on some different slides. And one of them has to do with kind of a conflict of terms. On the clinical decision support, the certification criteria, it says ability to track the CDS interventions and user response. Now response to me seems like something verbal that you would do. I think just for clarity, it should be more like an action, did they X out, did they cancel it, did they just ignore it and move on. But a response seems like something they did – not did, but more of a verbal thing. Okay, so just for clarity.

The other one had to do with, it looks like, there are actually two actions that are required under one and it's demographics and patient information. It's under the header of reducing health disparities, I didn't see it on the actual list of recommended objectives under the reducing health disparities. There's no category for reducing health disparities, but that – it's under its own header on the slide deck. But second to that, there are actually two actions. There's the ability to capture, so you've got a lot of abilities, there are four abilities and then there's communication preferences will be applied. So you have two things that are necessary and they don't necessarily kind of go together. So I was just curious if you could take another look at that. Other than that, I'm very pleased. I mean I do want to give accolades, I think accolades are due. I haven't had the pleasure of joining in like Deven has, but I would have loved to be in the room when – during this whole process. So I appreciate everything that's happened and I appreciate the consideration.

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

Paul and George have some more wrinkles and gray hair, I think. Would you guys like to respond to his question for clarification?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Reducing health disparities just reflects our move to the six system back to the four system, so this just kind of got left along the top. So that could be under quality of care and safety and disparities, remember out original category. And it's – this is – I mean, we could view the second half of the clarifying comment that the way that the first thing, preferred method of communication will be used is in those other objectives. And so perhaps that should be on a liner note instead of part of the objective itself, because it's not actually asking the provider to do anything in that point, so we can make that change.

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

And disparities is addressed in that last part of the presentation where it says, report a CQM stratified by some disparity variable. And I like your idea about user actions – thanks.

**Paul Egerman – Businessman/Software Entrepreneur**

Just to make a comment. I'm glad you brought that up because those three things in demographic data are like they don't belong together, they're like three separate objectives, but they're put there to make it look like we have fewer objectives, I guess. But there are some clarifications on each one of them that are important. The issue of sexual orientation and gender identity, in my opinion one of the valuable things that ONC can do is actually to define the data that will be collected to define the results. You don't just ask the questions, you have to tell us what are the correct answers, and there is some controversies that currently exist about how to answer those questions.

The issue about occupa – coding the occupations and industry, I mean that only will have value, in my opinion, if you do something like go back 10 years, I mean because first, people have multiple jobs at the same time. But also, if somebody had a job that had some risk factors associated with it, but they don't do that anymore, it's still important to know because maybe then it occurred two years ago or ten years ago. And so – and that's an issue that we haven't talked a lot about, because there's a significant administrative burden in capturing that data. I mean that's a very difficult thing to do.

And then the preference issue about communications is really technically not demographics. I mean – although it could be put in that area, but it's overly – being overly prescriptive to say you have to put it in that area. So that issue is – could be handled in the place where you handle like user name and password. There are a lot of other sections where that could go. So those are three very different things.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Paul, thanks for that comment. One quick thing to mention is the Institute of Medicine is publishing a report this month about social determinants of health and how they belong in elec – whether they belong – which ones – their relation to electronic health record. That first part will just be giving the evidence of which social determinants like ethnicity, race, gender, etcetera, has evidence that they can affect healthcare and the second half of the report comes out in the early fall, I believe, and that'll go into the detailed metrics that are – that should be measured for it. So that may – it's too late for the Meaningful Use Workgroup, but it won't be too late, at least the first one, for the ONC/CMS process that goes on now, and the second half for the NPRM phase of this, to inform them on things of what is the best way to characterize the – to standardize those answers. So that'll be another group working on it at least in parallel with their work.

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

Great, thank you George. Devin Mann?

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

Thanks, a couple of questions. Well, I guess more comments. One is first to touch on what Marc was talking about, the need for outcome data from Meaningful Use 2 I think would be really important for engaging and motivating folks who are actually kind of living in this. Because there is a sense that the criteria just keep moving forward before anyone has a good sense of whether they're really making life better or worse in a more empiric way, we kind of have a lot of stories about this place it's going great and this place it's terrible.

But, I think if we are concerned about the PR that David was talking about, this would actually help us kind of make a case that it's helping you and even though you may be experiencing or I'm experiencing some difficulty in kind of achieving these things, that would be important. I am sensitive to what Neil's saying, I don't want to slow everything down to do that, but if we could find some sort of compromise to kind of have that data still possible to affect what we launch, I think that would go somewhat far in convincing folks that we're listening while we're writing these rules.

Two, getting specific; actually a couple of specific things, one is, in the criteria that you revised to 24 hours for the VDT, I'm just a little nervous about that. Just was in an operations meeting recently and our hospital is now, through great pains, lowering our discharge finalization from 30 days to two weeks. So, and it's not going to be an easy process. So getting to 24 hours, if I'm forced to I know we can do it, but what will we do to do it. And I'm just concerned that when we put these kind of hard stance when I'm not sure how much thought there was into where that number comes from, it may cause some downstream effects that are unanticipated, so, be very interested in that. And one last comment, then I'll let you respond. The disparities issue, which is really important and I saw there were some letters distributed to us from Congressman or whatnot before the meeting. It is very important to me, I've worked in – hospitals my whole life. But one of the things when I think of technology and disparities, in addition to good demographics, is how do people actually access the technology?

When we used to design trials in the past to do disparities, we'd say, well they'll access them from the libraries, and that was always kind of the loophole that you would give to the NIH. But the reality is, our patients have great access, but it's all through their phone, and I'm just a little nervous that there's not much talk about making sure the Smartphones are a part of things. Even in great systems where I've worked not with patient portals, you can't even sign up through the Smartphone and so it just cuts off half of our patient population. So, I don't know if there was conversation about that, but I feel like we have to be very aware of what the point of entry is for the disparity populations if we want them to really be engaged in the IT aspects.

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

Let me just respond to a couple and then see if – so the first one about the hospitals and the 24 hours. And I think this is maybe something we just aren't clear about. So it's the discharge instr – the same thing you actually have to – are required to hand out on paper, make that available within 24 hours. So it's not everything about that hospitalization, so that – I think that would be clarifying, if we made that statement.

Second, about Smartphones, I think from the start we've been trying to be technology agnostic, and hopefully, if there's one place where the market is driving, that is the place the market is driving and that we don't have to, in response to some of the other folks who have been saying, let's not overregulate things. I'm not sure we have to regulate and say, it must be – anyway, that's a personal opinion.

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

Okay. David then Judy – David Lansky. Oh, I'm sorry Christine, I didn't – Christine, then David, then Judy.

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

Oh, me first, okay. So I want to – I'm going to do my specific comments, but I'm just going to come back to the general discussion for a second and say that we've heard a lot of comments in this room about listening to CHIME or HIMSS or having the users and the developers being the central nervous system. And I have to say, I think this conversation, whether it's in this room or in the workgroup level would be a lot different if we had a lot more patients and families in the room. We have been extremely responsive in and heard a ton from providers and users and developers and others. But again, having more patients and families on the committee and in the workgroup I think really changes the conversation. We're not asking ourselves: How are patients and families experiencing Meaningful Use Stage 1 or 2?

We know the National Partnership for Women & Families did a survey that we presented to the Policy Committee on patients experience pre-Meaningful Use, it was right when Stage 1 was rolling out. I'm really delighted that the National Partnership will be able to do that survey again and see how patients and families are experiencing Stage 2. But I just want to ask people to think differently and really think about what is it that patients and families need? And so to that end, I am going to disagree with my lovely colleague Deven and I am going to bring up one of the things that we did cut, because I think it is a mistake for the patients and families and I want to make sure the Committee is aware of that and that is, reminders. So reminders are a really essential part of making the healthcare system responsive to patients and families, which unfortunately it still often isn't. It is essential to performance under new models of care and population health management. It's also something that really is a good option for specialists and I'm worried that we're...in removing some of these options, we are actually creating less flexibility for the diversity of provider types that are out there.

And the last think I'll say is, we just had this discussion about communications preferences. By removing reminders, we've removed an important context, because when you think about communications preferences, all of us would say, it depends. Sometimes – if it's lab results, I might want that by phone, or I might want it on the portal. But if it's an appointment reminder or a reminder to come back in to get my blood pressure checked, I might want that in a different way than I had said for lab results. So, removing that is problematic on many fronts. So that's my first comment and that won't be surprising to Paul or George, because they've heard me say that a lot. But again, we don't have enough patients and families to bring, I think, some of that view in.

So, the second specific comment I have is around health disparities. And Devin, I'm glad that you raised the issue around mobile phones. There are a couple of things – so, we received letters from 24 members of the House of Representatives and 5 Senators around this health disparities issues. And they asked for a couple of different things. One was mobile access, one was using more granular standards for race and ethnicity in particular. So right now, under Meaningful Use the standards are the OMB standards. The HHS standards though, are more granular, more specific and I strongly believe that we need to sug – to recommend that the certification criteria for race and ethnicity really actually move to the HSS standards, which are again, to Neil's point earlier, much more granular, but they're specific.

They don't have such a huge degree of granularity like the IOM has proposed to make it unworkable in an EHR. So this is an easy way to make some good and immediate progress. The letters also asked for quality measures, which I think is good although they asked for quality measures to be reported by two variables, not just one. And actually for some reduction in health disparity to be reported as part of the program as well. What I find really interesting is how much this resonates with patients and families. An action alert went out to a broad group of individual patients and families, not DC type of people, and this was yesterday. And by this morning, there were 3500 patients and families who wrote in, not to your personal email, but you will be getting a delivery to the Secretary and –

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

Did it come with Valentine candy?

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

Yes, we'll –

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

Because that makes it nice – I don't think you can send me – cake actually – I'm just teasing.

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

– I know it's a little late, but we'll figure that out. But anyway, so this is something, and again, these patients and families were asking for these very specific things, mobile access, more granular data collection and better reporting of quality measures. So I want to raise that and ask the Committee to very seriously consider adding both of those dimensions.

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

Thank you Christine. I'm going to go to David and then back to Judy.

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

So, just a couple of specific things, one is a question to you guys. On the remove items, the family history was taken off as a criterion and I'm wondering if the – is it a fair assumption that the thinking was – you want to challenge that Paul? On objectives removed from the draft recommendations was the slide 6, down at the bottom.

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

I think it's still on – yeah I know, but it's still – we'll keep looking, keep talking –

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

So my question is really whether we can assume that the thinking was, if you've made it through Stage 1 and 2, we're assuming a level of performance around capturing data that we don't have to continue to monitor at Stage 3. And my particular question, it sounds very trivial, it's back to the PR, the old clipboard, we started this discussion about now 10 years ago, with the simple idea that we would no longer have to require repopulating that basic data on every office visit, which I think is still the case almost everywhere. And that seems like a simple objective that would have resonance for the public, and if there's a way to capture that as we go forward, either say it's done and we can just check it off or retain some evidence that we had solved that problem, that would be a nice thing. That was one.

The second one is kind of might sound like an odd paradox. I think the UDI recommendation is a good one and I think, to Marc's earlier point, leveraging the menu options to move the needle forward is a good idea. But it's paradoxical to me that we don't have advance directives being required with the same level of data capture, as we are UDI. We're still letting people get a menu point on advance directives by knowing that someone has them, not by having access to the actual document at the point of care. And I think it's very important that we support – we continue to support, as we have on multiple occasions, that advance directives be available to the providers at the point of care. And now that we have a certification proposal that would make the document potentially avail – certified, but the products can make it available, we should be requiring users to make it available if they're going to get menu credit, and not let them off with a pass on the old standard of that someone has an advance directive.

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

Let me try, so – I don't – unless you know the family history – I will note that family history is still on VDT, it may be just removing it from the CDS –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

We used to have a – because we didn't think we had standards that were sufficient.

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

So there was a family history objective, it did get removed in our removal process, but to your point, we did add it as an element to be included within VDT.

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

Right, so it's still there, one of the challenges is the lack of standards. So, it's – I have to go back and look at the exact objective to see, but it did get removed as part of that process. The process, as you know, each one of these had its history and its importance, and it's just a matter of focus, which was one of the prime objectives here.

The clipboard, actually one of the ways we're approaching that is the whole structured data – the patient-generated health data and that – so, you could imagine the pre-visit questionnaire as literally being – and that's what we do for pediatrics, for example. Post that out, it gets submitted as part – through the portal. So that would almost replace that. Your last point was –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Advance directives.

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

Advance direct – you know has been an important item from Stage 1 with this group, and we just keep moving in that direction. And I guess a lot of us share your frustration that why can't we just make it, so –

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

Can you explain why the committee is not endorsing a recommendation that we continue to make the advance available to the caregivers?

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

I think –

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

As a menu requirement.

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

I think it's on here. I have to go –

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

As I saw it, the wording was –

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

Here it is.

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

– whether the patient has an advance directive, it doesn't require the document to be available.

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

Oh, I can sort of briefly sum – because we've had a hearing on this. So the question is, how do you make sure that what that document in there is the most up-to-date, etcetera. And how does it follow it all state requirements. So, there are smart some states that actually have a repository, a registry, where you can go to and that's why – and in those states you'd want to use a link, for example. In others where you do have a document, you'd want to obviously date and time stamp it to give clues on how fresh it is, but it's really – the challenge, can you really ascertain that that is the most current document. So requiring that everybody have this may be a check the box thing and not solving all the other issues that came up. So, it's just trying to get to where we are in the state of storing and maintaining these records. So, we heard a lot of success stories and to the extent that that's available more universally throughout the country, that would be good.

**Paul Egerman – Businessman/Software Entrepreneur**

There was also feedback from somebody that the concept of storing the document was a bad thing to do, which was what the current certification criteria was so, that's also just an observation.

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

So this actually is a certification criteria is that the EHR be able to contain either a link to a registry or a document, and it's up to the local workflow how do you deal with it. So, that's what Paul Egerman said is one of the objections to –

**Paul Egerman – Businessman/Software Entrepreneur**

Somebody sent us feed – that was not the right thing to do anymore, you should actually store the document. And so, that –

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

– to the link, I think either solution is a good one, but not having access to the document seems to me, crazy. So – menu, why we would give credit to the users to note that there is an advance directive, but there's not access provided to it.

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

Well can I just jump in, I think it is possible for access to be provided to it. So if you have MyAdvanceDirectives.com or you have a state link, this certification criteria will direct a provider to it. The other thing that it will do – it should do, is allow the provider to document, okay, for the most recent advance directive, contact my attorney and here it is, dah, dah, dah. The concern that people had was, what if I change my advance directive and I decide that actually, I no longer want life-sustaining support, how do you know you have the latest copy? So there was more of a risk in actually storing the document than instructions around how to find the most recent copy or a link to it, depending on how the patient really has – stores the most updated version. So I think this is a good balance between the two, it's probably safer for respecting patient and family wishes.

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

Thank you. And Judy.

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

Umm, two things; first, I do think you've done a good job on this, so, congratulations. Second, I think we do have a 100% patients and families represented on the workgroup members because we're all that. So going down this list, under the clinical decision support, I just want to comment there, nothing to change, but I just wanted to comment that as much as possible now, we're trying to stay away from pop-ups or the things that are going to come up and say "yes" or "no." And we're trying to make decision support more and more the flow that is chosen by the physician, so there's not the alert fatigue that comes with pop-ups. So I do think that that first one there could be usable, but isn't the direction that we should be going as how we develop the EHRs. The next one I have here is the overdue results. I would like to suggest an amendment to that that says, if it's not auto-generated there's the ability for the provider to indicate a date because much of what is going to happen is that the –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

(Indiscernible)

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

– well, if it's not auto-generated –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Where are you?

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

What is not –

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

– oh, the order tracking, your new order tracking.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Order tracking, thank you.

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

Yes, I'm sorry...that a lot of rules can be automated and where possible, they should be automated so that the provider doesn't have to do that that will reduce the burden on the provider. And then I don't think that there's going to be much of a need to have an optional override, then, because it's going to be what it's going to be, but that's less important. I think there should be an emphasis on auto-generating the data.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

You mean – so normally for lab data, I expect it back in two weeks, that's the kind of thing you're talking about?

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

Exactly, because usually it's the lab that knows when the tests will be done, not the provider.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Right.

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

The next thing is unique device identifier. This should be a requirement for the site placing the implanted device.

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

It is.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

That's right, that's what we've intended.

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

Oh –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

It's the provider who places the device.

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

– when patients have a device implanted – that's what it means? Okay, you can read it either way, you might want to just clarify that.

The next thing, I liked what you said on the demographics of disparities. But what you had said was, it's the decision of the provider when it's relevant and I like those words that you said, and I hope they get into this, because I do think we need to do it that way or weird things could happen.

Patient-generated health data is good. I'm going through this – okay – secure messaging, umm, I need to just check my notes here. Oh yeah, okay, so this is tracking that we're responding to the patients, and I think there's a lot of concern about just how that will be done and that's pretty tricky, I think. So how do you document what phone call went with what message or what call or what email or what what? I think that that one really needs to be looked at, is it really going to be both of inordinately high work for the doctor to go back. And say anybody keeps you – a lot of time management lists, okay, I did this, where am I going to find that I said I had to do it and go back and cross it off, sometimes that's very complicated. And I think that one is worry, that it might be too much work for the – both the physician and the nurses and the...

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Just to clarify on that one. So what we're measuring on the pro – what we're measuring is the being sent the message and we want the system to have a place where you can optionally say whether the – record the response. But that's not part of the measurement on the provider. So we're not ask – we're not going to measure how many times the provider responded to the message, we're assuming the provider's going to respond appropriately. We just want a place that they can document it if they want to.

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

If they want, okay, so that's optional.

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

And let me give you another automated way. So obviously when you reply to a message that's automated, you're capturing the thread –

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

Yeah.

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

– let's say you turn that message into a telephone encounter that also can be – that the link can be made. So where it is possible, automate, that's great, it's encouraging innovation in that area.

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

Okay. I think – I'm fine with – want to make sure that that's clear, because –

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

Yup.

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

– I don't think it was. Then on your notifications, the four hours, it's another area I'm confused about. Are you talking about automatic inoperability here where everybody in the care team, we've got to know where they came from, how to get the information to them at their other sites that they work?

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

Are you talking about notification?

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

Notification, yeah, so it says –

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

To the known members, so if –

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

Okay –

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

– so if you know who the PCP is, and you have a – they're a clinical trading partner, then it would be nice for you to notify that person that this person's in your ER.

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

Okay. I think that that is good, but you've got a lot of problems if they're not on the same system. So in other words, is where they're coming from automatically linked to the organization that this patient is currently at so that a message can be immediately sent within that timeframe? You're really getting into, I think, the whole interoperability thing here and the...what it's really seeming to ask for is automatic interoperability in those cases.

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

Well, actually we are.

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

Okay.

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

So, as you know –

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

Well then it should be, for those places where there is already established links for interoperability.

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

Yes, presumably there'll be a threshold and right now we indicate low threshold. It's the same – the summary of care document, it's trying to get some kind of low threshold accounting for not everybody is up and available, etcetera. That's how we account for that, but the goal is to move this – right now, you're supposed to do it on paper, either call or FAX it, we're trying to move that to an electronic world. We understand that the whole country isn't there yet and that's why the recommended threshold is low.

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

Well I just – thinking of all the interoperability challenges that there are –

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

Which we're trying to act on.

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

– it's going to be very tricky and I do think it should be saying that if there is no automatic link between your organization and wherever it needs to go, that link has to be established first or else it's not going to work.

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

Sure. Maybe it's an appropriate time to remark on the – to comment on the general comments in this area.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Yeah.

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

In a sense we are trying to work on things where – it's just like the first FAX machine, or the first phone for that matter. If we don't get the thing up and running, nobody gets to work...nobody gets to take advantage of it. And that really has been where we tried to focus our areas – our attention, and focus the level of effort. So, no, we aren't trying to do a full certification for everything, but clearly in interoperabil – let me put it better, in care coordination, we are asking the country to up the ante.

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

I was talking to someone at HIMSS who was talking about the struggles with the inoperability and the thing – the struggle that they were having was the lawyers writing the agreements to go back and forth, which was taking a long time. And so – those are some of the things I think they're going to get into this. But the other interesting topic to bring up is the whole thing of selfies, which is, do you get credit when you send the C-CDA to yourself. And right now, that is, I believe, the way we're hearing it is being accepted and so that if you want credit for that C-CDA being delivered. When you have someone on your same system, you cannot only know that they can access your system because they're on it, but you can send them a C-CDA and it gets counted. That's a very weird thing.

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

I appreciate actually that you're raising the issue of the interoperability and thinking about where we might want to be in 2017, and also Judy you raising the point about some of these are regulatory or business barriers that can be overcome. Clearly there are technological issues, but some of those may be more straightforward. So I – predicated on our conversation last time, what we'll discuss in April, this group seemed pretty interested in solving some of those interoperability issues, because capturing data is important, but freeing it up to put it to use is more important. And so it might be a good place for us to challenge ourselves to say, we think that that's important enough and this is important enough for patient care and cost savings that we would want to push it, so, yeah. Okay –

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

And I – one or two more.

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

Go ahead, thank you.

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

There's a lot of concern about CDS going along with immunizations, basically because you might get multiple decision support information from different places, so – that was a concern. And then the last one I have is about the registries. I think sending information to registries is fine. The standard C-CDA usually doesn't match up, you look at the tumor registry or the ACC or the STSS registries, the C-CDA is not a great way to transmit the information to those registries and I think that that has to take it into account that it isn't a very good match. That was the end.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And we can – I mean, I would suggest we try to leave that. I mean what we want to say as a policy point of view is we want standards there and we want the Standards Committee and ONC/CMS to decide what the actual right answer is. We try not to put standards in as much as possible, but we do, so I understand what you're saying.

