

# **Health Information Technology Policy Committee Final Summary of the November 9, 2011, Meeting**

## **KEY TOPICS**

### **1. Call to Order**

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 29<sup>th</sup> meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC Web site. She conducted roll call, and then turned the meeting over to HITPC Chair Paul Tang.

### **2. Review of the Agenda**

Tang announced that the December meeting would be held in person, and would have a full agenda. Then he reviewed this meeting's agenda, and the Committee approved the minutes from last month's meeting.

**Action Item #1:** Minutes from the October 12, 2011, HITPC meeting were approved by consensus.

### **3. Update on CMS' Rule on Accountable Care Organizations**

Terri Postma from Centers for Medicare and Medicaid Services (CMS) discussed the basics of the Medicare Shared Savings program and where HIT fits in, and then described in detail some of the changes in the final version of the program as compared to the proposed rule. Medicare Shared Savings is a voluntary incentive program. It offers incentives for members to form accountable care organizations (ACOs) to improve the quality of care given to the Medicare fee-for-services population. CMS received more than 1,300 comments during the comment period for the proposed rule for this program. So far, Postma said, it appears that the final rule has been well received by the community.

The sometimes-fragmented health care system was developed in pieces, without any well-designed connections between hospitals, clinics, and other medical care facilities. The fragmentation in payers contributes to this.

The Shared Savings program has a three-part aim: (1) better care for individuals, (2) better health for populations, and (3) lower growth in health care expenditures. Participating providers and suppliers will continue to receive fees for services as usual, but the ACOs will be judged on quality performance and reducing per capita costs. The ACO will share in those savings with Medicare.

The goal is for ACOs to promote seamless, coordinated care, with proactively managed beneficiary care, reminders at points of care, innovating around improved health care and lower

costs, and investing in team-based care. This is the vision, Postma said, and clearly HIT can play a part in many of these goals.

The strategy is to create multiple pathways for ACOs made up of organizations in various stages of readiness. There will be a shared savings program, and an advanced payment initiative to assist particularly small groups and physician-only groups in accessing up-front capital in exchange for future savings. There is also a pioneer model designed to test and implement unique payment strategies with the more sophisticated groups. The CMS will incorporate successful pioneer strategies into the national program.

The goal in the final rule was to create different pathways for organizations at various stages of readiness, and to create a stronger business case. The CMS wants to be a strong data partner for ACOs, and to implement a robust quality measuring and performance monitoring system. They also have formed strong partnerships with the anti-trust agencies.

Postma then presented a series of slides with a side-by-side comparison of the proposed rule versus the final rule, so that Committee members could see the modifications. She explained that an ACO participant is a Medicare-enrolled entity, and bills Medicare directly for services. ACO participants are joined together and designated by a taxpayer ID. There is a critical subset of ACO participants, which are those who bill Medicare directly for primary care services. In the proposed rule several entities thought to be eligible for participation were highlighted. In the final rule, eligibility was expanded to federally qualified health centers (FQHCs), rural health clinics (RHCs), and any other Medicare-enrolled entities.

The final rule implements a two-track approach. ACOs will have the opportunity to choose track 1, which is a minimum of 3-year agreement of single-sided share savings only. Track 2 is a shared savings and loss program, with a higher rate and cap. The second track rewards groups for taking on a greater performance-based risk. Initially, it was thought that those in track 1 would transition into track 2. However, that is not the case in the final rule.

The first period will begin on April 1 and July 1, 2012, versus the January 1 start date that will go into effect in subsequent years. The CMS heard feedback from groups indicating that they would take some time to get organized and would not be able to meet a January 1, 2012, start date. After one agreement period in share savings only, ACOs must renew under the track 2 model.