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

Did you – I don't know if people took a look at those registries to see what they were, it might be really valuable to have matching.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well I think the previous registries are using a CDA template, but not C-CDA, from whoever's starting on Stage 2 is using a CDA, but not C-CDA, just as you said.

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

Okay.

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

Thank you Judy, I appreciate that. Devin took his card down, are you – okay. So that would be Paul and I'm looking at the time, we are –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
And Art.

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

Oh, I'm sorry Art. Were you before Paul?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I believe so.

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

Let's give Art a chance because you've been – yes.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you. So I have a few comments. I'll just go back to one of the general ones, indeed Judy we need engineers to build cars and we all aren't drivers, so we are in the room. But there's also a whole effort at the national level to assure that we had seatbelts, that there's highway safety, that there are guardrails. There are a variety of other things that need to go into this regulation, as we start to build a better EHR. So, I don't think it's just about having the engineers and the patients in the room, the variety of other factors.

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

What I was saying, the physicians, the actual users, because if you built the car with somebody who never was a driver of a car, they might say okay, the handlebars have to be both – the handles have to be both for right-handed and left-handed people and they've got to be this size and this metal, and stuff like that. And they might not do the right things, because they've never been in or drove a car.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, that's all I wanted to say in general about the earlier comments. I have a couple of comments, pretty specific, and it relates to Judy's last comment about the C-CDA. Because I think that was something that I tried to push in our work here. And I agree with George, it should be around standards. And it's interesting that only in the last couple of weeks have I learned a little more about how the CCDA is playing out in Stage 2. With an unnamed vendor, we're trying to do a project to have transmission of a referral to the Quitline services in our state.

And we thought that we could use the standard C-CDA to do that. It turns out that this vendor has set it up so that the C-CDA is inflexible; it contains everything. And we thought that there would be an opportunity to have templates within the C-CDA that you select and that is turning out not to be the way that they've built it for Stage 2. So I think one of the things we might want to consider as this – in the summary of care document, we don't want to send all the medical history when someone is being sent to a Quitline. We don't need them to know that their HIV status or their psychiatric history or the drugs – all the drugs that they're on; there may be reason to put some limits on that. So it might be something for us to consider in this summary care document, to say, how do you make it more flexible to serve that need?

The idea about the C-CDA was to say, there's a standard way that anybody could send and receive a message. And maybe we have the wrong term there, I think what George was saying is indeed true, we may be looking more for a standard there. And that same goes as well for the issue about registries, because we don't need to send to the registry about a BMI or a blood pressure, their HIV history. So, there's something there that we might be able to tweak a bit to make sure that it's not perceived as sending too much, it's sending the right amount of information to achieve our goals. Whether it be about a registries or about a referral to a public health service, or even to a physical therapist, who might not need to know all that other information.

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

Any feedback for him on that?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

No, it sounds good.

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

Are you okay? And Paul.

**Paul Egerman – Businessman/Software Entrepreneur**

Right, so I'm actually going to pick up where Art just left off because I thought your comments on the registries were excellent. It's one of the problems and challenges I see in general is a lot of things are being proposed here that are new and they sound good when you write them down. But then you look at the practical aspect of implementing them, and there are significant challenges. So you just listed what you saw as the problem with that whole registry issue, where the CCD wasn't quite right for you. There may be other practical challenges, for example, can these registries handle hundreds of incoming messages at the same time? Are they set up to do that? There's some technology that's involved in being able to do that. And my point is, there needs to be a lot of testing on a lot of these issues.

And Christine referenced the letter from the Congressman and Senators, I actually happened to see one of the Senators on Sunday and I talked to her about patient education and what I said was, I wasn't sure what it says on patient education, it's either something that's very easy to do or it's very hard to do. If it's easy to do and all you do is pick up something from the Internet, that doesn't accomplish anything. If it's very hard to do, it could accomplish something in terms of literacy, but at the same time, we've got to test it first. And at least that Senator said, yup, that sounds right to me. And so I just say, there needs to be testing and there are a lot of issues like that.

To go through some of the specifics, I had just a few comments on specific issues. On electronic notes we're raising the threshold and my comment is, is that really an important thing to do. I mean, if we did the threshold in Stage 2, if people find that useful, they'll use it simply raising the threshold, especially when we get to the penalty phase, I'm not sure that that necessarily accomplishes anything at all. I don't think people only used electronic notes at the minimum level necessary to make Stage 2. So I don't think we need to raise the threshold.

I made a comment about patient education, I want to add to that comment that the certify – I criticized this before because the criteria had been you only had to do it once, and now it's a count of a small number, so I guess that's a little better than once. But I also see that as not – it feels like checking the box. If somebody's going to do this they're going to find five non-English speaking people, give them instructions and then they'll be done. That's not necessarily accomplishing anything.

And then Judy raised some issues about secure messages and notifications and I listened to a – there was a Listening Session that the Information Exchange Workgroup did on Stage 2 and transitions of care and what I heard in that Listening Session was that there are some challenges using transitions of care and the Direct protocol. The challenges are that there are physicians who have two or three accounts in Direct and they don't know that, and the transitions of care documents are being sent to them and they don't know that they are receiving them and so they are just sitting there. One person gave an example of what they're currently doing is that they're transmitting it through secure messaging and then sending a letter to the physician to tell them that he's got a message and asking him to look for it. And my comment there is – still goes back to we really have got to look at what's going on there in Stage 2, because you have notifications here and you say give notifications in four hours. The notifications in four hours make no sense if all you do is you run around in four hours and you get something into somebody's Direct mail box and they don't know that it's there. And they have no way of knowing that it's there unless somebody calls them or sends them a letter or something to tell them that it's there. And it's – I think that needs to happen.

So those are my comments. Actually, I have one final comment, Art and Judy talked a little about cars and what it takes to regulate a car. My comment is, a car – the technology of a car is simple compared to this. I mean, this is far more complicated than a car, you have far more people involved in implementing these systems. The car is a consumer-oriented device. Electronic medical records are an enterprise-oriented system that involves business processes and work flows, it is much more complicated than a car.

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

I wonder if I could take that last statement as a kudos in the sense that this is hard work.

**Paul Egerman – Businessman/Software Entrepreneur**

Well it is, oh it is, absolutely.

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

And the folks on the workgroup do represent a lot of the stakeholders in that and do consider the complexity and draw a vast amount of experience, actually represented in the workgroup.

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

The car analogy started with ONC, so I think it's a good one to –

**Paul Egerman – Businessman/Software Entrepreneur**

Like everyone else, I'll use it when it works for what I want to say, but –

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

Well I appreciate you ending us on that note of complete honesty and transparency, which is I think thematic for the day. So I sit here as Chair with a little bit of a conundrum, and so I'm going to throw it back out to this Policy Committee. I – first of all, big frame again, Meaningful Use is – capital M, capital U, one of the many tools that we have been given through HITECH and that we have an opportunity to use to advance the use of health information technology to improve care, lower costs, improve health and create a learning system for our country.

So let's keep that in mind that this is, as has been said, the next chapter of this program is kind of focused standard data capture, not the last chapter, so everything doesn't have to happen. And to that end, I think the scaling back by 30% of the expectations since we were last here was a big step in that direction. This is also, for this set of recommendations just that, it's a set of recommendations that allows us to start a process within CMS and ONC and the Standards Committee. That will allow us to begin testing and thinking through the re – the realistic technical opportunities, some of the – what do we think that the outcomes that we might achieve are achievable in this large frame of suggestions. There will be a set of opportunities of Listening sessions in April. There will be a process of the NPRM process, but even before that, other opportunities to sort of weigh in and give some feedback. So, listening to you all I'm trying to sit here and do a vote count, to be perfectly frank, if Paul's looking over my shoulder and the –

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

Sorry.

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

– I feel like – that’s okay – I’m doing that solely because I think we have to make a decision as a FACA about whether we want to push for a vote and allow, if not everyone’s feeling comfortable going forward, for there to be some dissenting opinion. Sort of that model where people would have the opportunity, even if they want to vote for it, to weigh in and say, yes, this is where we are today, but we want to make it clear, Christine for your example, that there are some things that you all would have liked to have seen, etcetera. So, we have that option.

We have the option of not voting and postponing, I would prefer not to do that if we could. There’s also the option, by the way, of unanimously endorsing this, still with some caveats in the letter. We could say this is our recommendation, we want to put this back out into the world and within it we want these things to be thought about. We want to think about, is the patient’s voice adequately heard? Have we adequately heard from, in a meaningful way, the providers using this more than 50% of the time? Are the standards ready for this? What are the ways that we might actually drive Meaningful Use and interoperability or outcomes and quality of care that might need to be nuanced within this. And I believe that we – once we set this in motion, we have the opportunity to do it. So let me be clear, we have really three, or probably more options. That we could just move forward with some caveats, we could take an up/down vote and have a dissenting portion of the letter or vice versa and – or we could just postpone.

So that’s what I want you all to weigh in on now if you could and, I keep checking the time. Unfortunately, sort of we’re getting down to a few minutes, so Christine, what are your thoughts?

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

I think we should vote on these today. Certainly I’m not sure there’s any more work left to do at the workgroup level, we’ve been –

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

Okay.

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

– around this tree so many times. I will say though, it’s unclear to me if we’re making any changes that people have raised. We haven’t really as a committee said, so for example I raised these two issues around HHS versus OMB standards and adding reminders back in. I don’t know – I know where you guys are, I don’t know where anybody else is –

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

All right.

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

– on those things, so it’s harder for me to vote without knowing that.

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

So noted, so maybe Jodi and Michelle can think about some of the edits that were suggested, you can start to compile those while we’re talking and if we have to make amendments, we could vote on those, if you all want to handle it in that way. Okay. Deven, Deven.

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

Yeah – this is Devon McGraw – I have to stop saying this Deven, it doesn't work anymore. I do think we should not postpone. But I do think there is this sort of rich dialogue that's taken place at the Committee level that would ideally be represented in a letter that would transmit these recommendations. And so in some ways, certainly with some of the more difficult issues that we've handled on the privacy issue, all of that richness, when it's captured in a letter, you can – the Policy Committee feels better about moving it forward, because some of the anxieties get expressly addressed without necessarily having people have to dissent necessarily. So, that's an option, which I think was that middle option that you said which is, that there's a sort of richness of dialogue represented in the recommendations, which then we might actually be able to reach consensus on.

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

Just a quick follow up on – so Deven, in your group, when you do the transmittal letters, does your group actually look at the draft transmittal letter? Because we have not done that for the Policy Committee and that's been an issue.

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

For the hardest issues that we have done, yes.

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

Okay. Yes Jodi.

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

I think that I was going to suggest, I think it's going to be really hard for us to try to make edits on the fly –

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

Okay.

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

– consensus, so perhaps if folks want to vote, understanding the recommendations and the discussion that's happened, we can try to take a stab at working with Paul and George on drafting a letter. And then let the – let folks see that before it goes forward, and make sure that we've captured all of the issues before there's a formal transmittal memo.

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

And how do you handle any edits in that circumstance? So let's say that it wasn't captured and they want to redline the edit, does that go back out and get voted on? Do we have to bring that back to the Committee in April, how is that handled?

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

I mean I think to some extent we would, unfortunately keep everybody on the email team so everyone's aware of the changes that are being made. We would track the changes and make sure that there's agreement once we kind of get to final consensus from the group. We could have an email vote, essentially having everybody give a final approval once everyone weighs in and then it would get sent as the letter of transmittal.

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

And the proceedings are transcribed in case anyone on the phone or listening isn't familiar. So the accurate information is all contained, it's not just relying upon notes, so that's the reason I suspect you all are –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Can we send the minutes of this meeting with the letter? Would that be representation, because everyone has two objectives they want to add and two they want to take out and some of them were expressed and some they weren't expressed. If we take the minutes of the meeting and then also work on the letter; I wouldn't have another presentation and I don't want the Policy Committee to have to go through what the Meaningful Use Workgroup went through for six months –

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

Right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– because you don't get any – it won't get any better. It can't get any better than this.

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

Right I think that's really valid, George –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

That probably is the best – we've been in two years.

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

– and yeah, that's right, you guys did, I mean two years of work actually, it's six months of intense work, but this reflects two years of thoughtful listening and conversation and adjustment and winnowing. And, before I forget, the – to my qualitative and quantitative information about Meaningful Use 2, we will have an opportunity to incorporate, we just won't today. And if we wait until the fall or ne – or in 2015, it's just too late to really make the process begin to unfold in a test – to allow for testing and Standards to really weigh in. Hang on, I'm going to go to some other folks so Neil, David, and Troy. Oh, I'm sorry, Devin, I skipped you, Devin with an "I."

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

Actually, you almost totally answered what I was saying, but just to clarify. I know we're going to have this opportunity and George had mentioned it's better to have more and then we can pull back. But could you describe that a little bit, what the opportunity really will be to modify what goes forward, based on the data that comes in. Because that is my only concern, that – a die in cast that we can't really change by the time we get – when do we think that data will come back and what will be the process to use it to guide the recommendations?

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

I would defer to Jodi to tell me if the Policy Committee would formally weigh in again or if that is something that happens at CMS, ONC and in the NPRM process.

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

It would happen – so Paul and George were talking about having Listening sessions, so there is more opportunity to weigh in on the discussion. But then we would come back formally to the Committee with the proposed rule for folks to weigh in and give us feedback.

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

Okay.

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

And that usually will be formal recommendations from the Committee.

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

But do we anticipate having qualitative and quantitative data prior – like how will the timelines work?

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

I believe I can sort of – we're going to continue the flow of information and feedback from now until Final Rule. The next stage is a Listening Session that our ONC and CMS colleagues will also attend, that will presumably inform their writing of the NPRM as well as any qualitative and quantitative data that comes in between now and the NPRM writing. We will then weigh in formally, based on everything we've heard from now until that process, on their NPRM, which is another time when we formally will respond, including the information that has become available between now and in the fall. And then the listening continues from then through the writing of the Final Rule. So there is plenty of opportunity for the people who write the rule and another formal opportunity for us to respond in the fall time period.

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

Right, I'm sorry to be a stickler, but I'm just trying to understand, is – but do we anticipate some useful data coming back before the fall when these opportunities, or will the opportunities have passed before we get reasonable data back on Meaningful Use 2?

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

Jen – when – Jen and team from ONC are pretty fast at turning around, and so is CMS – Beth back there and they may be able to give you some sense. Quite frankly, some of this depends on the pace of Stage 2 attestation and so, we're not going to know that for few months, but the goal would be that we're assembling as much data, and we can do that from early attesters and begin to feed that back. So it doesn't even have to be, wait until everything's in. So I would say starting in the third quarter of the calendar year and then move in – so, that's around the right timing to start thinking about the Final Rule.

Okay. I lost track. Yeah, you all are going to self-regulate? Neil, David, Troy then Christine and then I think we're going to have to take a vote, or make a decision about taking a vote.

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

So I just wanted to speak in favor of voting on this now. This has been to the full Committee, it's been back and forth to the subcommittee multiple times. I don't – I agree, I think we can keep adding and subtracting. I just want to point out that we have an opportunity, if I'm not mistaken, in the NPRM to actually highlight some places where there are controversies –

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

Um hmm.

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

– and ask for particular comments on that, and I think that was particularly useful in Stage 2, to be able to actually put in a request – a specific request for comments in areas where maybe all of us together don't have enough information and where we're specifically seeking input from others.

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

Thank you. David?

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

I think it's been a great conversation and the work of the committee has been phenomenal and difficult. I also think it's time for us to vote on it and I hope we could have a place for I'll call it constructive dissent. And with whoever – whatever dissenters there are on the vote, if there are some. They might be able to work on drafting part of the submission letter with a kind of minority report, for lack of a better word, that would express some of these high-level issues that we've been talking about today, probably less of the detail on the individual elements.

For myself, I don't think what we are looking at today is bad, I don't feel opposition to it, but I do think it's insufficient. And I don't know – in our process it's difficult to express that by voting yay or nay on this particular measure. So an abstaining feels like an abdication of the participation. So anyway, I think having a way in the letter to transmit more thoughtful comments about where we stand in the process as a whole, would be help – may help instruct CMS about where to go.

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

Great, and to put it into con – the greater context of where we all want to go. Troy?

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

Thank you. I really echo what Neil is saying, I mean there – we do have an opportunity to the NPRM to allow the public, much like what – Christine is worried about, to weigh in. And given that opportunity, I mean, there will be modifications to it, there's no doubt. It's happened every time, and that's really what I believe we need to do. I'm ready at this point to move forward and agree with the proposals that have been presented to us, with that caveat, the fact that it's not done, that there is more to come and it's going to be looked at by a broader audience than just the people in this room and the MU group.

I do – one thing that I kind of keep in the back of my mind is thinking about all of the other workgroups that are out there that are waiting for the decisions to come from us to say okay, these are the foundational aspects, okay, move forward. This is what we have, now you can begin balance your futures and the work that you have to focus on from here on out. And they will – they too will have the opportunity to look at work that's been done, work that's in progress and things that they have in their mind that they're grinding with, to compare it with what we've come work with – with what the MU Workgroup has come up with. So anyways, that's just a commentary.

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

Great, thank you Troy. Christine, then Marc, last word.

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

Thank you. So I actually would like to ask the Committee to weigh in and vote on my two requests, which were one, to encourage ONC to consider HHS standards versus OMB to reduce health disparities and also to add reminders back in. The reason I'm asking for that is not to be a pain, but because if ONC and CMS don't mention those things in the Notice of Proposed Rulemaking, it doesn't matter how many people from the public come and say we want reminders. If they're not in the rule, they cannot add them back in later under the Administrative Procedures Act. So I really – I hate to do it guys, but I really would like to have the Committee sense on those two things.

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

Marc?

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

Oh I love having the last word, thanks for that. I see two things and so one is, is this a good list of requirements; the next set of requirements that we should put out there. And if we're voting on that, I can pretty easily say, yeah, I think this is really good work and a really good list. However we never get an opportunity to say should we be continuing the program the way it's going? And so the only vote we can – I can give is no. Because if we put this out there without any facts supporting it, I mean, it's like going through and doing an implementation of a system and saying, boy, that's a really great system, but having no facts to say I can get that in by September, the whole work plan and all the effort that goes with it. So, and that's the challenge I do find because I think this is excellent work, I just don't believe that our community one, believes we've got the facts to support it, that says this is the next step we should take and that the current timing that exists out there is something that's doable in the industry. So, I don't know how to vote.

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

Let me respond in two different ways, if I might. One is, as I appreciate the process Marc, the idea that we put this out there so that we can then begin to understand if it is reasonable and feasible and loop back with the information coming out – coming in from attestation and from other places. And so the further we wait, the harder it will be to actually get into that information and understand, so that's one issue. The other general issue for us as a FACA is, if we can begin to pu – if we can make a set of recommendations for technical and other folks to begin to think about, listening sessions, etcetera, we can then turn out attention, as a FACA, to what I keep hearing you all saying you want to do, which is just to think more broadly and bigger about where it is we're trying to get. This is a stage in a program. I think what we all keep talking about is the opportunity that's out there through market innovation, through patient voice, through the opportunity to do better care coordination.

And that's what we're really hoping to get to do in April and May and – is to begin that set of – because those are – I said it earlier and it's the truth, this is a fifth of our nation's economy. This is the health data for a fifth of our economy and I think we have such an important responsibility to start thinking, to settle this and it's an incredibly important program to do what I think is great work and move it down the pipeline, but then begin to think about, what is really happening on the ground? What are we missing that we should be doing differently and/or what should we be influencing or supporting? And I'm not trying to – I'm really not trying to be ethereal, I think that's really what we're here for in this room.

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

But historically, this has started the ball going down the – .the stone going down the hill and it hasn't stopped.

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

Right.

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

And it hasn't taken those things into consideration, and I hope we do, because I think there's so much we can be doing. But I am concerned that if we – well, if I vote yes on this, it starts that ball down – I actually think it's going to start anyway, but –

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

Okay. I'm going to have to leave, so I'm going to have to –

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

Call the question.

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

– to call the question, I guess. But if Christine has a request about a vote...

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

So I'll just do this sort of cleaner –

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

Okay. Thank you.

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

I'll make two motions before we go to the full vote. So the first will be to add patient reminders back into the recommendations.

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

And I'll second that.

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

Okay, thanks Neil.

**Paul Egerman – Businessman/Software Entrepreneur**

I think we need to have a discussion on that issue. I mean there were reasons why that was removed, I mean – and one of the reasons was as people have maturer systems for patient reminders and part of what is being requested here potentially could undo what people already have in place. And we also had a physician on the workgroup who felt it was burdensome to have to deal with it on every single visit, to have to change what your reminder process is on every single visit. So those were the reasons why it was removed.

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

Is there other discussion on the motion? If not, then I'll call the question. We're voting on Christine's request to add back in the reminders and – separately, reminder is that to contextualize the workgroup discussed it and in the end, did not – they had it, they pulled it out as something that wasn't going to be a part of the – recommendation.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well actually, more accurately, we went through a very long, stressful process to decide which ones are out and which ones are in. We voted, we agr – we more or less agreed on it as best we could achieve a consensus and we generated this document today. So we went through an entire process and this is what we came up with.

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

So not to continue it from Stage 2.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Not to continue it beyond the first two stages it was in.

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

Great. Thank you. So I'll call the question and when we vote in this body, do we raise our – how do we vote?

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

People raise their hands –

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

What's that?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

However you tell us.

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

However I tell you, not – all those in favor of adding reminders into the workgroup's recommendations, raise your hand. And all those not in favor – hate to use the word, but – And Gayle on the phone, is she still on the phone, is she voting?

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

Yes, I'm still on the phone and I would vote to keep the recommendation of the workgroup and vote no.

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

Vote no, okay.

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

This is Scott, I'm on the phone, I would vote no as well on that.

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

So did you count?

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

Yeah, so there wasn't enough to put it back in. Yes, the majority voted no.

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

Thank you.

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

So the second motion is to encourage you guys to use the OM – HHS standards instead of the OMB standards for race and ethnicity, which get to a slightly more granular level of data. Can you second that for me, too?

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

Second.

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

Thanks.

**W**

Demographics –

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

Well it's certification criteria –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So we would add that, because that's not currently in the – remember that the –

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

It says –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– that race and ethnicity dropped off – remember, it's not in the slide right now because that was something that was in the first two stages. This would be an addition to demographics to say we should change –

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

This would be a certification criteria for race and eth – for the race and ethnicity fields, which currently use OMB – it's really not standard in the technical way, it's vocabulary and should be using HHS.

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

Doug, do you want to weigh in on that at all or –

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

Can I just ask a question, I'm sorry Christine, but because the Committee hasn't seen what – how specific those are, I'm wondering if perhaps we could share that with the group?

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

I'd be happy to, but Michelle, and I don't want the group to be mistaken, but because I've raised this several times at the workgroup level, and this is the first request – that's why I'm here to do – so I'm happy to do that if – but I don't know how that feeds into the vote today, that's the question.

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

The other way to handle this, it's already up to ONC how to specify the standards and the vocabulary to use for existing Stage 2 requirement, ONC on its own, through the Standards Committee – using Standards Committee advice can make that decision.

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

So can we recommend they look at it?

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

I mean, that's the way –

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

Right, but it is a policy matter more than a standards matter, actually, standards, the word is misleading.

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

Doug, do you have any comment on it.

**Doug Fridsma, MD, PhD, FACP, FACMI – Chief Science Officer & Director, Office of Science & Technology – Office of the National Coordinator for Health Information Technology**

Vocabularies are standards, so it is an issue that I think the HIT Standards Committee can address. I would second Michelle's recommendations, we'll send out a link to the minority – to the actual HHS website and it – the website itself describes the relationship between the HSS recommendations and how those map into the OMB recommendations. But this is a perfect thing for the HIT Standards Committee to sort of come up with and have that conversation. So, I think we –

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

If you think it's good for Standards Committee then – and it's more suited for them, I'm fine, as long as one of these two bodies really looks at this issue.

**Doug Fridsma, MD, PhD, FACP, FACMI – Chief Science Officer & Director, Office of Science & Technology – Office of the National Coordinator for Health Information Technology**

Yeah, okay.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Christine, what about this proposal, if we put in our letter that we believe that this needs to be looked at again, race and ethnicity, one of the options is HHS. We also understand the IOM is working on this exact topic and that it needs to reconsider this.

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

Great, I'm fine with that.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And would that sit –

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

Yes, I'm fine with that, thank you.

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

Okay.

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

No, I think that once we reached an agreement this goes in the –

**M**

Put it in the letter.

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

– letter, we're good.

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

So you withdraw the motion for formal parliamentary procedure, great. Can I call the question then on the recommendations from the workgroup on Meaningful Use 3?

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

I have one quick question.

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

Yes ma'am.

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

The difference between CDA and C-CDA are C-CDA is a constrained CDA basically and I'm wondering whether in some cases, we should have CDA?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

No, no, I think that we got that message back and I think that is a change that –

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

It's going to be –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– we're going –

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

– that's right, flexible.

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

Oh good, okay, great.

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

Okay, all of those in favor of advancing – thank you sir – advancing the recommendations from Meaningful Use 3 Workgroup on a set of measures that would be further moved through the process for Meaningful Use Stage 3, please raise your hand. Or if you're on the phone, you can email or declare yourself. And all those opposed?

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

Gail and Scott on the phone.

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

I will vote yes to –

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

Gayle, we didn't hear that, can you just – can you repeat yourself?

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

Okay I will yes to move forward but – .

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

Sorry Gayle, we still didn't make it out. Do you approve?

**Gayle Harrell, MA – Florida State Representative – Florida State Legislator**

Yes with –

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

Thank you.

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

Yes, this is Scott. I vote to move it forward as well, I have some concerns about it, I'm going to transmit them in writing. But I think the workgroup did very good work and I think from the standpoint of our role here, we should advance these.

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

And so it's approved. Thanks again to the Meaningful Use 3 Workgroup and I'm going to turn the chair back over to Paul and I'm going to step out. Thank you all, great discussion, looking forward to April. I'll be back, though.

**M**

Great job.

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

Thank you.

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

As we transition, if you wanted to place a lunch order, if you could fill out your form and I will come around and gather those as we switch to the next presenter.

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

Thank you and thanks for the vote to move it to the next stage. And thanks for keeping us actually on time. So we're going to get an update from CMS and ONC about how things are moving. One of the – Rob Anthony has shifted his job responsibilities and Beth Myers is going to be our new representative from CMS to be giving us our updates.

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

Just make sure I have the hang of this. All right, thank you everyone. My name is Elisabeth Myers. I am the new Policy and Outreach Lead for the HITECH Program at CMS. I have a couple of updates on our registration and attestation numbers. I did not include as much on individual measures this time; as you all know, we're in the middle of an attestation period. We will have a lot more data on that next time and the time after. And we also have an announcement to make today at the end of the presentation on data.

So our registration is up to 296,000 for Medicaid eligible professionals – Medicare eligible professionals, I apologize, and we do have 147 Medicaid providers who have come in. Our total is hovering just under 450,000 for registration. You will note in the Medicaid totals that we now have 30,000 Medicaid providers who have been meaningful users and been paid for Meaningful Use. Our total there shows the 142,000 who have been paid. And for Medicare eligible professionals, we have paid out just over 4 billion dollars and for Medicaid eligible professionals, the states have paid out 2.6 billion dollars. And you'll see the hospital number is including a nearly 2 billion – or million dollar payout for attestations that we have received for 2014.

So this is our current month – or I'm sorry, year over year attestations. So you'll see that we do have – I'm sorry, paid. I'm sorry guys. We do have 218,000 paid providers for Medicare and we are up to 112 for Medicaid and our eligible hospitals, we've had 4477 paid, that does include the new ones who have been paid over the past few months. So overall we are up to over 90% of our hospitals are registered. We have paid almost 90% of hospitals for participating in the program. We have total registered Medicare, we have just under 300,000, it's about 55-56% and out paid eligible professionals are over 200,000, as mentioned. The total there and I'll touch on this again later, is now at 65%, so we're looking at nearly 2 out of 3 eligible professionals have been paid for participating in the program or making a financial commitment in the program.

So, the highlights, approximately 89%, just under 90% of eligible hospitals have received an EHR Incentive payment for either Meaningful Use or to adopt, implement and upgrade. That is nearly 9 out of 10 hospitals have made a financial commitment to an EHR in their hospital system. Approximately 60% or 3 out of every 5 Medicare EPs are meaningful users that does include the new update from Medicaid. And below you'll see that 79% or 4 out of every 5 Medicaid EPs have received an incentive payment, that includes AIU and Meaningful Use, but please note that 21% of those Medicaid EPs are now meaningful users. And you'll see that again, the 2 out of 3 Medicare and Medicaid EPs have made a financial commitment to the EH – to implementing an EHR in their practice. So total we have just under 350,000 Medicare and Medicaid EPs who have received an EHR incentive payment.

So as I mentioned, we do not have updates on attestation at this time because we will be providing further details. We are having high volumes of attestation over the past month; as you know, we have extended the deadline to March 31, to allow as many providers as possible to get through the system and submit their attestation for the 2013 reporting year. We have nine hospitals who have attested for the 2014 reporting year and we also have an announcement to make about hardship exceptions. There have been a lot of questions about them and we have a new policy that was announced by the administrator at the HIMSS conference two weeks ago. And that is that hardship exceptions will be available for providers who are unable to obtain or implement 2014 certified software that is software that is certified to the 2014 edition.

And that that – the way that works for providers is that the payment adjustment's on a two-year cycle so for 2013's reporting year, the payment adjustments begin in 2015. For 2014's reporting year, the payment adjustments begin in 2016. So in addition to updating the forms to allow providers to apply for these, we've also put out guidance that explains the deadlines for them. The deadlines are a little bit confusing. For 2013 and 2015, which is the period that we're in right now and accepting hardship exception applications, that does include any new providers in 2014 who may not be able to obtain 2014 certified software. Those providers would be able to apply for a payment adjustment hardship exception right now. For returning providers, the time for them to apply for a hardship exception is by April 1 of next year, so that's April 1, 2015 for eligible hospitals and CAHs and July 1, 2015 for eligible professionals.

So again, that form is up right now for any new providers or anyone who missed the 2013 Meaningful Use and wants to apply for a hardship exception for 2015 and you will see the new forms for the 2014 and 2016 years following the close of this particular period. That is all I have. Do we want to do questions on any of this now or do you want to –

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

Umm, yes, I think let's do the ques – yeah.

**W**

Beth, maybe you could describe how people could find those applications –

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

Sure. No problem. The applications and tip sheets are all available on the CMS website that is CMS.gov/ehrincentiveprogram. On the left hand side you will see a set of navigation options, one of them is payment adjustments and hardship exceptions. If you click on that, it will take you to a page that contains information on how the hardship exceptions work, what the payment adjustment would look like, who can apply, what the various categories are, an overview tip sheet that explains all of the different categories including this new classification for 2014 cert. As well as two brand new tip sheets, one for eligible professionals and one for eligible hospitals that explains the 2014 cert availability exception.

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

So, I think that's a major announcement.

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

Yes.

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

If you could just clarify, you said, are not able to obtain, I understand that part or implement.

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

Right.

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

What qualifies as not being able to implement? Who decides?

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

So we will be providing further guidance on how – what documentation will be required, we're going to be working with ONC and with the vendors to determine that, so that will be available later. I can't answer directly to what that guidance will look like right now. We have provided instructions on what the timeline looks like, so that should help get us started. What we have found from the research that – and the projections that ONC has done is that just because something is certified on a day does not mean it is necessarily implemented in a day. So we're trying to be cognizant of that and figure out what the best method will be, as I said, working with our partners at ONC and with the vendor community to understand what their projections look like to come up with further guidance on that.

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

Thank you. Well, you heard it here first.

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

And as I said, I will have more information on the data, as we're getting attestations in, for our next meeting.

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

Good, thank you. And Jennifer, do you have an announcement for us?

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

Nothing that exciting.

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

I'm sure Marc was looking for that.

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

But I do have some data that I hope you all will be interested in, to follow up on our conversation from last month about possible ways to measure progress towards one of the goals that was included in the HITECH. So that goal is the utilization of an electronic health record for each person in the United States by 2014. So as we started to discuss last meeting, there are many different perspectives you could take to try to measure progress towards this goal, many different data sources and ways to go about calculating measures of this goal. And so we've done some work to assess possibilities and compiled some of the existing data here for further discussion at this meeting.

So we really boiled it down to three possible perspectives that you could use to measure progress towards this goal, to understand what share of persons in the US an EHR is being used for. So the first perspective is the provider perspective. This is a perspective that you hear about a lot in these meetings and it's the perspective that ONC typically relies on in terms of performance reporting and it really asks the question of what share of providers in the US are using EHRs? A slightly different and complimentary perspective is the encounter perspective, so looking at what share of healthcare encounters are taking place that providers using EHRs? And this really focuses more on the extent to which EHRs are being used across the healthcare that's being delivered in the US. And the last perspective is at the person level, so asking the question, what share of people in the US have their medical record in an EHR?

So there are, as I said, many different data sources that could get at each of these and we've identified several different surveys that provide information across all three of those perspectives. So first the provider perspective, these data here are from surveys of physicians and hospitals that show that a strong majority of physicians and hospitals had adopted some type of EHR as of 2013 and 2012. So in 2013 over three quarters of physicians had adopted some type of EHR. And in 2012, over 9 in 10 hospitals, 93%, had adopted some type of EHR.

Looking at the encounter perspective, we see that in 2012 the vast majority of hospital admissions took place at a hospital with some type of EHR, 97%. And on the physician side, the most recent data we have on this is from 2010 where just over half of all physician visits took place at a physician with some type of EHR. So since in these data are a little bit old, we tried to project out what we would expect this to be in a more recent time period. And in 2012, the percent of physician visits at physicians with EHRs was really highly correlated with the percent of physicians who had an EHR, so that percentage was about 52% in 2010. So if we assume that that really close correlation will persist in future years, we can project that about three quarters or more of physician visits in 2013 are taking place at physicians with some type of EHR.

And then the last perspective is the person perspective, so the percent of adults who report that their medical information is maintained in an EHR. So, the slide shows data from two different population surveys that asked similar questions of US adults; they asked, to your best knowledge, do any of your healthcare providers maintain your medical information in an electronic health record. And the percent of adults that answered "yes" to this question ranged from about 65% to 88% in these two surveys, that were fielded in 2012 and – the end of 2012 and into 2013.

So if we look across these three perspectives to try to get at this question of how much progress we're making on the HITECH goal of an EHR being used for all people in the US, you can see that across these three perspectives EHRs are being used in the vast majority of cases. One thing to note is that these measures reflect any type of EHR, so still a lot of progress to be done in terms of the extent to which advanced health IT functionality in Meaningful Use is making its way through the entire healthcare system. The extent to which we're reaching beyond the healthcare system to engage the population that has less contact with the formal healthcare system and the extent to which these data are being put into the hands of patients through accessible electronic formats as well. But, if we look at the HITECH goal of some type of EHR being used for all persons, across these three perspectives, in like the time period of 2012-2013, we see that EHRs are being used in the vast majority of cases. And that is that data that I have to update on the request from last month, so, happy to discuss in more detail.

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

Let me ask David Lansky if that's what he was looking for.

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

Yeah, I think that's great. Thank you for doing that, it's a very good perspective and very good conversions across a lot of the data points. Thanks.

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

Thank you. Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, also I want to thank you for doing this and it is a hard issue to do. As I read this, I get the interpretation we're doing really well, but we're like not – we can't say we're at 100%, I mean, that's sort of like the conclusion. Although 100% is the goal, although no one really knows what 100% means in like political context, because – I mean, I don't mean to say that in like a sarcastic way. But I mean it is clearly the case that there are some segments of the population who never see a physician at all, possibly for religious or cultural reasons, so they would not have an electronic health record.

But my comment here is, as I understand your methodology, but the goal is not that every single encounter be in your record or that every single hospital admissions be in your record, you just have to have a record, at least one. Because people have more than one electronic health record, so my suspicion is that the percentage of the persons who have records is actually much higher than this number indicates. In other words, if you look at the provider encounters that are not on a computer – I mean one specialty that we'll talk a little bit about this afternoon is psychiatry and remember, the number's right something like half the psychiatrists in this country, for different reasons, don't have an electronic medical record. And my comment would be, well that doesn't necessarily mean that their patients don't have an electronic medical record, because those patients see – have primary care providers and see other physicians so they most likely have records there, and they may even have some indication in their record that they're – of whatever the reason that they're seeing the psychiatrist. So my point is that somehow, while I think this is very good, I think there might be a way to look at this data and come to an understanding that the number for 2014 may not be 100%, but it's well into the high 90s, and actually be able to quantify that. And in quantifying that, being able to do a victory lap because it would be a significant accomplishment.

And so one of the things I encourage you to do is to think a little bit about what is the nature of the organizations that do not have electronic health records? And – because I think a lot of them are probably people who practice in single specialty groups and whether or not it's likely that those patients have other records and one source you could look at, in terms of trying to get some of that information, I would suggest to you actually would be the vendors. Because the vendors will be able to tell you very clearly to what extent they're installing new customers, are they replacing a system or are they installing a new system. And if they're installing a new system, they should be able to tell us, if they're really taking somebody who's manual and putting in an electronic health record, they should be able to tell you something about that group, is it a single specialty group? Is it in a rural area? And I think that that information might help you to understand these numbers a little bit better and come to a conclusion that we're actually very, very close to the goal.

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

Great, thank you for those comments. And it's a good point to look at some of these, especially the encounter perspective, perhaps broken out by different specialty or other characteristics, to try to really get at some more – primary care specialties, for example, where we would think that the penetration might be even higher. Thank you.

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

Any other comments or questions? Well thank you. I think it's good news from both of you and we look forward to drilling down on now, once it's in, what do we do with it and all the – and showing the good things that we can do with it. Thank you, Jennifer and Beth. Okay. Next we're going to have an update on the classification of health IT workforce, and this is Larry Wolf and Norma Morganti. (Indiscernible)

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well good morning, so let's see if we can keep you awake for all this exciting stuff that we've got going next. So workforce development is really at the hub of what we're trying to do, right, if we don't have folks who actually can use these systems, then they're not going to get much use. The workgroup has had several charges, and we're quite a diverse mix of folks, we represent academics, providers, vendors. I'd say there's even a fair number of patients and families in there, too. And we have representation from several federal agencies that relate to workforce development.

So we'll actually talk about three things today. The first one is a statement about where things are with standard occupational codes, so – no – yeah, yeah, standard occupational codes not as it applies to where people work for patients, but to classify the workforce. So that's a periodic update that Labor does and we'll talk about that. We also presented previously on some of the ONC-funded Workforce Programs, so this is an update on that and there is a recent report from ONC that we'll be referencing. And finally there's some really pretty exciting work for those who are in workforce development, we'll do the human resource side of Health IT, making sure that they're actually – the people with the right skills available, and I think there's actually a great model that's been developed we'll be sharing with the Committee. I guess I should keep an eye on time, too. So what I'd like to do is split the time so that we do really a short presentation on the occupational codes and then have time to focus more on the other activities.

So, what is this? This is a standard that the Office of Management and Budget has in place, it applies to federal agencies and is used for statistical reporting. It addresses a lot of government analysis and also private side analysis on supply and demand, it both supports through funding opportunities and through helping organizations understand where there are education and training gaps and resources, as well as being used in job search and placement. The important thing for us to know here is that there is a Standard Occupational Classification Policy Committee that makes recommendations to OMB on this topic and that they are in the process of getting ready to ask for input.

A little bit about the code structure itself. So, it's a hierarchical classification scheme; there are some major groups, some minor groups and it keeps breaking down. And it this is a structure that's revisited every eight years and so we're beginning the update cycle for 2018. I guess I should point out that when the workgroup first started doing its work, we asked what are the statistics on who is in the workforce, and we were told, basically, well there's a gap. We can tell you who are healthcare worker and we can tell you who are IT workers and we can tell you who are IT workers in healthcare settings. We can't tell you who are the informaticians. We can't tell you who are the people who are actually skilled at implementations. We can't tell you who are the people who are good trainers because we don't collect that information because it's a kind of job that isn't in the classification system. So that really is the gap that we're looking to address. This is an example of what sort of the major, minor groups – occupations do and then getting down to detailed occupations, which might actually align to a job description.

So a bit on timing; we expected that the first Federal Register – better get good at saying that, I'm going to say it a lot today – Federal Register notice would have been out already, we were anticipating that at the end of 2013. It is not yet out. That kicks off the cycle of getting input. So maybe the good news is the workgroup is in advance of that and might have something to submit when the solicitation for input goes out.

So this is where we are, we're going to be recommending that a new minor occupational group is created for Health Information Technology that sits at the intersection of Health Care and Information Technology. And these are some examples of the broad occupations that we would want to recommend. The workgroup is still tweaking this list, so input is welcome on things you think we should address or areas where you see confusion. But there is a fair amount of fluidity in the headings people use and at the risk of becoming a standards group, we would like to get some useful information out there so it can be early in the cycle and then there will be opportunity for tuning as we go.

And we've done a lot so far to solicit input. The column on the left is information that's being asked for by the Policy Committee and the subgroup has been working, as you can see on the right, to do a wide variety of things to bring in various professional associations and other resources that might give us input into what the job classifications ought to be. We've also asked for some providers to provide us with their job descriptions, so we're getting – looking to get as much hands-on feedback as we can for how this is really being done. So as I said, this is all in anticipation of a Federal Register notice and then we'll be bringing back some recommendations to the Policy Committee once that's out, because we would like a formal recommendation coming from this group as input to the Department of Labor. So, that's it. Any comments, questions on this piece?

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

David Lansky?

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

I just have one quick question. I just paused over the classification within the healthcare practitioner's major group.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

And partly because I think of so many people working in this space are not in healthcare organizations per se, they're somewhere else, does this also get placed in some other part of the hierarchy or is this where everybody in this skill set is going to be categorized?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, so, that's a really good question. The thinking of the workgroup was that this could have gone in various places, it could have gone in a tech classification, it could have gone – could go here. We decided to put it here because it is primarily about health care, but this does not constrain where you do your work. So, if you were a software developer, you could presumably fall into the IT side, which already has a robust set of buckets, or you could say, well the kind of IT I do is in here. And the fact that I'm an IT person doesn't prevent me from being in this group. So it recognizes that this is a hierarchy that forces distinctions but doesn't require that because you pick an end point that you're in a healthcare organization. I don't know if I'm helping or hurting by answering it that way.