Postma discussed beneficiary assignment, indicating that many people misunderstand beneficiary assignment in the context of the Share Savings program. In this context, it refers to the operational necessity of determining what beneficiary the ACOs should be held accountable for to achieve payment. Beneficiaries remain free to choose their providers, with no enrollment period. She then described the assignment algorithm for beneficiaries, saying that ACOs will be given upfront information on their fee-for-services population based on the population that the ACO has been caring for during a 3-month period. The CMS knows from modeling data gleaned from the Physician Group Practice Demonstration that many of the beneficiaries assigned in the year continue to see the same providers in the year. There is a rolling 12-month

assignment period, so ACOs will be able to monitor how that list changes from quarter to quarter.

ACOs cannot share in the savings without meeting quality measures. The proposed rule contained 65 measures in five domains, which was whittled down to 33 core measures in four domains in the final rule. Because of stakeholder concerns regarding an electronic health record (EHR) measure that had been proposed as a condition of participation, CMS eliminated that measure but retained it as part of the critical core set of quality measures, and weighted it twice compared to other measures. The measures align with CMS measurement and incentive programs and are consistent with the statute dealing with the inclusion of process and outcomes, and patient experience.

Regarding data sharing, Postma commented that the CMS has a committee for sharing identifiable claims-based data with ACOs on a monthly basis. The ACO must enter into a data use agreement with CMS, and once it demonstrates that it has taken the necessary safety measures, it can participate. The ACO can request identifiable data from the CMS for its clients after notifying the beneficiary that it would like to request this data. In that way, the beneficiary could decline to give that permission.

Because of the staggered start in the first year, the first agreement periods will be slightly longer than 3 years. Those agreements will be 3.75 years or 3.5 years. Those periods will be broken into three performance “years.” The first year will be longer, depending when the ACO starts, as it will conclude at the end of 2013. Thereafter, they will be synchronized with others who started at the beginning of 2013. This approach will benefit early starters.

A significant amount of inter-agency coordination is taking place with this program. The CMS worked with the Federal Trade Commission (FTC) and the Department of Justice (DOJ), as well as the Internal Revenue Service (IRS) and the Office of the Inspector General (OIG). These agencies have concurrently released documents along with final rule for the Share Savings program. These documents address stakeholder anti-trust concerns. There will be a voluntary review process for those ACOs concerned about running afoul of anti-trust laws. The proposed rule included a mandatory anti-trust review, but in final rule the process will be voluntary.

### ***Discussion***

- In response to a comment made by Paul Tang about the EHR requirement, Postma explained that in the proposed rule, there was a requirement for EHR use by year 2. The CMS heard from many stakeholders that they are not quite there, and they are hoping that the shared savings achieved through this program will help them to cover the cost of putting those systems into place. Small practices in particular were expressing hesitation to participate because of this.
- Christine Bechtel asked about quality targets. Her understanding is that participants do not get the benefit of the shared savings if they do not meet a quality target. However, in the first year there is no target; participants just have to report. Postma concurred, saying that after the first year, there will be minimum requirements for measures. The final rule indicates that

ACOs must be in the 30<sup>th</sup> percentile for most measures as compared to the national performance standards. This will move up on a sliding scale. In order to qualify for the maximum amount, in the first year they need to fully report on quality measure. In the second year. It is pay for performance for about half the measures, and in year 3, it is nearly all the measures.