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

So, interesting, I'm thinking about the sort of political social analysis of the top group, of all the people who are going to work let's say in the apps world and start-ups and happen to be doing health-related projects, they're now going to be classified as healthcare practitioners, in some high-level industrial taxonomy, which is interesting. I'm not against it, but it's part of the evolution we're going through in the whole field.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

And they may not see themselves that way –

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and they may say, no, I don't think that I'm a –

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– a health IT systems support person, I'm a network guy and I want to be in the network bucket.

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

Or in fitness or who knows what other –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

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

Neil?

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

So I'm missing an important piece of information here. So as an employer, how do they get the information on the – these – all these crazy jobs that we've created that are in between healthcare and IT? Like how did – number one, how did your committee get input from the broader community of folks to know that these are actually the jobs that are being created? And number two, what does it mean to me because I don't remember ever taking the thousand people that work for me and classifying them as anything? So how does that impact me?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, if we were in the workgroup, I would turn to one of my labor department folks and ask them that question. My understanding is that some of this is – will show up in like census surveys. So it may not be something that you as an employer are using this specific classification code, but I might be wrong on that, there might be someone in your HR Department who's actually filling in some forms that are picking this up. That's a good question, we'll get – I'll get an answer on that.

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

Any other questions or comments?

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

Yes, just one follow up comment. I think the labor unions have an enormous – a lot of what we're doing now with 1199 and other unions is really trying to define what the jobs are of the future and I'm just amazed that you're on an 8-year timeline. It feels like 8 years from now, people will be – won't even understand the language that we're using now for these jobs and it just seems to be – it seems amazing that for parts of industry that are evolving as quickly as this that there isn't an opportunity to short – create a shorter timeline. And it may not be so much in terms of the people working on an assembly line in the automotive industry, but in this industry, it seems like we're always going to be far behind what's actually happening on the ground.

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

Statistics are hard.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I can see Neil's point –

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

– meaningful, they have to be –

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, so we did have examples in here of some jobs that you look at now and you scratch your head about how did they ever get in. Not so much in the Health IT area, but we did see some others, and that's part of why the Department of Labor has a pretty high bar to getting something set in this, that they want things to shake out in the world before they formalize it. But it does create a problem of, you don't know – you create a blind spot around that activity.

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

It's a really high bar – IT. All right, do you want to go on to your second topic.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, so let's move on, thank you. So I'm actually going to pass the baton to Norma for most of this work, she's been very close to the programs and some of the new work. So Norma, will you introduce yourself and I'm ready to advance the slides for you.

**Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College**

Oh great. Thank you. This is Norma Morganti and I'm Executive Director for Health Information Technology here at Cuyahoga Community College, Corporate College Division. And prior to December of 2013, I had been involved in not only the first part of the Workforce Development Program leading the Midwest Consortium, but also the development of some supplementary materials for ONC focused on patient-centered care with Health IT. So I'll be talking to you about all of those and I'm really pleased to support the – report back out to the Committee about the ONC-funded Workforce Programs that we received at the working group level. Next slide, Larry.

So this is a really nice overview of all of the hard work that happened under the Workforce Development Programs funded by the ONC. The first part was a curriculum development, looking at the slide, 20 components and 18,000 plus downloads of that curriculum that fed the University-based Training Program and also the Community College Consortia Programs. Which you can see did a great job in graduating a lot of students out of their programs and also getting those students into meaningful employment, either in health IT or up scaling them many times in the Community College Consortia Program, to utilize health IT in their current jobs. So this is just a really nice wrap-up. In addition, over 9500 exams were delivered for the HITPro Exam, which was a competency exam that was delivered to many of the students coming out of the Community College Consortia Program. Next slide, please.

So we wanted to just really point out the highlights and some of the crosscutting findings that NORC, who was the evaluator. NORC, out of the University of Chicago, posted a final report. I do believe that that's up on the ONC's website. You can get, I think it's 200 plus pages of a report and we really just wanted to synthesize for the Committee these crosscutting findings that we found very informative. Really I think that none of us who were involved in guts of the program would be remiss in saying that communication and clarity of purpose at the outset probably was an area that would have created more momentum early on. Though the developers of the curriculum had felt that more communications up front with the community colleges and the HITPro exam folks would have helped them target those materials better. On the flip side, from the Community College Consortia, I think it really set us up to have to collaborate more and communicate more effectively across broad areas. So I think there was a lot of innovation from our work regardless of having all of that alignment up front and communication.

The ONC really did, from the findings, develop flexibility within the Workforce Development Program, and that was very helpful. So in the community college world, many of the regions took different approaches, so it gave us an opportunity not only to see what best practices were, but learn from each other about different approaches and really then develop for local communities as appropriate, because we know that all of this didn't happen at the same pace across the country. And then also the connection with the employer community was really of paramount importance to the graduates coming out of the program, so, for those who had really strong connections with employers, they had great feedback from the students coming out of those programs or internships that were developed, apprenticeships that may have and practicums that may have been developed. But many felt like this was an area that we needed more work on and that employers really were unaware of the training programs. But once they learned about them, and once they interacted and hired some of the graduates, they really did make the connection as to the quality of the training programs, both the University-based and the Community College Consortia. Next slide, please.

So, just wanted to let you know that all this work really did feed a lot of great sustainability across the country as far as Workforce Development Programs, 63 of the original Community College Consortia members and 9 of the UBTs, all of the University-based Training Programs, are continuing to offer health IT training. And the developer material, the curriculum, is still being used and, as a matter of fact, I think that Bill Hersh, who led that initiative just posted in a recent blog that those are now on the AMIA site, so, they're being hosted by AMIA for others to continue to use. And many colleges are moving the curriculum into other existing health IT programs and I think a lot of them are looking at ways of infusing them into other healthcare areas within the community college or the university space. So how do we use those – the health IT curriculum to support nursing education and allied health training, a lot of those different areas are valuable arenas for us to apply also.

And I think the other big piece that came from plans for sustainability is that we need to continually adapt it. Based upon some of the previous conversation, as fast as health IT is moving these days, education needs to keep – and training needs to keep up with the pace of that transformation. So, one of the challenges that the workforce – the working group level is definitely, how do we advocate for the sustaining of new materials that come out? How do we curate others? And I'll talk about that in a minute. Next slide please.

So a second piece of the work that we had provided here at Cuyahoga Community College under some additional funding from the Office of the National Coordinator was an opportunity to actually go to that next level and ask the question, how do we help practice-based staff utilize health IT in support of patient-centered care? Next slide, please. And part of that work led us to really try to scale the journey that practice-based teams would be going through in a visual, because we know that definitely transformation is a journey. Sometimes that journey is an upward climb from a paper-based record world into Meaningful Use Stage 1 and then ultimately into a patient-centered medical home.

So, one of the deliverables from that funding was this visual, and really, the purpose of this slide is to help you understand that at the very bottom level, where we see stage – the second step on the journey with electronic health records and then to Meaningful Use Stage I type of application of electronic health records, that there's really been a broad base of materials and work already done. That's that first bullet that says healthit.gov, all of that material for that were developed and hosted there, the National Curriculum, 20 components, etcetera, HRSA the Department of Labor has funded a lot of other training programs and materials. So there's a wealth of material available to help support practice-based teams and healthcare at least implementing and adopting electronic health care records and attesting Meaningful Use Stage I.

Then we came to help develop some frameworks and some additional resources that would help practices move from Stage I type activities to patient-centered medical homes. We used a model and I'll share some of those competency frameworks. But, there's this additional level of work that we need to do around training, really focused on the incumbent workforce. And then also educators to understand the pipeline of what would be needed for new workers entering into the healthcare space, and what kind of competencies would they need to have to support health IT. And then of course at the higher levels, we're going to have to look to advocate and build and curate additional workforce resources to support those higher levels of transformation, because once you get past Meaningful Use Stage 2, you need to continue to optimize and – you're into this continuous improvement cycle. Next slide, please.

So this is an example of one of the resources that is hosted now at the HealthIT.gov site, but these are some very broad competency frameworks that were developed, leveraging subject matter experts and content experts who had been doing the hard work of patient-centered medical home and other types of transformations. And truly it breaks all of the necessary competencies down into unique learning objectives. And then to the right-hand side of these frameworks, we've detailed at a very discrete level, if you are a physician, if you're a nurse, if you are a practice manager, what would you need to know? And so the intersection of a learning objective and a role indicates that is something that would be a critical competency for you to understand. Next slide, please.

We also know that it's important to point folks to those resources that I had mentioned before, so much had been built already. So we asked our subject matter experts to share with us some of their best practices in areas that they found really good resources, and we incorporated those into secondary frameworks. And so you can look at a discrete learning objective and then look at the resource of the recommendation, find some really good materials to help you either learn more, access some training or perhaps develop some training or educational program. Next slide, please.

And then part of our work in addition to that journey, that visual journey for transformation, was to say, what are the leadership competencies that are required in the space of transformation? Because if you look at some of the basic workforce competencies, you'll see a lot of them around change leadership, around team-based care, around effective communication and patient engagement, quality and continuous improvement processes. So we took a step back and again engaged some subject experts to try to help us understand what were some of the key areas and key competencies that physicians as leaders and others within healthcare would need to have in order to support the sustained uphill climb of transformation. And we developed frameworks and some additional resources out for those. Next slide, please.

And along with the notion that continuous improvement is critical to transformation, we also developed a course that focused on the principles for the patient-centered medical home. Again, could be applied to any of the different models, we just selected patient-centered medical home as the model that we built out for, which really a vast array of objectives, but not intending to teach anyone to be a master greenbelt, but certainly give you enough to understand what is the continuous improvement? How does this apply to becoming a patient-centered medical home? Next slide, please.

And so some of the pieces that we now as a working group are continuing to focus on is, how are we going to continue to support the diverse healthcare workforce and the different modalities of training that will be required? We've had some presentations from folks who are working in the direct care worker space, learning a little bit more about what their needs are with not only different payment reform models that are in place, but also electronic health records and health information technology and telehealth, moving into that space. So we know that again, it's moving fast and transformation is going to require much more training, but also different modalities of that training.

And then certainly we're looking at what are the new pieces that should be incorporated into training for the current incumbent workforce and those that are new to the workforce, saying that we have the new payment models, ACA, Meaningful Use Stage 2 and Stage 3 being right there on everyone's radar. And then the last piece would be, what are the new and innovative education platforms or delivery mechanisms that can really support that continuous learning that is going to be required for transformation and sustainability of that – of continuous improvement and the new delivery of healthcare. And certainly we're going to look to learn more about different models that are out there. And with that, Larry, I am done with my part of the presentation, we can open for questions.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you, Norma.

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

Thank you, Norma for this nice complimentary, once we find them and count them, we need to train them – to the workforce. So, thank you for doing that. Comments or questions about the workforce training? It's nice to see the outcome of that section of HITECH.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'd just like to comment this is maybe not as jazzy as some of the tech things we usually discuss, but I think it actually is critical for being successful. There are a lot of resources being developed, there are materials in the appendix and so anyone who's got someone who's involved with workforce development, I encourage them to avail themselves of this material.

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

How can you argue with the sun at the end of the rainbow? Okay, Terry, please.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah, I just want to publically thank ONC for work, it's clearly benefitted the VA. We're hoping our work helps benefit the federal community, but by establishing that leadership and that recognition of how foundational the training is, I think we really are transforming the health IT landscape. And I agree with you, it's not quite as sexy, it doesn't have as much appeal, but this is such a critical part of what we're finding, at least in our large organization. So thanks.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you.

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

Doug, please.

**Doug Fridsma, MD, PhD, FACP, FACMI – Chief Science Officer & Director, Office of Science & Technology – Office of the National Coordinator for Health Information Technology**

Oh, I'm just going to pile on with Terry and to thank the committee for the work that they've done and to put a special shout-out for Chitra Mohla, who has been in ONC doing a tremendous amount of this work. One of the things that the Committee may not be aware of is that the Memorandum of Understanding between the US and the EU includes an activity there around workforce development. There is international interest in extending this expertise out there and Chitra and her team, as well as the work of the Committee actually is having an impact beyond the borders of the United States and actually across the European Union.

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

Good, thank you. Troy?

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

I think this is great, it's fabulous to see that workforce development is on the docket. One thing that I'm really curious about is, as we continue to move forward, I mean we're talking about Stage 3, we're talking about the future of healthcare as we know it. I mean, the old mantra, if you can't measure it, you can't improve it, and there's a lot of – you look at the lean processes in here, performance improvement through the IHI, different things like that. Is there anything in terms of – I mean there's doing it and then there's actually measuring it, right. I didn't notice anything about data analytics or data processing, research in these curriculums. Is that something I missed?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that is in our occupational code structure, so we do recognize the need for that. I'll have to let Norma or Chitra comment on how much analytics was addressed in the training materials so far.

**Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology**

So the evaluation that was done through NORC actually did measure the outcome of these programs and how many students graduated and how widely the curriculum was used. So we have extensive data available that's part of the evaluation report that was just published.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah I think –

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

Maybe I misspoke, maybe –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So you were asking about people who have skills in analytics?

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

Absolutely.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Not whether we did analysis of the programs.

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

Right.

**Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College**

Larry, could I –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Go ahead.

**Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College**

Yeah, it's Norma. So the framework that you saw that showed the competencies and the learning objectives, we developed four frameworks in total. One was just around patient-centered medical home, one was around health information exchange, answering the question how does health information exchange impact patient-centered care? We had one for Meaningful Use and then the final one was around population management/data analytics. So there is a whole framework and aligned resources around that piece. And then we developed out four total hours of e-Learning and one of them is really around how to utilize – I mean, the data analytics is really embedded throughout all of them at various levels, but certainly it's something that deserves its own framework in and of itself.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I'm going to jump ahead into the appendix, just to give you a little bit of support for that. So there's – it's there somewhere. Here we go, so I have up the competency slide and so you'll see that we've got – do I have the right one up? Are there two of these? Okay, yeah, I was looking for the – I thought there was another one on data in here, deeper than what's shown – there we go, thank you. So we have in population management, turning data into action, data and documentation.

**Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College**

Um hmm.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So it doesn't have the sexy analytics word in it, maybe we need to pay attention to that.

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

I think that's where the trend is heading. Being – having people that are savvy with understanding the database structures, how to extract the data –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

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

– and then presenting it – present it in a meaningful way, as well as exchange it with registries and others...

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

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

– that would utilize it. So we need them on both ends, not only on the creation side, but on the receiving side so that they can actually manipulate it and make it meaningful. We have a huge issue with that right now as we've – we're very data rich, but it's extremely difficult to communicate that in a meaningful way to say, we are improving health care, we are improving outcomes. So if we can make that part of the key point of the slide – and as we move forward, I mean obviously we get more and more and more data, we're going to need to filter through all that stuff and we need people who are savvy with doing that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Good point, thank you.

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

And any remaining comments?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I'll toss out one final thing that we considered and it came up during our discussions with our folks from the UK as well. So, the biggest workforce is unpaid, is the family, the caregivers, the people who actually are in the home helping someone take care of their health. And so we did look at that as a piece, in the end we decided that it was a little bit out of scope for the workgroup, but I think that a lot of the resources being developed at the granular level will be of value to individuals improving general health IT literacy. And that this is something we should think broadly about being not just for professionals, but start embedding in the elementary curriculum, like around just what is it to be healthy?

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

I think that's a really important point and it's one of those, if we can't count it, then we can't address it. And more and more, especially for an aging population, that workforce is crucial in almost the same way we talk about patients and families being part of the health team and being part of the HIT serving that group. If we can't identify them – that's a ver – and if we have to wait another eight years before we go, I mean, I'd almost think we need to think about that seriously.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, I think it's outside the job classification, but clearly is an important role in health care.

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

Yeah, absolutely. Any other comments? Well thank you Larry, thank you Norma for a very enlightening presentation and summary of the work.

**Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College**

Thank you.

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

Okay, now we're going to open up for public comment.

**Public Comment**

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

Operator, can you please open the line for public comment? And as we go to do that, if there's anyone in the room who would like to make a public comment, please come up to the table. As a reminder, you have 3 minutes for your public comment. If you could please state your name and let us know who you're speaking on behalf of, we would appreciate it.

**Alan Merritt – Altarum Institute**

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

**Dan Rode, MBA, FHFMA – Independent Consultant**

Good morning, my name is Dan Rode, I find myself right now as an independent consultant, you know what that means. I'm also working right now with physician's offices, especially primary offices who are looking at both the implementation of ICD-10 as well as ongoing work with the electronic health record. And I wanted to make a couple of comments to this Committee because I think, as was mentioned earlier this morning, this Committee has a role in the setting of policy even beyond Meaningful Use and so things that you need to take a look at.

One of the first things that I discovered is that as we are moving through the various stages, we often get into a situation where the vendors of the software, following the certification, have often taken out functionality because it was no longer included in the structure, which is affecting the workforce or the workflow within those offices. So as we look at these criteria, I would really urge this Policy Committee to consider at least making sure that vendors understand that as we have built these in, and now you're no longer going to talk about them, as we talked about this morning. That vendors understand that as physicians have adopted these, they'd like to keep them and that we are building systems that have to be more than just the criteria, and I think most of you understand what that means.

The second piece of that is in the certification process again, and that is, does the output actually is it understandable by the patient. Now I have seen some output, follows the HL7 criteria wonderfully, you can't read it. And I think there needs to be a test of, can actual patients understand the information that's coming out. It was all there, but you couldn't read it and I've been in healthcare for a long time, and if I can't read it, I don't know what the average patient does.

I also, as a third point, like to look ahead, we're talking 2017, and as we talk 2017, I think we need to take an environmental scan of what's happening. So for instance, I'm beginning to watch functional status codes being developed as part of the Medicare Program. I think we need to look at how the US might look at international standards and other standards so that as we move forward and we're looking ahead, that we begin to put those in place, and certainly that deals with the outcome.

And then I'll just make a comment on the comments that were just made. Many orga – places, certainly I live in Fairfax County, Virginia, have education programs for the community, often put through the high schools or through the communities themselves. Wouldn't it be great if in our workforce education we take some of that information and put it out so that caregivers could receive it as well. I really appreciate the work you did, especially the Meaningful Use group this morning, and I wish you continued success and I look forward to this group getting beyond just Meaningful Use, capital M, capital U.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Good afternoon, I'm Mark Segal, I work for GE Healthcare but I'm speaking today for the EHR Association. I really want to underscore our general support for the Meaningful Use Program and our delight at seeing the major progress in adoption and Meaningful Use that we saw in the data that Beth presented. And we certainly appreciate the hard work and thoughtful work by the Meaningful Use Workgroup in developing the proposals and the discussion today and the focus on outcomes. And I've listened to the last three workgroup meetings and been very impressed by the nature of the deliberations. And particularly want to thank Dr. Tang and Dr. Hripcsak and the workgroup for the work in reviewing, revising, focusing, eliminating objectives to really increase the focus of the proposal and appreciate the consideration of the development burden estimates that the EHRA presented.

And overall we really believe that the Workgroup and Committee do very good work, but that a much more focused approach is still needed to get the most value from the program and we urge ONC and CMS to embrace that view as they develop their next proposed rules. We'll do a detailed review of the final recommendations, but wanted to give a quick, high-level response. Based on what we're learned from Stages 1 and 2, and that was a theme today, and as many folks have raised, we really do think that a more prioritized approach is needed, going beyond the work that we heard today.

Fundamentally the emphasis should be on greater and more effective use of the really robust capabilities that are in the 2014 and Stage 2 requirements, and any needed interoperability enhancements. This approach will enable providers to get the intended benefits from these significant capabilities in the 2014 certified versions, and enable us to really focus on the priority needs identified by our customers and reduce the extent to which government requirements are squeezing out development requested by our customers, slowing certification implementation and potentially hindering usability. It will also enable ONC and CMS to achieve their policy goals with excellence in implementation in the context of the diminished resources we've been hearing about. So what we – was adopted today, which still had many new or materially revised requirements that will impose burdens with uncertain value on providers. We've seen that providers now recognize the changes that only affect certification are really not cost-free.

And in general we believe that new and emerging technologies that enable value based payments and accountable care should advance in an innovative manner, outside of Meaningful Use or certification and shouldn't be forced into a regulatory construct. We think that the market will provide the needed functionality. So again we thank you very much. We urge that as ONC and CMS do the work, that they consult actively with the vendor community, particularly looking at the usability implications of each proposal. Thank you very much.

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

Acknowledge that during the Meaningful Use presentation, EHRA, thank you for providing some of the feedback, the input for the development effort required, appreciate it, it was helpful.

**Diane Jones – Senior Associate Director for Policy - American Hospital Association**

I'm Diane Jones with the American Hospital Association. Thank you for this opportunity to provide comment. I first also want to echo comments that were just rendered concerning the appreciation expressed to this Committee for the work that you have undertaken and frankly, the service that you have rendered. It is not as simple as one might think. I think someone talked about likening this to developing a car and it is significantly more complicated than that.

At the same time though, I do have a few high level points that I'd like to share with you for you to consider. I recognize that this group is very much focused on the aspirations for what the framework and infrastructure can support, but we are in 2014 in a time less perhaps of aspiration and more in terms of implementation and action. And a number of the comments shared today underscore, I think, the chasm between the aspiration and the reality on the ground. While it's encouraging that 9 hospitals – eligible hospitals to date have attested for Stage 2, yay 9. The reality is, we're what, 20 days from the end of the first half of the year for eligible hospitals, so clearly there is a challenge with respect to the current construct, in terms of the ability of those who are required to comply with the regulatory framework to actually do so. And certainly in this context, to do so safely, so that they're not also doing anything that would endanger the care that is rendered to those individuals who come to them. So I would urge you certainly to keep in mind, going forward, as you are thinking about the aspirations, to think about the very real challenges on the ground.

And second I would note that there's nothing in ARRA and HITECH that requires an adherence to a timeline above all, nothing. It's okay to not race ahead in advance of data that we would hope would inform the guidance that you as a FACA are giving to the federal government and ultimately to this larger activity intended to redesign the healthcare system. So with that I'll stop and thank you very much.

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

Thank you.

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

Thank you. We have a couple of comments on the phone that we're going to defer to; if Martha could please go ahead.

**Martha Philastre – Director, Palliative Care Administration – Baylor Health Care System**

– Philastre and I'm calling on behalf of Dr. Bob Fine – work with the Palliative Care Service at the Baylor Health Care System. Our – at Baylor Health Care System, we have an advanced care planning strategy that involves making advance directives and advance care planning as a routine part of preventative services for all persons ages 18 and over, as well as encouraging people to have a digital advance directive. Our system-wide strategy has been approved by our Board of Trustees and that would be really significantly enhanced by a Meaningful Use criteria supporting it.

We adopted this strategy because we believe that limiting advanced care planning and the creation of advance directives to patients over the age of 65, or to patients with terminal illness, has clearly not worked well historically both in our clinical practice and nor in famous end-of-life cases, to reach public and legal scrutiny, such as Terri Schiavo. So we believe all persons over the age of 18 should have a basic advance directive indicating his or her medical treatment preferences, in the setting of terminal or irreversible illnesses.

When patients at any age develop a more serious illness, advanced directives could then be reviewed or updated and when a patient is terminally ill or irreversibly ill, then transitional care planning based upon prior living wills or medical facts in the case and surrogate statements may ensue. We believe that advance directives will be more useful when created, updated, stored and retrieved digitally via a service that has accessible to patients and healthcare providers in any location. So we often see copies of advance directives either in the patient's chart or as a PDF in the EHR of one of our physicians or facilities, but that cannot easily be transmitted or delivered to other hospital providers that's not part of our healthcare system, and even, frankly, within our own healthcare system. And it's commonplace for our patients to change providers or to require treatments by physicians at other facilities other than within our own system, and our – only a digital directive can make this easily meet these needs under these circumstances.

Patients may also change their minds as time moves on about their content of their advance directive and a stored and scanned document or paper document. There could be many different versions over time and the wrong version may be retrieved, you may not be accurately reflecting what the patient's most recent preferences are. So a digital directive, on the other hand, is always up-to-date and most common recent, edited directly by the patient. We are working digitally – diligently within our own IT team to help embed this within our own EHR system. Thank you.

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

Thank you. There's one more comment on the phone, if we could go to them first. Scott Brown?

**Scott Brown – President and Co-Founder - MyDirectives.com**

Good morning, this is Scott Brown and I'm the President and Co-Founder of MyDirectives.com. We wanted to comment as well today on the Meaningful Use Workgroup recommendations with respect to advance directives. While we applaud the workgroup's recommendation to move advance directives from menu to core for eligible hospitals, and it's inclusion as a menu item for eligible professionals. We would strongly urge the workgroup, the HIT Policy Committee, ONC and CMS to finally take advance directives into the 21<sup>st</sup> Century by leaving behind the upload and store document functionality and require certified EHR technology to link to a live document when possible. It's a very simple change, remove the "or" in the "and/or" requirement for certified EHR technology. Furthermore, we would urge you to broaden the requirement to include all patients 18 and over, or at the very least, to include all Medicare beneficiaries.

With respect to the first point, we would point out that in August 2008 Health & Human Services submitted a report to Congress on advance directives and advance care planning that clearly stated that one of the major failings of advance directives over the past 40 years has been the focus on form over substance. The current proposed recommendation perpetuates a system that decades of research has revealed, with very few exceptions, to be a failure. You, the members of the Committee have the power and the opportunity to fix that.

During the Care Planning virtual hearing that was held by the HIT Policy Committee, Certification and Adoption Workgroup on September 23 last year, and during the follow up meeting held on September 27, multiple participants called for a more robust solution that involves the use of interoperability and structured data with real-time updates. Paper documents do not allow for any of this and the recommendation as currently drafted, perpetuates that system. The recommendation, as currently drafted, supports technology that has existed and been deployed for more than a decade, that's to say scanning and uploading a paper document, with very poor results. It does not raise the bar at all with respect to Meaningful Use of electronic health records.

As demonstrated HIT Standards Committee, in a meeting held on January 24, and this is critical, mature technology already exists to support the embedding of a dynamic, persistent and highly secure link into an EHR using well accepted standards and the C-CDA. Anyone who still believes or claims the contrary is simply misinformed and incorrect. On the age requirement, we'd like to bring the Committee's attention to several points. First, going back to this 2008 report to Congress on advance directives, as well as decades of peer-reviewed, published research, there's confirmation that one of the reasons advance directives has failed as the system's focused primarily on people who are older, frail and chronically or terminally ill. This is a perfect opportunity to address that problem. Furthermore, during the September 23 Care Planning virtual hearing and again during the follow-up meeting, again multiple participants called for criteria to include everyone 18 and over, and we would urge you to listen to the experts that you called to testify.

Finally, if reducing the applicable age to 18 really just – is just too hard, and if the Committee feels like it is constrained by the objective to limit the requirement in situations where Medicare reimbursement can be used as a carrot or stick, we believe the requirement should at least cover our Medicare –

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

Thank you Scott, your 3 minutes is up. I'm sorry.

**Scott Brown – President and Co-Founder - MyDirectives.com**

Thank you.

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

Please go ahead. Thank you.

**Jeffrey Smith - Director of Public Policy – College of Healthcare Information Management Executives**

Good afternoon, my name is Jeff Smith and I am here before you representing the College of Healthcare Information Management Executives, otherwise known as CHIME. Today indeed marks a milestone for Stage 3 Meaningful Use and the work performed by this group and many, many others is well deserving of the accolades that have been given today. But just as this is a very early stage milestone, there are many other milestones to consider and whether CMS or ONC adopts in full or in part the recommendations given today, we believe that a very focused and a prioritized approach is needed by the regulators from here on out. Specifically we hope that ONC and CMS will adopt only those measures and objectives that tie directly to prioritized use cases for interoperability. We also encourage policymakers to look at less prescriptive means for meeting Meaningful Use requirements in the next phase.

And also given the announcement that CMS made in relation to EHR hardship exceptions, we would like to take this opportunity to thank CMS for hearing us. But also know that we are going to be looking at this very, very closely. We appreciate that CMS is trying to get information out and out quickly, but at the same time, we need to make sure that the hardship exception categories are constructed in a way that deals with the fundamental deficiencies that we see in the program, mainly an issue of timing, availability and complexity. So if the exceptions of the office's EHR Hardship Exception provides the kind of relief that the industry needs, we will be more than supportive. If they're not, we will continue to push for the kinds of things that nearly 50 provider stakeholders mentioned in a letter to Secretary Kathleen Sebelius on February 21, 2014. Thank you.

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

Hi, Mari Savickis, the American Medical Association. I too would like to echo the thanks. Obviously, you're a group of volunteers, you've spent a tremendous amount of time and it is a volunteer effort, and for those of us who track it, I think we do appreciate all of the work that's gone into this. Also, would like to note some thanks to ONC and CMS for their recent announcement on the hardships, we appreciate that. We do have concerns that we don't think it goes far enough with respect to the flexibility that physicians will need to meet Stage 2, so with that in mind, we would like to continue pushing for that. We think that we need to get them across the finish line.

We'd like to note that going back to CMS' data on the 60% of eligible professionals who've attested, just want to note again, that was at some point in time, it does not tell us who is dropping out. For those of you who are not familiar with the GAO report, GAO found that for 2012, 61% of the Medicaid EPs dropped out and for Medicare it was 16%. So they started in 2011 and they dropped out in 2012. We're now, as Diane noted, almost at the end of the first quarter, and that means that 40% of eligible professionals have never even dipped their toe into Meaningful Use, so that is concerning.

It's also concerning that there is an indication that Stage 2 is going to be very, very hard to meet, and yet there's a lot of tinkering, which we greatly appreciate the scaling back of Stage 3, but if you're scaling back Stage 3 and we're having problems with Stage 2, we may never get to Stage 3. So we want to make sure that that flexibility is cooked in, as soon as possible, because right now, by our estimation, the physicians are making a decision to either not participate ever, or they will drop out right now. And so we need some indication from the government that that is – that help is on the way, in the form of flexibility.

We'd also like – we will be taking a lot of time to thoroughly go through the recommendations that you've made today on Stage 3. Again, we appreciate that you dialed back a number of them. We still think that there needs to be an increased focus on interoperability. We think the pedal on the gas with respect to certification needs to be lifted and that the vendors need to be freed up to focus more on the customers, which are the physicians and the hospitals, so they can better meet the usability needs. And we will – again, we will be focusing on this Stage 3 very carefully and we will work with the Medical Societies of states and the specialties to get all of their input and will provide a robust response. Thank you.

**Julie Cantor-Weinberg – Director, Economic & Regulatory Affairs - College of American Pathologists**

Hi, I'm Julie Cantor-Weinberg with the College of American Pathologists. I too want to thank the Committee for all its work. That being said, I'm kind of frustrated, we've gotten to Stage 3 and we still assume that all specialists are more or less the same or still focusing on the ordering provider, not the provider receiving the order. Laboratories and the pathologists that lead them are obviously key to the success of Meaningful Use. Pathologists in labs are eligible providers for Meaningful Use, but they're pretty much only eligible for penalties. CMS and the Stage 2 rule gave relief for pathologists, but they didn't give any clarity as to whether that relief was available for any more than the first year. So we need that relief for the full five years allowed by law.

According to the most recent CMS data available, less than 4% of pathologists are attesting to Meaningful Use. Those that are in large academic medical centers where they're writing the data of others. Pathologists have not control over whether or not they have that ability to engage in that data writing. So here you have a specialty whose information is so critical to the success of the entire Meaningful Use endeavor, but after 2015, they may very well be eligible just for penalties, and get no money for upgrading interfaces and the like. So when you talk about specialist, please consider not just those that place orders and have direct patient relationships, but the very unique and important role that specialists like pathologists have. Thank you very much.

**Lisa Conley – Senior Vice President of Global Sales and Marketing – Sunquest Information Systems**

Hello, I'm Lisa Conley, I'm a Senior VP at Sunquest. I'm here to speak more as a patient and not as a vendor. I am a Type I diabetic, I have been for over 30 years. For 25 of those years, I actually carried my medical record around as a military wife and in 2014 I still do that today. I live in a city with very good health care, but there are three major healthcare enterprises in there that do not communicate. So today I still carry my record around. I applaud this group, I think that we need to move forward with healthcare, but I ask are we ready for Stage 3? Should we be stopping and looking and seeing what is really happening out there and really listening to the patients today. Thank you.

**Jeff Coughlin – Senior Director, Federal Affairs – Health Information and Management Systems Society**

Hello, my name is Jeff Coughlin. I am the Senior Director of Federal Affairs at HIMSS. Thanks to the Committee and the Meaningful Use Workgroup for your hard work over the past several months, and I promise to be brief, because I appear to be the last person standing between you and lunch. HIMSS is committed to moving the community forward on the path to interoperability that leads to information exchange and supports healthcare in transformation.

We share the government's interest in open dialogue with the health IT community to ensure the maximum number of eligible professionals and hospitals could attest to meaningful use. We applaud the government's decision to extend Meaningful Use Stage 2 to allow more time for incorporating lessons learned from Stages 1 and 2 into the draft regulations for Stage 3. For Stage 3, we recognize the balance needed between preventing the overburdening of the provider community with ensuring all communities receive the benefit from health IT that can drive improvements in care delivery, improve access and control costs. So we support a less prescriptive approach to Meaningful Use Stage 3, one that focuses on encouraging and assisting providers to take advantage of the substantial capabilities established in Meaningful Use Stage 1 and especially Meaningful Use Stage 2.

We're currently conducting a survey of our eligible hospitals, eligible professional and Regional Extension Center stakeholders to identify particular Meaningful Use Stage 2 challenges. We'll release our findings, analysis and recommendations by the end of March and we'll share them with the group. I also just wanted to take a moment to highlight the relatively new HIMSS Value Suite, which documents the value of health IT and provides a highly credible source to the Health IT Policy Committee, the government and all stakeholders as the work continues towards Meaningful Use Stage 3.

Health IT return on investment includes several key areas including patient and provider satisfaction, improved quality outcomes, financial savings and cost avoidance. In using levels of evidence the HIMSS Value Suite has compiled over 1000 case studies and 7000 examples highlighting the tangible hard and soft return on IT investment. And our tool is freely available on HIMSS.org. So thanks again for the opportunity to make some comments today.

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

I want to close the morning by thanking everyone on the Committee and especially the Meaningful Use Workgroup that's really gone through this for a number of years now. But, and Mari also said, we're all volunteers and we show up and we participate because we all believe in this mission. And so I'll make clear how important that is, so thank you for the participation, thank you for the discussion. We really benefit from it. Thank you for the public comments today, I mean, they're all very worthwhile and significant. And vis-a-vis some of the comments that were made earlier, everybody listens to everything that's said and so that goes into every – the calculus for every discussion, decisions. There's no perfect decision, but everything is weighed.

So thanks everybody, the public, the Committee, for this very robust morning and productive morning. And so we'll break for lunch and resume at 1:15 PM. Thank you.

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

Operator, can you please open the lines, I think we're ready to get started.

**Operator**

All lines are open.

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

Thank you. We're going to have a little bit of a change in agenda real quickly. Steve Posnack is here and he's going to make a few comments before we start with Larry and Marc.

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

Okay, thanks. A new announcement –

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

No, no, not really. All right, am I mic'd, I'm going? Go, roll tape – so yes, Steve Posnack from ONC, and Larry was just mentioning this to me, so I am here to do a quick hype session for Marc and Larry's presentation, as well as just to note that we did issue a proposed rulemaking a couple of weeks ago now at this point, for our 2015 edition certification criteria. There are proposals included in that rulemaking relative to the certification program as well, on which this group will comment on. And I think we're targeting for the May 6<sup>th</sup> – did I get the date right – all right, thank you Michelle – for the Certification/Adoption Workgroup to come back to this Committee with any input that they may have. That's a little bit after the comment period for the open public, but given that this is an Advisory Committee and you have set dates, that's fine.

So the one point that I wanted to mention, and we do have some mention of the Certification/Adoption Workgroup's efforts to date in our preamble for our Proposed Rule. And our anticipation of this discussion today, relative to the specific settings and the five factor framework, so I am not stealing any thunder, that would be discussed by the Certification/Adoption Workgroup relative to the policy. And that's really what the discussion today is, in my estimation, going to be about. What we did in terms of a proposal that's important for people to understand is create a new regulatory structure pathway in our certification program. And to best explain this, I'll start with the current state.

So the current state is that for an EHR technology to get qualified, it's really a two-step process. The first step is the functional capability that needs to be assessed and then there's the second step saying, does this functional capability support a percentage-based measure. And if that's the case, then the product also needs to include some functionality to assist a provider calculate their percentages for the numerator and denominators, and then the product can get certified to the criterion as a whole. What we've introduced in our proposed rule is to put an "or" step after step one and so you have the functional capability, which would remain the same in all cases, and then you'd have an "or."

And so the path "A" would be for Meaningful Use purposes and path "B" would be for non-meaningful use purposes. And in the non-meaningful use purpose pathway, they would not have to get separately certified for the percentage based measure calculation, which is kind of specific to the Meaningful Use Program. So we've created this Step 1A pathway, which would be the Meaningful Use pathway that currently exists. And then we have a proposed pathway for non-meaningful use type certifications that would remove the current regulatory burden that would exist for products that are designed for other settings that are not specifically designed to support Meaningful Use. And therefore the EHR technology developers wouldn't need to get into the root of the weed relative to how to calculate the measurement responsibilities for Meaningful Use purposes.

So with that as a set up, I will turn it over to our great colleagues here at the Certification/Adoption Workgroup. And just to mention again that this is a structural change to allow for more flexibility in our certification program and then hand it off for the to the policy discussion on what would build on that if there was a decision to go forward and have certification criteria for other settings.

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

So just to introduce the topic, as you know, long-term care and behavioral health were not included in the Meaningful Use EHR Incentive Program as provided for in the statute, but ONC is considering a voluntary certification. Steve just clarified to, it wouldn't be the same certification process, i.e. it would remove the burdensome part about doing an actual measure calculation. We are going to talk more about certification per se in its broader form later on this year, because it is an area where we want to look at and see if we can improve. But, getting on to behavioral health and long-term post-acute care, Larry and Marc are going to talk about the work that's been going on in the Certification/Adoption Workgroup.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Take it away Marc.

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

Well thanks for that Larry, and so we were tasked as the Certification/Adoption Workgroup to look at this area of voluntary certification. And so when Larry and I were tasked, what that meant was, Larry, you're going to get a lot of work and occasionally I'll call into the calls. So, Larry has been awesome in driving this sort of – stop laughing Michelle. We have had a lot of help in this workgroup and for the topic that one would have thought was kind of innocuous when you walked into it, clearly not, you never know what you're walking into when you get into these workgroups. But what tremendous help, and we have Elise, Jennifer, Liz, tremendous content and we've had tremendous presenters provide input to the workgroup, that I think has been very helpful, and really, really helpful conversation. It's been critical and it's driven our thinking in a lot of ways, it's also added three or four meetings because we couldn't get through all the content that we wanted to in the timeframe that we had.

But great work and great work by Larry, primarily, this is content he knows very, very well and he's kept us moving forward. In the Pirates of the Caribbean movies the gal Elizabeth goes onto the ship and she walked onto the ship and there's this Captain Barbosa and she says "parlay." And that's supposed to mean something and he kind of looks at her and goes, what does that really mean, and lists of three things, but the third thing he says the code, "parlay" being the code, the code is more of what you'd call guidelines than actual rules. So when we talked about voluntary certification, we were talking a lot about guidelines and there are things that we do believe value – there will be value in certification. And providing that kind of guidance to these non-traditional electronic medical records or EHR vendors and that can really help move forward some the things that we're trying to do, whether it's around interoperability or whether we're dealing with things like privacy and security. And as you can imagine, in areas like behavioral health that's a pretty awesome topic.

This was our charge, to recommend a process for prioritizing the IT capabilities and what we should look at relative to interoperability across all these different care settings that aren't what we typically talk about and to take into account the adopted ONC certification criteria that exist today. So that was the charge that we had. We did a two-step process, I'm surprised to see those completes there with Larry, we did well – you did well. We wanted to draft a process that could be used to do that prioritization and then recommend looking specifically at behavioral health and long-term care, LTPAC, those things that might be good exemplars of what we should be certifying, I'm looking at. So our agenda for today is we want to look at the recommendation for Step 1, and it's a five factor framework that Larry will drive us through, the healthcare or health IT landscape for LTPAC and behavioral health, look at certification criteria principles, also were well debated. And then a recommendation for Step 2 of the charge. So I think at this point, it starts turning into real content, I'm going to turn this over to Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well thank you Marc for the introduction and thanks to all the workgroup members who've really done quite a job on this, and for all of the heated discussions because without heat, you can't make a cake. So here we are, we'll see what we baked and get some feedback.

This first slide is one that you saw a few months ago. And we've really stuck pretty much with this framework as a set of touch points for ONC and CMS to consider whenever they were looking at additional certification programs. And really looking to say, in the case of Meaningful Use we had a very clear legislative mandate that said do it, you have to have certified health IT in order to have a Meaningful Use Program and to invoke the payment structure. So where that's not the case, is there still value in certification and how should ONC think about creating these programs.

So we really looked then at putting together a broad framework that should be tied into National Priorities in addition to where there are mandates. That it should be about aligning existing federal and state programs. And that theme really of how do we in some ways of less is more, fewer programs that are better aligned will help all of us help move forward the technology and also help move forward the improvements in healthcare that we're all looking for. Similarly it should build on existing pipelines, so we heard some of that discussion this morning about how mature are standards? How much technology is already in place? Where we can build on what's already in place, let's use that. And what do the stakeholders feel about this? We're creating a program, we may call it voluntary but voluntary may turn out to be in the eye of the beholder or in the letter of the law and not in behavior. So, let's actually engage the stakeholders and see what they're asking for and understand what they're trying to accomplish.

And finally to recognize that there is a balance between costs and benefits and there's been a huge investment made through the HITECH funding that's driven great adoption in use. A whole lot of technology exists today that didn't exist five years ago. We've also seen an impacts of that, of – you could say that when you invest money, you also drive up the cost. So, where – we need to be judicious in where we put regulations into place, because they do come with costs as well as potential benefits. Okay, so now beginning to move into, from where we were a few months ago, to where we've been in the last couple of months.

So we took a dive into both long-term post-acute care and behavioral health to bring forward some of the ways in which this has already being addressed in those areas. So I'm not going to walk through every piece here, but to bring forward that we already have national priorities that apply in these care settings and that there are areas where healthcare improvement is the important part of the care process and where technology could be an enabler of some of that. Some of the biggest drivers, in terms of federal programs involve payment programs. And as much as we like to believe that people are responding to all the incentives we put in place for health IT adoption, in the end, that's only a small piece of the total activity involved with providing health care and the total costs and potential benefits in providing health care. So in many ways the payment process is what's driving it.