- Regarding the exclusion of hospitals in terms of reporting numbers of meaningful users, Postma said that it was a challenge for the quality metrics because there may be some ACOs that do not have hospitals involved. As the program develops, most ACOs may choose to include hospitals, and that might prompt a change in the program.
- Bechtel said that from a consumer perspective, the unique contribution of ACOs is care coordination, and it is not possible to get that without connecting to hospitals. This represents a missed opportunity. Bechtel said that she understands the logic, but she does not agree, because CMS has plenty of experience in applying exclusions to measures to make things work.
- In response to a comment from Judy Murphy, Postma explained that most providers feel comfortable evaluating their managed care system. Patients have proactively enrolled, so they know who their beneficiaries are. The Shared Savings program specifically builds on the fee-for-service setting. Three-quarters of Medicare beneficiaries have chosen traditional fee-for-service settings. The data-sharing aspect is an effort to mitigate that. Although the ACO may have an understanding of the claims it is billing, it probably does not know what other providers are billing, so that could be helpful. Murphy pointed out that the big concern is when a patient is going to a non-participant provider.
- Neil Calman complimented CMS on how responsive they were to comments from the community. Regarding the EHR requirement, one of Calman's colleagues indicated to him that the way it was structured was "brilliant," because nobody could possibly do this without having not only EHRs but also solid connectivity among systems. He commented on the need to stop micro-managing the systems and to start focusing on the outcome. Calman said he agrees with his colleague, that nobody could create this level of integration without health information exchange (HIE), not just EHRs. This is going to be a tremendous push for people.
- Calman also noted that it is advantageous not to lock people into a managed care system. Providers should be held accountable for the kind of loyalty that this kind of program will reward. Earning that loyalty will be a major side effect.
- Calman also asked about whether the CMS considered other measure sets when creating these. Postma acknowledged that the measures piece was one of the most challenging because they did not want to impose a whole new measures set. They made sure it aligned with other CMS and HHS quality initiatives, as well as other private-sector measures and measures central to chronic disease states. Calman said that this Committee is responsible for reducing the burden to the healthcare community. People become immune to this when

there are too many measures. They just start measuring everything, and it becomes another pile of papers rather than something that drives focus to the meaningful, quality issues.

- In response to another comment by Calman, Postma explained that while this program is focused on the fee-for-service Medicare population, the CMS anticipates that these ACOs will reach out to other private payers as well. One of the required processes of the ACO is that they have to demonstrate on their application that they have internal processes for monitoring the quality of care for their population. They are expected to develop that capability, beyond the metrics that CMS is assessing for quality.
- Gayle Harrell asked about the possibility of providers being able to examine claims-based data and eliminate from their ACO certain high-cost patients, essentially “cherry-picking” their beneficiaries list. Postma explained that one of the reasons the CMS implemented the assignment process was to eliminate this type of activity. The CMS will provide ACOs with information about who is being assigned, but at the end of the day the ACO will be held accountable for those beneficiaries who are receiving their services from that ACO. The methodology is to risk-adjust the baseline dollars and the performance year expenditures. That takes into account risk concerns regarding up-coding or “cherry-picking.” The CMS will also be looking at the additions and deletions of beneficiaries, and adjusting the ACO’s risk score accordingly.
- Regarding the role of specialists, Postma explained that while the program is very primary care-centric, there is still an enormous role for specialists to play. Much opportunity is lost in the lack of coordination or communication between primary care providers and specialists, and many specialists effectively become the primary care providers. The CMS wants to make ensure that whatever variety of specialties exist in an ACO, that the ACO is focused on primary and preventive care. So, if a specialist wants to retain the primary care of a particular beneficiary, it is incumbent on that specialist to get them the primary care they need. Also, often there is lack of communication between a referring primary care provider to a specialist and back again. This program incentivizes that transition to go smoothly. Avoiding duplicative testing is another useful outcome of this collaboration.
- David Lansky said that ACOs create the opportunity to align measurement strategies to allow for payment redesign. He asked what measures might change over the next 3-5 years, and what Postma recommends so that the measures this Committee recommends align with those of CMS. Postma explained that the CMS expects that the measure set will remain fairly static over the next 3-5 years, although there will be changes if there are problems with particular measures. The CMS expects to be learning from the ACOs over time. Some of the measure gaps relate to the outcomes-based measures. The CMS wants to examine at care-transitions measures, and more guidance would be helpful on how to accomplish that through the quality measures. To the extent that CMS can collaborate with this Committee in future rulemaking, they would appreciate that opportunity.
- In answer to a question from Judy Murphy about benchmarks are for success in this program, Postma indicated that between 50 and 270 organizations might be participating in the first 3 years, serving 1-3 million Medicare fee-for-service beneficiaries.