We've seen a lot of the early pieces of healthcare reform, penalties on readmissions, driving much tighter alignment between acute care and post-acute care, for example. Because now the acute care hospitals have a reason to bring in their post-acute partners, so big environmental drivers. And we're really looking to build consistently on the existing work that the vendors have done in the space. Existing standards in the space, existing regulations that have created de facto standards if they will, that maybe haven't been through the Standards Committee and an HL7 process, but are – if the regulations say you have to provide this data in this format, we've got a standard.

Similarly stakeholder support, we've heard a lot from both providers and vendors in this space about the importance of having certification both because of what it brings technically, that its seen to provide a level of assurance that the technology does what it says it's going to do. But specifically around issues of interoperability that it gives very clear definition of, we want one way to communicate and that needs to be consistent in all the care settings and looking to the federal government as the place to make that happen. We've also seen a level of hey, just because my software doesn't qualify for your getting Meaningful Use money doesn't mean it's not good software. And so let's get out of the second class citizen status and actually be encouraged to be a part of the mainstream program. Some of that, as we'll see, is already in place, some of the vendors have already gotten voluntary certification because you don't have to be only selling to meaningful users to get through the certification program.

And clearly cost and benefits is an ongoing trade-off and so we've really picked up on a theme that's in – particularly in the NPRM that just came out, a really increased focus on modularity of, can we get modules that are right sized so that they only include the things that are really essential. And where there are extra "ors" embedded in there that the vendors turn to "ands," that maybe those get split out into separate certification criteria, so if you're only doing some of it, you can still get check the box for that criteria.

Okay, so some of what we've heard, and this actually ties into one of the – closing recommendations. So, there have been existing surveys among these providers and I think they're really telling, right? So this says 43% of home health agencies have an EHR. Okay, well what does it mean when a home health agency says they have an EHR, right? Does it mean they can produce a schedule for their nurses to go out to see an individual in their home and the nurse can say, I was there and I was there for half an hour. And if you use payroll and it supports the bill, but it doesn't collect necessarily a lot of clinical information. On the other hand, some people have very complete home health EHRs, so they can go into the home and do an assessment that's an electronic assessment. It can feed into the OASIS documentation that's regulatory. It can feed into the payment process and it is very much a robust electronic system.

The problem is that there really is no good definition. So one of our recommendations is going to be that ONC works with the existing survey processes of many kinds, federal and others, directly federal and others, to get consistent definitions. So when people are checking a box that says I have it and then they do the drill down on what are the attributes of the thing they have, that they're comparable? And not just did it do the percent counting I needed for my MU system, I don't need for my non-MU system, but more substantially. Does it actually collect the kinds of information we're looking for? As opposed to if we look at the long-term care hospitals and the inpatient rehab facilities and units, that data comes out of an AHA survey that's been supported by ONC and HHS over the years, that's asking a set of standard questions and they're answering comparable to what other hospitals are answering.

And we saw in some of the stats produced this morning, reviewed this morning, that the definition of an EHR is actually pretty high-tech, and so the base EHR that these systems talk about is not the same as the EHR in Meaningful Use. So even here we have shades of gray that are important shades of gray, so as we go forward learning more about what's in this space. The most important thing here though is that there is some technology in the space, that there is a base to build on and that all the providers in the space really see that that's a valuable base to build on.

We did sort of a pre-session – so we had a public hearing for both long-term post-acute care and behavioral health. And before we did that, we brought in some experts to educate us about the providers in these spaces. And so I bring this up as a reminder of the diversity of the providers here and that we have both inpatient settings and community-based settings and the level of services among these vary greatly, right, so long-term acute care hospitals might look like a hospital. They have procedure rooms, they have patients on monitoring with IVs running, on ventilators, very sick folks that look like a patient in a hospital.

You get into an intermediate care facility or even a nursing home in a rehab context and you go wow, these people are hardly sick at all, you're not doing a whole lot for them. You maybe make sure they get their rehab services, that's important but, they don't seem so sick. So the scope of services being provided varies a lot and then we transition into people in their homes with a whole different set of technical challenges, how do you get good remote services? We like to think that the cell companies are complete in covering the whole of the US, but that's really not the case. There are lots of pockets, even in an area – dense urban areas that have a lot of good signal coverage of dropped signal and certainly more rural areas that don't have very good signal. On the other hand I know some rural folks who get better service out of their cell phone than out of their landlines in terms of felled trees and things, so – anyway. So a range of settings here, so that was a key piece as we went into thinking about our recommendations, is how do we address the broad scope of the different providers?

We also looked at where people have already used the existing certification program. So there are two slides here, one that talks about the 2011 certification and the one that talks about the 2014 certification. And the primary takeaway here should be is that there already is some use of these tools of the certification criteria and that they cover a mix of attributes, right? So we have some vendors chose to go ambulatory, some vendors chose to go inpatient. A few vendors chose to do complete and the rest did modular. And Steve didn't mention, but one of the shifts in the new NPRM is no more complete because complete as a concept was getting people in trouble. It was complete with respect to Meaningful Use, it wasn't complete with respect to everything you needed to do to run a hospital, to run a physician practice or in this case, to run any of the settings that we've looked at. So I think it's actually great shift and this whole shift towards increased modularity, I think, is really an important overall transition that's really good.

And so looking at 2014, so even at the 2014 level where we've heard about how this is a tougher bar, we still have a few vendors with a variety of products that have been through certification here. And I should comment that we also have some of the traditional vendors who are expanding their products into these settings as well. So we both have growth among the traditional vendors building product in this space, going through certification and we have some beginning indications that the existing certified EHR technology vendors who've been selling primarily to acute care hospitals and to physician practices, also see this as essential to what they're doing. And I think it speaks to the fact that patients don't just stay in one setting, right? They transition and we need a system that supports not just, as would like to say at Kindred, in order to interoperate you have to operate, right? So you don't already have some base technology in place, the fact that you can receive a message but then can't do anything with it isn't very helpful, so both parts of this need to be built-up.

We did a similar look at behavioral health. So again, here are some of the settings in which behavioral health is delivered and questions about use of EHR. And so, for example, clinical social workers we have evidence that it's used, but we don't have a good survey to tell us how widely is it used. Community mental health centers on the other hand, we do have good surveys and we're looking at 21% adoption, so definitely above zero. And again questions about what does it mean and so we have roughly 2% saying that they would be able to meet Meaningful Use at sort of a base level. We have psychiatric hospitals that again are responding to the AHA survey, so consistent definitions with the other hospitals, even though these hospitals are not covered by that incentive program. And again the number in part may be so low, not that other psych hospitals don't have systems, but answering the question of well, what have you automated? So if they had a looser definition, the number might be much higher.

We didn't do the dive into what their vendors have done, that's a missing piece here. And again, the variety of care settings, so we have inpatient and outpatient and we have a variety of services. So getting the mix right of what are the things that would apply to a different setting has been one of our challenges. And really in both cases a reminder that there are eligible providers who provide services in these settings and those settings – those providers, in many ways, have had unique challenges.

Because if you're a physician who's primarily practicing in a nursing center, seeing patients who are there and the system – so it's not like a hospital, they have the system and you're now covered as a hospital physician, hospitalist, right. But you're now an ambulatory doc and you're billing as ambulatory services, but you're not using your EHR in that setting, you're using the system that the setting provides, so it creates some challenges. And the same thing here that the psychiatrist may be eligible as eligible professionals, but if they're working in a setting that doesn't support the technology, it makes it harder for them to qualify. So some of them have experience with the existing exception process.

So a little bit about hearings, so we had a hearing in December with a range of panels giving us a pretty broad perspective. One of the things I thought was interesting and I'll bring it here as a random piece out of those hearings is we heard about the value of clinical decision support. And it was presented that while we usually think of clinical decision support as an ordering activity that it's also very valuable as a monitoring activity. And so we shouldn't just think about the use of technology simply on the order writing side but it's also on the whole of the care delivery process. And that good alerts that tell you a patient's condition has shifted and maybe you didn't notice because it was gradual over three or four days and multiple shifts. Or maybe they're a home person who's got some telehealth happening and you're doing some remote monitoring and that may be actually the value of the decision support in that monitoring process might be a high value proposition.

And the same thing, behavioral health where I'd say a lot of the learning here was more in addition to the wide range of providers here as well and their specific needs. Again beginning to really dive into some of the issues around the added privacy requirements for patients in substance abuse treatment programs, that's a federal requirement, as well as the variety of state programs that add other privacy requirements, consent requirements. Okay, let me pause and catch my breath for a minute. So, that's what we heard, that was sort of the input side.

And then the workgroup said, so, what makes a difference here? And so the first thing we did was make a distinction between adoption on this slide and certification on this one. So we heard that there are a lot of things driving adoption. So there are payment models driving adoption, there's the need for care coordination driving adoption, there's internal performance improvement programs driving adoption as well as public reporting of some quality measures. There's the opportunity for administrative efficiencies that might sort of be very traditional ROI kinds of activities, that there might be selective health IT funding into this space, not something as grand as HITECH, but that there may be limited funding opportunities and consumer engagement. So all of these are acting as drivers in this sector – these sectors as well as they are in the acute care spaces.

But then our charge really is around certification, right, so we felt that there were two that jumped out as the primary drivers around certification. One was the requirements for care coordination, and this really addresses some of the interoperability focus that we had, and the second one was around funding. So those of us who were involved in this pre-HITECH may remember that the reason CCHIT came into being was that there was some other legislation, including for example, Stark Exceptions, that said you can pro – a hospital can provide technology to physicians and it doesn't violate Stark anti-kickback rules, if that technology meets a baseline of functionality as determined by certification process. And that created CCHIT and their initial certification programs.

So we have examples of various legislative initiatives that may or may not have federal dollars tied to them that drive certification programs and the need for certified software. We've heard from both – from multiple HHS agencies of their history of funding IT as part of their grant process and their continued intent to do that. And that they would really like to have certification criteria that applies in these spaces so that they also can say as a requirement for this funding, you need a level of technology that will help do the things – help provide the care improve – the base for care improvement that we're looking for. So both of these seem to be drivers that come through as why certification is important.

Okay, so now into sort of the work of the committee – the workgroup. So we looked at – so what sense do we make of all of this? We'd spent hours and hours in hearings and very long phone calls of what is it that we really value and what are the things that we think are important here? And the first piece is that this is to leverage the existing certification program, so we're very much not saying spin up a whole new program. And we're saying with very few exceptions, don't think about criteria specific to these care settings, this should really be building on the criteria that everybody else is using and building on the certification program everybody else is using.

A reminder to all of us that this is a voluntary program, so as we look at how the certification criteria are put together to understand that in the desire to – well, it sort of bleeds into the modularity. In the desire to simplify things and create fewer categories of things that we might be lumping too much and we should be really mindful of the complexity that we create when we bring in capabilities – functions into certification criteria that might not be needed by everyone who would like to use that. Interoperability, interoperability, interoperability; I don't know how many times people have decided that I needed to here that that's the one thing the government could help us get right. So I'll put that back to all of us that's one thing that we could help get right. And that this is both exchange and use, so – and it's two-way exchange. So these care settings need to be able to receive information about patient status, patient condition, patient history, patient plans from the prior care setting. And when patients leave their care, to be able to extend that information flow with the patient wherever they go next, so whether that's a readmit to the hospital, a transition to a lower level of care, but still within the post-acute settings. A lot of behavioral health is chronic so you're seeing multiple providers, eventually people hopefully get mostly well and are seeing their primary care doctor occasionally. So keeping everybody connected requires information flows in both directions.

Privacy and security, so almost from the beginning interoperability and privacy security were kind of lumped together as these are the key building blocks. We want to know that when we send you information that you have the ability to control its access and respect the privacy that's been requested by the patients and is inferred by all of our understandings of how this ought to work. And actually has legal requirements, things like HIPAA and many state laws that affect this, as well as a reminder that it's not all about technology. It's not just – you can't do piracy and security just because you have the right tech, some of that's how you work with the information in the systems you have.

There are some setting specific needs, and we'll drill into that. One piece actually came out in behavioral health and I don't think this is in our detailed recommendations, so I'll mention it here is we think about individual medical records, right, individual health records those are about one person. But it's not uncommon in behavioral health to have group sessions and the group has a dynamic and therapists are documenting that dynamic, so it's more than just the individuals. So that there are needs for those providers to do things that might not show up in other care settings.

Alignment, alignment, alignment. This is one of the places where it's both at the macro level and at the detail level, and we didn't get into all of the details or all of the federal programs that would apply here. But, it's really important that when there's a new federal initiative or is an old federal initiative that's going through a refresh process that it look at what else is in the landscape and that Office of the National Coordinator, that there's an effort to coordinate all the different regulations so that we get consistency and consistency of code sets. Because if you ask one set of demographic questions in one piece of the regulation and a different set of demographics in another part of regulation and now you're looking to use a common system, it gets a little screwy for the providers, right, and for the patients. I'm answering the same question twice, but the answers are different, this doesn't – this is not reassuring to anybody involved in the process, so getting harmonization here would be really helpful.

That there should be minimum burden, there's a lot of pressure and healthcare. As much as the total dollars are going up, the money available for any one interaction is going down. The providers in these care settings all are very low overhead shops. It's not uncommon for home health agencies to change locations every time their lease is up because they get it cheaper rate four blocks down the road. Since most of their workforce is mobile, so what if we move our office. Oh, that's where all our data lines go, hmm, maybe we just picked up more overhead from moving. Okay, so recognizing that what might not be a big deal for a hospital that's fixed real estate in one place, becomes a big deal for some of these other settings, especially where they have mobile workforces like home health.

Limited funding. I don't know how many times we heard about champagne taste and beer budgets, but the level of funding here is easily one and often two orders of magnitude less than what's available in the incentivized settings. And again a reminder that it's a very heterogeneous provider group.

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

Larry, I think it was pretty key from the workgroup around these criteria and it was really important that this not be a heavy burden, that we really try to leverage what we could that existed today. There's a lot of conversation, should we even be dealing with certification in this situation in these sites, but overall felt that there were areas we could provide some structure. But again, really – when you get to limited – or minimize the burden, we were looking, how can we do that and really still provide guidance to the industry in these particular settings?

#### **Larry Wolf – Health IT Strategist – Kindred Healthcare**

So again, looking to Steve and his laptop, so he should be here, his laptop is here. In the 2015 edition NPRM, there's this notion of packages as a way to group certification criteria and so that might turn out to be actually a useful concept for how to group these without making it a hard grouping that increases the burden.

Okay, so I'm going to talk through this and then I'm going to pause for some reaction before we get into all the details. So in the end we wound up really saying that there are three sets of criteria here to be looking at. Oh, excuse me. There are some things that apply for all providers and this is not just these all providers that we've been looking at, which is a pretty diverse group, but we really mean all providers. And so there should be consistent certification criteria for transitions of care, privacy and security and the one that we've added, enhancements to privacy and security.

What we learned in the behavioral health setting was a reminder that I think a lot of people know, because it's not just a behavioral health issue, is that based on patient condition, based on state law and federal law, certain conditions have extra privacy protections. Certain states provide extra control for patients to require consent for information to be shared and what's happened is that as a result of those, in many cases certain information is not shared at all. So existing health information exchanges have said if you have any information that fits these rules, don't send it to us because we can't further control its release. We don't know how it's supposed to be restricted, so don't send it to us because then it would be our problem to not send it on and we'd have to shut down the whole exchange.

So the request – the recommendation here is actually to move forward with some enhancements that look to more broadly look at the privacy requirements coming out of behavioral health and ask, and we've asked the Workgroup on – the Tiger Team on Privacy and Security, for example, to make some recommendations on what's the state of the art? What can be done? Because if as a behavioral health person I have a great system in place with lots of consent and it's all automated and I flag the documents appropriately, there's a new HL7 standard. I know of at least one major vendor who's going to have that in their spring release of their product, but if it's in the document and the receiving system doesn't know what to make of those flags, they're not providing any security, they're not increasing the privacy. So, that really becomes something that needs to be implemented broadly if it's actually going to be effective.

We had some specific things about the care settings. So long-term post-acute care settings, several of those settings have mandated assessments. So there are federal assessment instruments that need to be filled out, they have a specific reporting format. If you're going to have a system in that space and there's any kind of claim that it's been certified, if it doesn't support the regulated assessments, it sort of raises the question of well, what does that mean to have an LTPAC certification if the thing that keeps me in business isn't a part of the package? So we've identified a few of those.

And then finally the area that's in gray, is purply-gray I guess, are things that are more or less important to different care settings. So they range from medication related things to you might be in a setting where you're not involved with meds, so why would you need a system that manages meds. You might still want to know that someone is on a med and want it in the summaries of care you receive, but you're not actually doing things to modify the meds. There's a lot of complexity in some of these things, so like lab and imaging. Imaging requirement is access to the images and we've heard that that may create a large burden and so we have a specific recommendation here actually to split the diagnostic imaging piece into three parts to say I have a result, here's a narrative, interpretation of study. Here's how you could get to it electronically and then actual access to it, to see the image. So we're making a recommendation to ONC to think about breaking up that criteria into pieces.

So I'm going to stop here and look for feedback from the Committee on sort of the overall framework that we're looking to put in place before we dive into the details. Because my experience with the workgroup is we will raise – the same issues you're going to raise now, we're going to raise with every single bullet point on the subsequent slides, so I'd rather get them out as a group rather than sort of slug through them one by one in all their infinite detail. So with that, I'll turn it back to the Chair to let us hear from our members.

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

All right. Thank you and I'll make one opening comments is thank goodness you're starting with the existing certification program and working backwards. You would not want to create the process again. Josh?

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

Thanks. I think it's great to be thinking about these other areas, but I have two comments. One is that if I were to start fresh, setting aside the question of the certification requirement and say what is the purpose of getting involved in behavioral healthcare settings and long-term care, I would want to know what problems we're trying to address and that's what I don't understand from this. That's the first thing, what are we actually trying to improve? And I'm not sure by the people that you've got – you've been hearing, you're necessarily really getting some of the fundamental problems.

Because they – some of them may be recognized by the people who are in that world and some of them may not be. But for long-term care – I run the Public Health Department in Maryland, we're very concerned about readmissions, we're concerned about preventable infections. There was just a report from the HHS IG that some enormous percentage of nursing homes and patients have preventable incidents that happen, I don't understand how any of this connects to the actual problems in long-term care.

In behavioral health we have a national epidemic of overdose, we have a huge need for comprehensive healthcare to take place in behavioral health settings as you're defining them. So to me it would start with like, what do we think we could accomplish, and then work back into well, what are the certifications? It's – I'm just losing the forest for the trees completely in the presentation and I'd just be interested in your reactions to that.

The only other thing I would mention is, particularly with behavioral health, there's an enormous amount of behavioral health that happens in hospitals and clinics and primary care. And even though it may be just semantics, I think if you're thinking about the public health side of behavioral health, how do we reduce overdoses? How do we – it's partly to integrate behavioral health into the rest of the healthcare system and to think of this just calling it behavioral health as implied in a completely separate physical space is maybe a little bit averse to that ultimate goal, too.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, I'll risk commenting and see how this goes. So thank you, because those very much were a lot of our topics of concern. And the extent to which that doesn't come through here maybe I'm too wrapped up in having been immersed in this for months and living in the trees or in the branches or in the twigs or something, tripping over the roots. So the things that you mentioned broadly were the things that we thought were driving this. So it is about how to we have coordinated care? How do we ensure that when someone moves from one provider to another that their information moves with them and that when it gets to the next setting, that it's valuable in that setting and that the care that setting can be communicated to subsequent providers. So the transitions of care, the use of CDA documents, the standards that go with those are seen as in some ways fundamental. But I agree that this was not intended to be kind of a support for broadly why these providers need better systems, which is a lot of what I'm hearing from you is like so if we're trying to address these very – .

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

No – sneak a little – two sentences –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure.

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

– I would just say that even in that issue, coordinated care is a great goal, reducing readmissions is a public health problem.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

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

And so to really think about we're oriented towards certain probl – and that gives you a sense of how you decide whether something is really going to work or not, ultimately.

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

And I think in the hearings we had a lot of these issues came up and of the specific use cases or needs for these, but again our charge was to really look it certification of EHRs and what could we do to facil – even just prioritize those issues that should be looked at. So I don't think we got a comprehensive list of problems that we are trying to solve. We are more looking at the hearings and trying to elicit what kind of problems were there and then define a process for creating a priority of recommended certification criteria.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

I guess what I'm hearing though in your comments, Josh, is there may be an opportunity here to look more broadly and advocate more broadly. In many ways, we're living within the constraints put out by HITECH where initially this conversation was, we don't even have the time for this conversation because these providers are not getting paid and we have a clock that we're working against to get regs in place. So we broaden the conversation to going oh, a third to 40% of hospital discharges go to one of these settings, that's a lot of people, that's a lot of transitions. We need to make sure that those go smoothly.

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

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that feels like a big step forward. But I agree with you, if we could somehow use some of those needs that are broader needs than a single provider's needs to drive broader adoption in this space –

**M**

You don't have money so you –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and free up funding, right.

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

So it's a real public health goal to aspire to –

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you.

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

As Karen says, this starts a process. Terry?