- One Committee member noted that on the ONC Web site, there is a crosswalk between the Shared Savings program measures and the Meaningful Use measures. Only 16 of the 33 Shared Savings program measures correlate with Meaningful Use measures.

#### **4. Update From ONC: Results and Implications of the “Putting the IT in TransITions”**

ONC’s Janhavi Kirtane and Leah Marcotte described the work from an October 14 meeting that focused on hospital to post-hospital transitions. Fourteen of the 17 Beacon communities are focusing on applying IT to transitions, as well as four challenge grantees. The Standards and Interoperability (S&I) Framework is working on transitions of care. In a recent mobile application contest, around of the 20 applications focused on the transition from a care environment to home.

At the meeting, participants were asked what can be done to define an agenda around transitions of care. There is a significant gap in reaching implementation. The ONC is hearing a great deal of feedback indicating that there is not enough detail relating to infusing technology into what providers are trying to do. Also, the role of government has not yet been determined, as a convener and a signaler to the market. Depending who is asked, the problem looks very different. The challenge statement for this ONC endeavor is defined by patients and caregivers. At the meeting, three patient stories were presented, highlighting three different sets of clinical and social factors.

Kirtane described the ONC event as a “do” meeting. Participants focused on defining the intractable challenges. The meeting was attended by 200 people and was divided into five concurrent workgroups. Two worked on information flow and feedback, one looked at the discharge process, one examined patient and caregiver activation, and one discussed medication reconciliation.

The ONC heard that there is not a lack of technology—providers have what they need, but do not always know how to use it, or how to translate the winning example into their particular market. The Office also heard that technology historically has been talked about in terms of information exchange, or focusing on EHR adoption. Instead, they want to explore how to infuse technology into change models. Vendors, hospital leaders, foundations, community-based organizations, and payers were all part of this conversation.

Marcotte commented that it was readily apparent that those on the ground were not as tuned in to the goals and processes of the S&I Framework and its initiative on transitions of care. The ONC wants to socialize the S&I work on transitions of care so that someone who is not technologically savvy can understand it and get excited about it. They also want to address those who are more technologically savvy to become more involved in the S&I goals.

Marcotte listed the following goals that were called out during the meeting: (1) convergence on a single standard for electronic transitions of care; (2) a continual focus on the clinical needs of patients and providers, with technical standards built around these rather than vice versa; and (3) highlighting the unprecedented amount of engagement by vendors collaborating with on-the-

ground clinicians to pilot this standard to make it clinical effective and aimed toward the goals of Meaningful Use Stage 2 and 3 goals.

Some of the discussions centered on the need for attention to high-impact transitions such as to long-term and post-acute care, as well as the need for aligned efforts of a number of disparate initiatives to achieve electronic HIE. How do they make sure that all of this work towards HIE is really aiming toward the same goals so that they achieve interoperability?

In five breakout sessions, small groups hashed out the important priorities related to problems that may have technological solutions. They looked at the current IT solutions that exist for some of the problems, the opportunities for innovations, and the enablers for spread and uptake. Each of the five groups reported out, and four main themes emerged:

- The vision of a plan of care is one that spans time and setting, incorporates social and medical factors, reflects patient goals, and is accessible to all care team members.
- Effective and efficient medication reconciliation continues to evade even the most sophisticated providers.
- IT-enabled feedback loops are underdeveloped and are critical to ensure safe care and self management.
- Shifting from the hospital-centric model is the most important enabler for spread and uptake.

Overall, the results of the discussions at the meeting were aligned with the recommendations of this Committee regarding transitions of care. Participants were given a post-meeting, 2-week challenge in that they were asked to report back about what they would be doing differently as a result of the meeting. Marcotte shared a few of the dozen responses they received. She also mentioned that there were partnerships forged at the meeting, such as between MedAllies and the New York Visiting Nurses Service, which will be partnering in the Direct Project.