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

So I am fascinated by this and freaked out, to tell you the truth. When I look at slides 10 and 14 and really it follows up on this note that if we want to address some of our epidemics we have to have the data. And when I look at slide 14 especially, I'm somewhat aghast. And so first off, I believe these numbers are valid and secondly, so let me take a different tact here.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

That's the level of current EH R use, as everybody scrambles for their slide deck.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Yeah, so do you – yeah, that's what they are, 2% in psychiatric hospitals, right, that's what that says –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

– 2% where psychiatric hospitals are probably giving meds or changing meds and people are coming out and I don't know about it. Do you think embarking on certification process will increase these numbers?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, we've specifically separated out adoption drivers from certification drivers. And so certification is a piece of providing some level of assurance that the software does some the things that it was certified – it does the things it was certified to do. But that's a very limited endorsement, right, we had a pretty heated conversation here a few months ago about seal of approval and good housekeeping, all that stuff and said no, no, no, that's not what certification is, it's very focused. So I think to – healthcare in general is a risk adverse industry and so I think having a certification process, so a risk adverse board can go, well at least the vendor's certified. At least they're credible enough they got through some national process. You're not giving me some complete flake that's likely to be gone in six weeks, doesn't mean that there's a level of financial assurance there, but so as a baseline that certification would help bring.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Will certification hinder adoption?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well certainly potentially it could hinder adoption if vendors wind up feeling that they don't – well, I don't know, there could certainly be paths by which it could hinder adoption.

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

I think it creates an awareness Terry, of the products and the things that they should be able to do. And if it provides confidence to the people that are purchasing them, then it probably can help. I'm not sure where I see where it would be a hindrance to adoption.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Okay.

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

It might be a hindrance to development or other areas if we were to impose it upon someone, but I don't know where it becomes a hindrance.

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

Paul Egerman?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So – sorry, go ahead Paul.

**Paul Egerman – Businessman/Software Entrepreneur**

So actually I was going to follow up on Josh's comment in terms of what are we trying to accomplish. I mean I looked at your slide 19 and I thought that was a like a very important slide, which is, what is driving these groups to get certified software? And it's really two things, it's either care coordination or if somebody gives them some money and right now I'm not aware of anybody who's giving them any money. And so my view is what this program should be don – should happen for this group is very simple is we should entirely focus on care coordination, transitions of care.

To partially address some of it issues Terry addressed, standardization of vocabularies, say this is the coding systems we want everybody to use, that would be very effective thing that ONC could do that would help us at least start to gather data that we can compare across settings. But I would give it a much more limited focus and simply say, care coordination. When I did propose that in one the workgroup meetings, the answer from somebody was, well that would be so small and my response is, no it isn't. I mean first of all, it would be huge if we could make some progress there for long-term care. But also if we're not going to give these people any money, maybe we should do something that is small.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I would say it's focused, I don't know that it's small, Paul. I agree with you.

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

Judy?

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

I think we really need to incorporate everything around the patient into a system to make sure that the patient's care is coordinated. One of the problems that you addressed a little bit Larry, is that a lot of it is billing and regulation. So while we're coordinating care of the clinical side, in order to have a viable system, you've got to do all the regulation that goes with hospice for example, the OASIS-B billing that goes with home health. And that, I don't know what you would guess is the large part of – the percentage, but when we look at it, I'm just going to take a guess, it's not a carefully thought-out thing, it may be 75% of the whole thing and yet you need that in order to have a viable system. And that's hard stuff.

We have a saying, we can't afford to build it and you can't afford to buy it and that becomes a problem we see sometimes, which is – and especially when you think of overseas stuff. If you are building something that you want to do well and it needs to work well and yet the amount of money to buy it is this much, what do you do? And just to put some perspective on this, we were looking at how much time it took for us to do Stage 2. Now what would you guess? How much time went into – because we track all our time at work, everybody logs time, so we know per project what it takes us. Well, it took over 350 person-years for Stage 2 and that's a lot of time. When you count about how much money that would be, maybe you're looking at over \$50 million.

So how do you then – now, let's assume though that we have lots of different modules, not everyone does – maybe we did it in different way than others did, I don't know the answer, it might have taken some more or some less. We were one of the first ones certified, though. And so when you look at that expense and you say this is really important, then I don't know what to do, how do we put the time in to develop a system? And I did a quick – where did I do it – I did a quick calculation for what it would cost and – I don't know what it would cost, anyway, a lot of money.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So Judy, I think to that point, our concern was to really build on the notion of modularity. That the stuff in red and the stuff in green seem like this is really key things that ought to be broadly available that anyone who's going to be credible needs to address – credible in these spaces needs to address. The things in gray that get much more into the broad base of functionality in the care setting, these were things that all surfaced above some imaginary line of being important. But in general I would say that there was some degree of contention in the workgroup on every one of these, to more or less degree about whether or not this was in some kind of core set for the settings or not. And so the reason we had those principles, I guess I should go back to those, is it's voluntary and modular. So we're going to hope to get real feedback based on which modules people certify against. And some of it is going to be, I can afford to do this capability or I can't or I can maybe do it, but I can't do it to the level at which certifications required and those would be useful things to know.

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

And it strikes me that adoption is much more important, assuming the system is a decent one than certification, because there may be a lot of things in certification that might be nice, but not essential – as essential as having a system that all works together.

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

I think the question comes down to – is there any help in having some guidelines out there, some leadership that says, if these are important to us, it's voluntary, you don't have to do that. People are already developing products, lots of products in these spaces, and this isn't saying you have to, because we don't have any money to do it anyway. You have to have this a place by some way too aggressive number, Karen, a year, that we have to those in place, but that if there were certain criteria out there that we all agree that we can give some direction to the industry, I think that's the question that's being asked. Is voluntary certification helping?

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

So there are no incentive and there are no penalties, right?

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

None of the above.

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

And the agreement is going to be done by – let me say this again, lots of people who use a system and who live –

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

(Indiscernible) Yeah.

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

– that life and know what it is, so that in fact it's really appropriate stuff.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I see we've inspired –

**Multiple speakers talking over one another**

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

– I do, I mean Paul is – Paul's so experienced in turning up his card that he'll be able to –

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

– it would help, I'm not so sure it's essential though –

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

Right.

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

– because I think any vendor really getting into this area is not going to spend people-years to do it and not have sat down with the perspective users and said, what is it you need?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Correct.

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

And followed them around and shadowed them and done all sorts of stuff to make sure you're on target.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess another thing that surfaced that probably should have been in our slides is a sense that the certification criteria also provide a roadmap. So for vendors who are looking at, what should I be doing? I have customers asking for these things, they're saying I need to be connected, I'm now in an ACO organization, I'm getting protocols for my upstream partners saying, please when the patient's in your care, follow these protocols. What tools do I have to implement the protocols? So that there is a ripple into this sector of what's happening in the more richly funded parts of healthcare and that there's a need to keep up, at some level. And recognizing that getting into an arms race can be a very dangerous thing and is not going to help anybody keep up. But that having the certification criteria does provide that kind of, oh, I see with the standard is, I'll build to the standard. Even if I don't get certified, I know what the standard is. I see what's expected in the acute systems, what they can do for decision support. I maybe can't afford such a robust toolkit, but I can do something that will be a beginning step.

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

What you're talking about is almost like an RFP for the industry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

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

– it's very interesting that in the panels that we had and the people within the industry that were part of the workgroup, they were almost pleading on the calls to get this kind of information.

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

Yeah –

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

– out. And so that kind of drove my thinking because I'm not real big on new requirements and new certification, but there was definitely a desire from industry to have more of this guidance, because there's so much unmet need right now in this area.

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

I wonder if that's what it could be like, rather than certification, it could be, here's the Request for Proposal type thing. Here's – and it could be many, many pages long.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

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

So, just for the record, so that was Judy Faulkner asking the questions and Larry and Marc responding and Dr. Karen DeSalvo wants to make a comment.

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

I'll defer to Westley first and maybe –

**H. Westley Clark, MD, JD, MPH, CAS, FASAM – Director, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration – Health & Human Services**

Wes Clark from SAMHSA. I really appreciate the work that you put in, you and the other volunteers. I like your organizing principles, I think they resonate with what we're doing at SAMHSA. The red box is of course, of particular importance. We have – we are – about integrated care, we have one project that focuses on primary care and mental health. And then in our 2015 budget, we have another project that focuses on integrating primary care and substance abuse treatment programs.

So the red and the green work well for us, because we do want to make sure that our people get appropriate care and we don't want our people to be denied appropriate care. The other issue of certification, other than cost of course, is that a number of our providers do buy software packages that they ultimately can't use. One of the problems is that a number of the packages are not behavioral health specific nor behavioral health sensitive. And as you pointed out, there's one large provider that's going to deal with the issue of – attempt to deal it deal with the issue of privacy. We have invested some resources in developing what we think are open source approaches to deal with privacy. We are concerned about privacy and security both from a substance abuse perspective as well as from a mental health perspective.

So I want to commend you for the work that you are doing in thinking about this from a modular perspective because a lot of our providers are also psychosocial, they're not in your witness list, you got the physicians and you got some of the organized groups. A lot of them are psychosocial – you've got some reference to residential and they don't necessarily see themselves as residential. But, they won't be able to gravitate toward the gray. But they are all concerned about the red and they should be concerned about the green. So we don't want people buying software packages, because we have had complaints about people buying what some fast, slick and jive vendor salesperson is able to – not that the rest of the vendor community is that way, I'm sure they're all very honorable and noble individuals. But, people get stuck with software packages that don't have the versatility that they need for behavioral health, so by breaking it down into the three parts that you've done, we can make – at least allow the vendor community to identify those critical issues. So, I want thank you for that.

And I'm not trying to diminish what Josh said or what Paul has said, but we do need to move in this direction. A number of jurisdictions are seeing health information technology in behavior health as an important transition and we also want to make sure our providers adopt ICD-10, be able to communicate because they also want to get paid from CMS. So they also have to deal with that as reality. So even though there are no independent incentives across the board at the magnitude of the Meaningful Use incentives, there is some incentive of getting reimbursed for the service that you provide. So making sure you're having certified software can facilitate that. And we do want our providers aligned with mainstream delivery systems, at least in terms of transition of care and reimbursement because our block grants are very modest and state resources fluctuate, Josh can attest to that. Sometimes they're very great and sometimes they're not so great. So, thank you for the work and I want to commend the Committee for tearing it's hair out for dealing with that, no pun Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you, Wes.

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

– let me try to intervene here. So Karen DeSalvo had a comment about Judy's question.

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

Yeah, I think Judy raises an really important point about the driving these in the marketplace and the adoption element. It is what it is and Meaningful Use provided incentives and penalties for a certain segment of the healthcare continuum. But I think because of that, what's becoming increasingly obvious is that if we really want to – if you want to call it a public health issue, lower costs, lower readmissions, unnecessary care, we have to be able to see the rest of the continuum.

And having been a provider that integrated behavioral health into primary care on the ground, it was really impossible to find a product that allowed us to have service lines that could accommodate a population. Whether they had severe mental illness or co-morbid situation depression, but keep that in a way that it was private and sufficient for the population and sort of not waste money, but to know what you're actually purchasing and know that it's going to be able to interoperate at the ground level. I've experienced that, and I can say it would be valuable and important. But if you just think about the big, important picture of how we're going to improve health and lower cost and all that in the country, this is incredibly important. I mean, this room knows this.

The life expectancy for people with severe mental illness is significantly less than for those without, but if you can intervene and get good primary care, you can make a difference, even for people who have comorbid diabetes and depression. Work that's – in the VA shows that if you treat the depression, you can reduce the readmissions for cardiovascular disease, for example. So these are – this is important for so many reasons and I guess what I – I asked some folks in the past and I think what we all need to think about is, how do you enable and support adoption in the absence of a specific incentive program like Meaningful Use? This is important enough, I think, to payers and to providers and to the public health community that we should be thinking this through, because it's part of what our society needs to have happen for all the data to be there. And so there are probably ways that we can consider it, but maybe this is a chance we have to think about market-based solutions and consolidation or making it modular enough that they're affordable. But I believe we – I just want thank you guys for starting to think about it. This started well before I came on the doorstep, obviously it's just such an important part of the care continuum that we have to standardize and make sure that we are able to share the information properly.

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

Thank you. David Lansky?

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

Well I think this builds on Karen's point. I have three questions for you both, one is, did you consider any of the purchaser or employer use cases in doing the initial design thinking of where you were – wanted to go with the recommendations? And I say that because in my world, this is a really pressing concern. A lot of employers obviously have EAP programs, they have carve outs, they have various wrap around relationships and they're really frustrated that the information about especially behavioral health, isn't following across all those providers both within the employer setting and with their various vendors and so on. So I think would be a win. The second – and that also raises a question of – additional provider types who aren't listed here, like EAP.

Secondly, I was thinking about the quality measures arm. I know you have a mention later on in the deck about coming back to the quality measures, but I do think it's one of the drivers that could address this last couple of comments, Karen and Judy's comments. If the quality measure framework put an emphasis on closing the loop of information between behavioral health and other medical and healthcare providers, it would – and like the comorbid – example that you gave Karen, it would help to drive attention. It would be another driver for adoption through the quality measurement arm rather than necessarily through the financial arm. And I think it would be desirable for us to do more work on the quality measures side to pull the pieces of the health care system together through measures of transitions in care and coordination and outcome.

And the third thing was just a – it's kind of a reaction as I was reading the rest of the deck. My reaction was are these recommendations a little bit caught in a medical model and while there are important parts of that we have to think about, these two domains in particular have enormous components that are not medical. And the data capture and the data integration and the contributors to health that come out of these less medical components, aren't really reflected in the initial recommendations you teased out here. I know we haven't gone into detail, but I just wanted to surface it and see if you've thought about that. And whether, is this an opportunity to do a partial reset and look at a framework for health information, which isn't driven by the medical components that we were driven by a in the original Meaningful Use design.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, a great transition sort of comments, David, thank you. So I think the EAP is a good example of, we didn't specifically look at that, but we were looking at the issues of care coordination that you say is such a problem, and the issues of behavioral health having good systems to check track their information with. We have – as another future that we'll get to, we have asked the Quality Measures Workgroup to give us some guidance on quality measures that might be applicable. But I think really your biggest comment is about are we caught in the medical model? And obviously a lot of these care settings deal with issues of activities of daily living, of basic transportation kinds of needs, of are people getting food? Is their Meals on Wheels delivering stuff? What's their home environment like? Oh, they don't even have a home, well how do we get them a home? Right, so there are questions really flow outside of healthcare as a medical activity.

And I guess we became a victim, if you will, of our principles that said we work within the existing certification program, that was our charge, address certification needs. And I think all the questions that have been raised here that are broader than that, really speak to some of the earlier comments this morning about Meaningful Use, is, there's probably an opportunity here. And maybe the timing is right to be looking more broadly at, now that HITECH is very much in its path, and it's doing what it's doing, there's still work to be done. And the charge is not just Meaningful Use, the charge is improving the healthcare of the country and that's not a medical model. So – that's not a medical model.

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

But yeah – short of though expanding the scope of what the charter was here, I mean there is a whole area we should be looking at. I'm not sure if that's the scope of the charter of this particular workgroup. I mean it could be, if we decided we want to define that. Because I think your points are right on David, and from an employer perspective, it's a huge issue and what we deal with day to day. But again, we are kind of dealing with a – well, we tried to get to a very defined scope because we had a hard time even dealing with that, with all the conversation in the workgroup and where it wanted to go.

### **Larry Wolf – Health IT Strategist – Kindred Healthcare**

So let me drive through the slides and then we'll see if you guys have reactions to any of the specifics. So, I guess this probably should have come earlier, this was sort of the model. But everyone understands this picture, right? Okay, so transitions of care. So we like the existing one, there's a great base to build on the existing certification criteria, but – and maybe this is a good point to step out of the slides for just a second. So we were in a constant back and forth between certification criteria based on additions, right. So using the 2014 certification criteria as a base, but then flipping, as in this recommendation, to Meaningful Use as the broader framework that's driving the work of this Committee and ONC in its regulations. And so I think that that's a thing for further advisement, maybe when we get to the end we can get some feedback from you guys about what the driver ought to be here.

So having said that, so we're looking to add something new. So we have an existing certification criteria, said use that, and we said, in addition there's been a lot of work on enhancing transitions of care standards, recent work expanding the Consolidated CDA that the Meaningful Use Workgroup has identified as part of MU3. Now, I don't know specifically where that wound up in this morning's debate, but there was an encouragement that some work has been done in this area about what these providers need when they receive a patient. And some of them get to these, it's not just a medical model, I need to know how this person lives their life. Because they're going to be going home for my care, and I have two weeks to get them ready to go home, the more I know about their values, their larger plan of care, the more I can do that well.

And if that comes to me as a blank slate and that psychiatric problem fell off the list when they were in the acute care hospital. And now that they're off of their high dose of everything and they're starting to actually act like a human being, I'm discovering they're a human being who's lost his mind, and they need a little help. And it would have been nice if we knew that rather than discovering that because a family member said, don't you know they've been on this med for 10 years? And we don't know, it wasn't on the list of meds that came from the hospital. So, the need to get good information in transitions of care is critical, and we're looking to actually expand a little bit from what's currently in there for 2014.

Privacy and security, let's do it, it's there, it's a baseline and because of the discussions we had about the need that you can't just rely on the technology is that we're also asking HHS to consider their education programs about what you need to be HIPAA compliant. And that's not just about having good technology, you need good policies and procedures.

And then enhancements to privacy and security. So we've asked the Privacy & Security Tiger Team to look at some things that have come up in our deliberations, specifically around behavioral health, As I've said earlier, those things ripple, it's not just for the behavioral health folks. And we also heard some discussion about doing this right. So it might be nice to say, okay, this document has some flags on it, but what about the document that didn't have the flags but was a narrative note that talks about the patient's mental status or that talks about drugs to avoid because they have problems with those kinds of drugs. Those – that information is important to pass on, but it also alerts privacy concerns so that we maybe need to be nuanced in how we address this and not look for technology to solve everything. And the future work is the recent HL7 information addresses some of the standards, but we're looking for further work on granular data, and I understand that there is work through S&I to do that – S&I framework to do that.

So, we see that as future work in this area. So looking at setting specific criteria, so there are assessment types in these settings. MDS, OASIS, IRF-PAI, Care Subset. And so we would want a new certification criteria that supports the ability of a system to create these assessment types that will then push on our federal buddies to start aligning standards, because these assessments were built out of the context of existing informatics standards. So the second one is use of vocabulary standards, so there's been some work done to map those assessments to SNOMED and LOINC. So that work should be incorporated into certification criteria.

And finally there is the ability to create an exchange, these assessments as CDA documents. So there was some work done, primarily by the KeyHIE in – the HIE for Pennsylvania, to create a conversion tool that takes the MDS and OASIS from their native formats and turns them into a CDA document. It addresses a subset of the information involved. So to encourage that work and include that as a certification criteria. And asking Standards Committee to assess readiness of standards for these things. And finally, continuing to drive for harmonization at the federal level with these assessments.

Survey and certification, this is all under future work. As a friend of mine said, oh, the surveyors have, I want a list as well, not just the clinicians. So, there's a long list of things surveyors would like to have when then come into a provider setting and they're tasked with reviewing the care. We had a recent survey that CMS – that yeah, CMS did of their surveyors, and I guess they had almost 1000 responses, so I guess these folks were eager to let their opinions be known. There are a lot of things they would like when they walk into a facility and so, let's head in that direction. Let's figure out what it is that they need and maybe we can get some guidance from CMS on what should be provided. Because we're hearing a lot of noise and we don't know if the noise is onesies or is the major issue. And then some of the specific things that the surveyors need, that there is a QIS process, a quality improvement process in place with federal reporting and that also should be tied into all of this. So again, opportunities for alignment.

Looking at the behavioral health side, so we had sort of the reversed situation here. So on the post-acute side, we've had a long history of regulatory requirements for assessments that created a standard. On the behavioral health, what we heard was, there is a huge diversity of assessments in place and very, very little standardization. And so while we reference two things here, we're mostly referencing some tools that are in place to create assessments, sort of question and answer assessments and some EHR – work that was done by HL7 to create the functional spec in this domain, but not necessarily sort of details for how to do an assessment. So this would be an area of future work coming out of the experts in this space.

And then there's the "some" category, so the remaining things are all in our some stuff. They're not – all these providers aren't the same, but we did find among the providers many pockets where multiple providers would benefit from specific use of EHR functionality and where a modular approach would allow people to then pick and choose, to Judy's comment about sort of like an RFP or an RFI. To say, oh, these are the things that are out there that if they're useful to you, you might look for them in your space, and here are some certification criteria. And the tough challenge is going to be to set the bar in that criteria to be useful enough, but not so function rich that it becomes prohibitively expensive and offers capabilities that the providers don't need.

So I'm going to go through these pretty quickly, so we still have some time for discussion. So, clinical reconciliations, this is beginning to get at now how do you take this information you received and do something with it. So there's a process that we've defined within the existing criteria that looks at meds, problems and allergies and so we're saying, those are important in this space as well, so that criteria would apply.

On clinical health information, this was sort of baseline. And we had some discussion about was this necessary or redundant, right? If you're going to require people to create documents to standards for exchange as part of transitions of care, aren't they going to have to do this anyway? On the other hand, we felt it was important to emphasize the standards, so this is an here. One of the things that came up though, which I think is important to bring forward, is that DSM-V, which is the primary classification for behavioral health, is not one of the standards currently supported by ONC.

And when we put that forward is as maybe we should recommend that, people on the workgroup pointed out, well wait a minute, the value of standards is that there's one, and every time you create more than one, you're creating a problem for the receiver. So you're okay to send it using DSM-V, but if I don't know what that means, it's not of much of value to me. So our suggestion here was actually to take on some work to harmonize DSM-V with SNOMED and create not just an effective crosswalk to the codes, but that DSM includes decision logic for, is this the right diagnosis and that should be looked at as well, as part of the harmonization of those two code sets.

Lab and imaging, it would be great to have the ability to easily receive digitally lab results into these settings. Right now, the cost of building those interfaces is almost universally prohibitive, so the extent to which the standards process and the adoption within the acute care providers, creates really plug-and-play standards that minimize the cost to create interfaces, that would be a huge value. And then to have vendors certify to those standards so that their providers would have assurance that they could then receive the lab results.

We talked about transmission as well. Very few of these providers actually have a lab and would be transmitting data. But again, with the context of this being modular, if you did have a lab then we would expect that you could send data to the standard. And finally we recommended splitting up the imaging results certification criteria to separate out the hard part, which is accessing and viewing images from the easier part, which is receiving a narrative interpretation.

Med related. We had a list of concerns about the variation among all the provider types of how much do they need to know about meds. If they're not ordering, do they still want to have access to interaction checks? Maybe they do because the person seems like they're falling a lot, it might be helpful if they had an alert that says, hey, guess what, these two meds, high risk for falls. So, it's not as cut and dry if they don't write orders, they don't need to know about meds. And the same thing with med administration, if you're not a provider type that administers meds, then you probably don't need MAR capability, but if you are an inpatient provider and you're giving someone meds, it would be great to have a module that collected that information and provided some of the safety checks. We talked a lot about the CPOE stuff and again, this notion of the 2015 edition is breaking this up into separate modules and we support that notion, because based on provider type, you might not need all three.

Clinical decision support, I've already talked about. This is not just for ordering, this is also for patient monitoring. So there's more value when you think about this as a monitoring tool, not just an ordering tool.

Quality measures, clearly an important driver, a place where broadly healthcare needs much better coordination of quality measures across care settings. So there are two classes of problem here, one is actually having measures that are comparable from setting to setting to setting. So if I'm doing an assessment in an acute care hospital and this person moves to a post-acute setting or moves to ambulatory care, that consistent assessments are used, so I can actually see their progress across all of the different settings that they're in. And there are currently virtually no measures that actually measure the goodness of a transition. And almost all the ones that are in process assume that you've got good electronic communication in place, so they're building on having good transitions of care – electronic transitions of care documentation. They are building on having closed loops that we heard about this morning.

Patient engagement, the level and specifics around patient engagement, we heard a lot of variation from the providers. Concerns about some things aren't shared with the patient that might be shared with some responsible party, particularly around some of the psych issues. In post-acute long-term care, the individual might not be competent to take care of themselves for dementia reasons or just the general decline of their health, so there might be other people who need to be engaged, besides the patient, to actually be effective here.

Advance care planning, some of the discussion already came up this morning about the need to extend this beyond just knowing whether or not there is in advance directive or an advanced care plan. So, we would like to see that work go forward in this context as well. As well as information about what's in the advance directive, so it becomes machinable. Although I have to say, going back to the hearings we held, one of the values of advance care planning was the conversations that happened. So it's not just, did you document and what does the document say? But have you talked with your loved ones, have you talked with your provider. Have your loved ones talked with each other? We heard comments about the handwritten note from mom about how she lived her life was really helpful as we made some hard decisions about ending her life – .as her life ended. What was it she really wanted? And then having that as a piece of closure about knowing who she was. So, a lot of very powerful things in advance care planning. It's not as simple as check three boxes and we know what we're going to do, but it's a very key piece of the human process of healthcare.

Data portability, it was felt like this is a down the road problem, primarily. We need to get the systems in before we worry about replacing them with a new and better one. But also it was pointed out that there are limits to what's currently in the certification criteria as it relates to data portability, that is says you have to be able to group export CDA documents, but there's no group import requirement. There's only individual import through standards and there are clear limitations on how much information is in the CDA documents that could be brought forward. And certainly a lot of the work of EHRs are doing things that don't wind up in this current set of CDA documents. So, this is, in many ways, acknowledging the limitations in the current criteria.

Public health transition of immunizations. So, people who are in long-term care often get immunizations in that care setting. And while the issue here might not be worrying about getting multiple immunizations because I didn't know you already got one, it's more about public health reporting so coverage is known, community coverage is known that this population is or isn't covered for this season's flu outbreak. And we also heard about some of the limitations of public health ability to receive.

We heard some interesting things, that we heard, for example, that while there's criteria for family history, there wasn't anything about past history for the individual. And at least one of our physician members repeatedly reminded of that as a problem with the existing criteria. It's something really important, but was completely missing.

We also want to encourage ONC to track what's happening and to do some national surveys that do a good job of covering providers in these spaces so that we have good, reliable, consistent data to work with. Our experience looking at the surveys to date is that there's more noise than signal in a lot of what was done. I think that's it.

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

All right, thank you. That was an exhaustive coverage.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It's the mini-version of this morning. It's a mini-version of this morning.

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

Well actually it's not a mini – it's a mini version of many years of Meaningful Use. Well, I think we'll have comments and I want to make a comment about maybe how we move forward today's some kind of recommendation. I want to pick up where David left off in terms of the medical model. I think we've left plenty of hooks for the non-medical model in the existing, but you also haven't seen the fourth dot yet. We haven't discussed it yet, but I mean one possibility of the fourth dot is personal and community health as a way to expand the whole notion of health and healthcare. So, it's to be seen but we've not – it's not left our sense of consciousness, but that's something we certainly want to think about. So I have Karen, David, and Terry. So, Karen DeSalvo first.

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

Thank you guys. As you're thinking about use cases and care settings, it would be helpful if you could include the prison population and jail population and care transitions of care to and from for those folks.

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

Oh, no? I'm sorry, no? Go ahead.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

Oh, sorry, I was out of – okay, we've been working this Quality Measure Group and you guys are probably aware that you kicked over to us. Thank you very much. So we had our first dialogue – our first discussion this week about quality measures, and it was related to long-term care. So I am going to do a huge plug here for standards and terminology. This is the crux of why we continue to have this issue, in my opinion. We will never get to discussing health unless we figure out the standards in terminology for whatever you want to call it, non-traditional determinants of health or the other psychosocial factors that affect it.

What we saw was the use of many tools, all – many of which seem to be semantically normalized, but they weren't normalized to standard terminology that we are using in the healthcare space. So I'm really intrigued Larry, actually I've sent an email about the DSM-V mapping to SNOMED. Oh man, that

sounds like a great federal responsibility to make that one happen. But what I really want to do is just remind us that this work has a critical dependency and we have not pushed into that space, despite all the years we've been doing standards in terminology. I think it does give us a different framing, a fourth dot might be very helpful as to push for that. But, I think the time has come for us to deal with this one.

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

**Larry Wolf – Health IT Strategist – Kindred**

I knew I really liked Terry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Marc's favorite subject, standards in terminology. Okay, Paul, you have some comments about next steps.

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

I'm trying to figure out how to move forward so I was just asking Karen if there was a timeline? The original proposal was a recommendation – coming back with recommendation next – I thought it was

April –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

It's April, yeah.

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

It seems like a lot to deal with and we want to be just as conscientious as we were with Meaningful Use for the same reasons that it is impactful in both ways, in a good and the way that Marc talks about it. So I'm wondering if there's a way to help us think through this, one is to figure out how to represent the changes from existing, so somehow color code so we can view what's changing. So, we've already preprocessed some of the stuff for the Meaningful Use, let's look at some of the deltas. And the other is to take advantage of a tool we use, which is, well what's the impact on the provider? What's the impact on the developer? And what's the impact on the standards? And your version of "some" is our specialist primary care.

But anyway, to have that ability to start looking at where's the meet, and maybe what – the way we came up with four areas of concentration, what's going to move the mountain? Again, this is well-known to Marc. What are those four for you or what are those end numbers? I mean, it could be the interoperability, care coordination, whatever that is, that just gives you a visor to look – to re-look at these things that will bubble up and offer great reasons. I mean, it's really a déjà vu for us. But how do we work through this so that we can focus more on the critical few and move this through the process? So it strikes me that that's not a one month kind of a thing and if you have any more in terms of time constraints, you want to put for this –

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

Actually might throw it to Steve. Do you have a sense of time constraints for this kind of feedback for this voluntary cert program for LTPAC and behavioral health?

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I think there was some hope that if there was a policy direction that the Committee wanted us to go in that for the subsequent rulemaking that we'd be pursuing for the 2017 edition. That those recommendations would be prepared in advance enough time for us to go through the process internally to chew on them and figure out whether or not there was enough to go on.

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

So it sounds like that gives us enough time, correct? I mean, several months at least. And what about – we put out our –

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Which month were you targeting?

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

Well, okay. So here's what we did – I mean, we found the RFC process also useful, both to us and to ONC in terms of putting – figuring out a way to display this so it can be digested fairly quickly. And then having the public comment on it as a way of helping to further – I know you've had actually extensive communication, a lot of presentation, but can we get more public on the ground kind of feedback. Again, it goes back to applying the principles Marc that you taught us so well, can we get that input before we give it to you and how much time do you have for us to do that?

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I was consulting with my calendar – so, hypothetically speaking, if we were trying to get a rule out by the end of the year, feedback by June would be the latest.

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

A rule or an NPRM?

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

An NPRM, I'm sorry, an NPRM.

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

Okay, an NPRM, which buys us more time because we can react to the NPRM –

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Yeah.

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

Okay, so, by the end of the year, that means June and this is March, that gives you three months. What do you think?

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

Yeah.

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

And feel free to use us again is a vetting board, I mean, we've gone through 50 of these things.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So Paul, I will engage you in administrative calls, to figure out how to move forward on that suggestion.

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

Right.

**Paul Egerman – Businessman/Software Entrepreneur**

I just wanted to point out that doesn't the Certification/Adoption group also have to comment on the NPRM for certification?

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

No how do we weave that into that schedule?

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

We're trying to first give input so they can do their NPRM.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

No, the second – another NPRM, Paul, he's talking about the 2015 edition.

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

For the 2015 interim we are hoping that they can have –

**Paul Egerman – Businessman/Software Entrepreneur**

– sort of like pointing at Steve, so that was perhaps too subtle a reference.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

(Indiscernible)

**Paul Egerman – Businessman/Software Entrepreneur**

The 2015 NPRM, the Certification/Adoption group is supposed to also provide feedback or comments, which will then be taken to the Policy Committee. And I just want to make sure we weave that into the schedule, because that train has left the station in other words, you have a schedule, we have to hit that schedule.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Yes, as I mentioned earlier, May 6 would be the point that I'm going to need feedback from the Certification/Adoption Workgroup to this Committee.

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

You're just commenting that they have to work double this next couple months. Is that all?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

There have already been multiple calls a week, Paul. I should bring my boss with me to these meetings.

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

Deven, do you have something to –

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

Deven McGraw, I just want to say that I'm pleased actually to hear there's a little more time for this, only because the topic that we have to handle on this set of issues would not have been an easy one to deliver by April or May. There's a lot of sort of digging in to sort of the actual experience of using some of the standards that have been created for the privacy and sec – enhanced privacy and security piece. As well as understanding how people deal with data that's subject to additional consent requirements today, and it's just – the more time that we have to really dive into all of that, the better we'll be able to consider that issue. So, assume we all want to package it all together for June, that would be great.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So let me back up and ask a broad question. So – so, this. Am I correct in saying that I have a broad sense from the committee that these are in fact good principles and we should go from here? This part's done, we're talking about the next drill down, which is how do we assess these, the things that are in gray, other things that might have come up? Things that are holes, that that would be the go-forward work, is that correct?

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

So to extent that you can use those 50 principles to guide your work, I think that's – yeah.

**Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration**

This is Terry Cullen, my only concern is that we're going to get in this leverage the existing certification program and you guys are trying to push, I think, a little on that to this concept of health versus how we've traditionally defined it. So if you're using that and you're saying, within that you can expand standards terminology, measures that are outside that, then I'm okay with that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess I'm hearing two things. I'm hearing one, which is, given the constraints of the 2017 process, what can be put forward as specific recommendations around that. But there are some broader topics that have been raised here and maybe we could begin in some of the public questioning, to address those. The same to Karen's request to look at prison communities. We probably spent four months doing what we did and I don't think we can do that effectively between now and June, but I think – we'll see.

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

Well, to – they're – I'm less thinking about the prison, but really more jail, where there's cycling. And so the folks that are at highest risk for mortality and often the highest cost to the healthcare system who are cycling in and out of local jails and local emergency departments and/or inpatient stays and are homeless, this is a devastating cycle and the information often doesn't flow. And they don't – whether it's substance abuse or mental health, they don't have information flowing within that, lest the care have not so much discontinuity. So it's especially –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah.

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

– I mean, Jeff Brenner type Million Dollar Murray model where you actually could conceivably do a lot of good to a small population that would help drive some of the benefit. And it doesn't even have to – it doesn't have as much of the privacy issues because you're maybe talking behavioral health to behavioral health provider.

I wanted to make a broad comment about that certification program and it seems like an appropriate time. And some of you may be aware that we've take – we're taking a hard look at ONC's certification process and program to make sure that it works more effectively and efficiently for everybody involved. As in other areas we've heard, there are some challenges. We know that there's an opportunity to make it better and so I raise that right now, which by the way, we have started it. We started some conversations and Jacob Reider is going to be leading an overhaul effort in that space. But it's a good time, as we're doing some uncoupling with a 2015 rule and we're thinking about certification of products that are not part of the Meaningful Use Program, like this.

And as we're thinking about expanding outside of a medical model, I'm not uncomfortable with – I'm not saying this is necessarily in your work bucket, but I wanted to tell the Policy Committee that I'm happy to hear that there's some thinking about other ways that we might create some standard vocabularies and opportunity for interoperability. And our certification program is not going – we're not going to be layering on top of what I think has been a kind of a bumpy program to make it significantly more efficient and better for everyone involved. And we're on a pretty rapid timeline to try to get that fixed, so it's a good time to get those ideas in.

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

So Steve, considering what you heard about the amount of work that the Certification and Adoption –

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

(Indiscernible)

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

Larry did.

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

I'm pretty sure Larry did.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

– with the rulemaking cycle.

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

You granted us a little bit of flexibility in the May, getting back to you on the 2015 NPRM. Can you grant us at least a month flexibility, or whatever the point is – instead of June, I mean, can it be July? And I don't know whether I can get Larry and Marc to buy into that.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Michelle, do you know when the June meeting is? I'm going to make a counter-offer.

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

Larry and Marc, how are you with July, even? Is it doable?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I have to say, I don't yet know what the scope of work is, so I have no idea.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Yeah, I mean, so let's – I mean, perhaps that might be a discussion you come back with in April, I mean, it could be that the group decides there are two or three top priority capabilities that they would love to see for these two settings, that follow the principles, that focus on interoperability. Maybe there's something related to the assessment, something unique to those settings that would be very helpful to have from a certification perspective and the scope is very limited. The more limited the scope, the potential greater comfort I would have in a slightly later timeline. But the fact of the matter is, there are processes in place through the – so anyway, the rulemaking process and the NPRM to get it through, get it written, get it cleared. Go over to OMB and I've already backed all those timelines out, so –

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

So since Steve just gave us July, why don't we get with you Paul and talk about that scope.

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

So, I like what – do you agree with July?

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I mean, I think – I appreciate you thinking July – do you know when the meetings are?

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

So June 10 or July 8.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

And this is Elise – the sentiment that there was a bit of consensus in the workgroup in terms of what the priority areas were –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

– and I think we can build on that. So, transitions of care, privacy and security and then –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Some of them we've already put out there, so I don't think – the first few are controversial.

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

Right.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

There's an open question to the Tiger Team about where things are with enhancing privacy and security. And there's an open question to quality metrics, which I think is going to turn out to be a quagmire. But – right?

**W**

– not a quagmire.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, here is not a quagmire.

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

All right, so here's – .maybe that's an easier deal. So –

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Final offer.

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

So here's what I'd like to put on the table. May is a given, so we're going to do May for the 2015. Why don't I propose July as the hard date, because I mean, we have to have Privacy and Security and Quality weigh in, and that if it tur – I mean, that's the hard date. You come back with what you can fit in the hard date is the three most important, then that's the thing that you give over, because that would be still worthwhile. But we need to meet their timeline and we do want to have the word in and we do want to be thoughtful. So, with as much as you can –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So maybe we should take a word from my friends in development and we should look about staggered deliverables.

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

Yup.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So maybe there are some things that we can do quickly and take an agile approach here, not make it one giant bundle.

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

Correct.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

See if there are some things we can't bring back next month, that's easy approval, half an hour presentation and done. And other things that are going to need more thinking.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I mean we were thinking of the prior precedent that we've used in other workgroups of having draft in June, final in July, which I think comports with your final deadline. But, if you want to go – take small bites, that's great, too. The sooner we see more of the elephant, the better.

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

So just like you heard July Marc, I heard the dinner is on Steve if it's June. This is negotiating.

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Anyone who wants a food truck out there.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Okay, so can I add to that point about staggerability? Most of the discussion we've just had was on Stage – on Step 2, but on Step 1, that was also one of the recommendations. And if maybe we can take that off the table, then that would allow us to kind of move forward and take that out. So, I'll leave that to you Larry, but I just wanted to raise that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

In terms of the framework?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Yeah, yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, to bring that to vote, oh, so that'd be an interesting question, right. Could we do that now, is that far enough along or am I throwing a curveball at people? I can clearly see I am throwing a curveball at the whole Committee.

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

I thought we already did that last time, actually. There we go –

**Steven Posnack, MHS, MS, CISSP – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

They said yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

They said yes. Done, okay, a check?

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

You actually got that – it was really done. Yeah, you got that check last time.

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

Larry, was this online? I didn't see it in my attachments.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This was sent.

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

Okay.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

This was sent and it's in the packet.

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

Yeah, I have it in the packet, I just wondered –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– yes. If it turns out it got lost somewhere, someone should shout –

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

Okay, good.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So we'll work on Step 2 and I think we have an easy bite, maybe next time to just check off and then we'll work on the harder stuff and keep out of jail.

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

I like – we're going to go to jail.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

We're going to go to jail. We're going to go to jail first – first we're going to go jail –

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

Take a field trip.

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

Let's not criminalize mental health, yes, that's a great goal for the Policy Committee, but, at least we can help them make the transition easier.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right, just a field trip, Marc says. We're not going to stay.

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

Okay, thank you very much to both of you and to the workgroup that's worked on this. And we'll be looking forward to your ambitious schedule in the next few months, thanks. Okay, I think we're ready for public comment, yes? Yes. Okay, why don't we open up for public comment please?

## Public Comment

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

Operator, can you please open the lines? And if there's anyone in the room that would like to make a public comment, please come up to the table. As a reminder, you have 3 minutes and please go ahead Ashley.

### **Alan Merritt – Altarum Institute**

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

### **Thomas R. Bizzaro – Vice President Health Policy & Industry Relations – First Databank, Inc.**

My name is Tom Bizzaro, I'm Vice President of Health Policy and Industry Relations for FDB, First Databank and I'm currently serving as the NCPDP Chair of the Board of Trustees. But my comments today are of as a pharmacist. As I've heard the comments today as it relates to behavioral health and long-term care, I think the pharmacy also needs to be considered as its requirements for access to information and Meaningful Use. This Committee is talked about pharmacy as a critical part of that continuum of care for the patient and I think we need to consider that further.

Pharmacy, unlike my other colleagues in healthcare has been – had access to an EHR through our pharmacy management systems for over 30 years and essentially we are 100% computerized and have access to those pharmacy management systems in all pharmacies. And so for us to have access to the information that we feel is critical to the care of the patient in the pharmacy is something I would like this Committee to consider further. Thank you.

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

It looks like we have no more public comment.

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

Okay. Well thank you. Very rich discussion, I mean, each of these are very productive, rich and they all go into input for our future deliberations and especially to ONC and CMS. So, thanks to everybody for the participation and I believe next month is virtual, right? Not that it doesn't happen, it just doesn't happen in Washington, DC. So thanks very much.

## Public Comment Received

1. YES, the ccda is to verbose for wireless
2. The amount of overhead data is huge for transmission over wireless system
3. For the conundrum of the C-CDA standard, the regulation required that the Summary of Care document and the Visit Summary for View, Download and Transmit have a specific set of data, if present. Vendors to certify for these criteria had to show that the C-CDA would contain the information from the EHR's database for all of these elements. There was no flexibility involved. There was the additional requirement on the measure threshold side. Was the provider or vendor required to assure that all data elements are contained in a C-CDA before it could be counted in the numerator of that criteria? This was not clear and is causing confusion. To allow flexibility in the contents of the C-CDA may be a difficult project and make the measurement even more complicated.
4. How many EHs and EPs have been audited? How many have failed the CMS MU audit and had to return the EHR incentive dollars?

5. The hardship exception seems to be putting a target on the EHR vendors especially in the area of being able to implement certified EHR software. It is often the facility not being ready for the software due to lack of necessary hardware and the money to purchase this needed software. The facility may upgrade to the certified software, but not be able to train and use it appropriately in the necessary, limited time frame. Please watch closely what is allowed as a hardship exception. Thank you.
6. Of the 9 EHs that have attested in the 2014 Edition, which vendors are represented in this group and are these 9 hospitals large hospitals?
7. how were the EHR vendor products identified as a LTPAC EHR product?
8. One of your observations was that the LTC/BH sectors are ASKING the govt for help in achieving interoperability. IMO, this contrasts with the general posturing of the hospital community 5 years ago, which has been reluctant to embrace govt intervention. What's different about underlying economics, timing, market conditions that account REQUEST for govt help here?
9. Building survey reports and templates could be a significant project for vendors and would be a new requirement to be in this space.