Kirtane explained that they decided to focus on hospital to post-hospital transitions, knowing that there are also many other important transitions. Also, she acknowledged that they did not discuss payment during the meeting—they wanted to focus on the technology, given where the ONC has some authority and where it does not. Potential roadblocks that Kirtane pointed to are an information gap that is hindering progress. There is a deficit of information for people trying to link the technology to real health care improvement.

### *Discussion*

- Tang asked whether the group is working on the content standards for transitions of care documents. Marcotte said that she believes they are starting a workgroup around the summary of care plan. The transition of care work is in the piloting stages, and they have several sites at which they will be piloting those standards.

- David McCallie commented that more support is needed for research in this area, as are measures. Also in terms of priorities, he said that another valuable component is the ability to have two-way communications between the various partners.
- Christine Bechtel noted that defining the care plan has been a struggle, particularly within the context of Meaningful Use Stage 1 and 2 criteria. A large amount of information could be collected, but there is no broad agreement about what information belongs in the care plan, and she encouraged ONC to help define it more specifically. She asked if they envision consumer access to the care plan. If so, does it include information about what to do if certain symptoms arise after discharge? She pointed to a program by Louisiana's Quality Improvement Organization (QIO) that has a simple approach and includes electronic and paper versions. For the paper version, the patient gets a green sheet, a yellow sheet and a red sheet when they leave the hospital. A symptom listed on the red sheet needs treatment; the green sheet lists symptoms that would not require a return to the hospital. When considering consumer access to the care plan, two different views may need to be available so it can be actionable for patients and families.
- Larry Wolf noted that sites of care work on different timelines with different goals and different resources. Plans would shift because the goal shifts from one care point to another. Depression is a good example—depression might affect the ability to carry out rehabilitation once a patient is at home, but it is not something that would be addressed in the hospital when that patient is having a hip reset. If that patient stays in a rehabilitation facility for a month, then that might be something that they would begin to address. A shared care plan is more than just handoff. He also pointed out that although technology provides the ability to examine a patient's history, which is beneficial, practitioners are now getting 200-300 pages of printout, which is not helpful.
- Gayle Harrell suggested that care transitions are likely the pivotal point where things can fall apart. There are entities that do not have the capabilities, such as electronic records, that the hospitals or other physicians may have. This is a significant issue because there are entities that do not have the capability—and probably will not have that capability, especially in the home health world.
- Kirtane noted that it was interesting to hear from home health providers about what they are doing to put things like iPads in the hands of the nurses and then building interfaces with their partners in care. In the near term as they wait for adoption to pick up, it is important to identify those bright spots much more deliberately and use those as a model to rapidly translate their learning to other home health agencies or providers.

## **5. Remarks From the National Coordinator**

National Coordinator Farzad Mostashari provided a preliminary statement about the Institute of Medicine (IOM) report *Building Safer Systems for Better Care*. The report was supposed to have been released the day after this Committee meeting, but the news came out early. Each analysis of the report seems to have a different angle. Improved patient safety has been one of the primary motivators for switching to HIE. There are many different ways in which EHRs make

care safer. In the report, the IOM reaffirmed its faith in the potential for HIT to improve safety, but also indicated that its potential is not fully realized.

The report was commissioned as part of a longer-term strategy. The IOM was asked to examine the topic because of its ability to assemble the best minds in the field and have the time to generate a thoughtful, consolidated set of recommendations. The IOM also has a long history of looking at safety in a comprehensive manner.

The IOM made the point that the EHR system software needs to perform reliably, but it is not about any one component. The issue is not about product performance; safety is a system. Successful use of HIT means understanding safety as part of a systemic approach. There are usability issues, and there is a relationship between the design of HIE and workflow, and this falls to vendors. Mostashari reported that on the day preceding this meeting, there was new movement on the part of the EHR Vendor Association to collaborate on reporting of safety events.

It is also necessary for providers to take the time to implement systems appropriately, and to place particular importance on training and creating a connection between computerized workflows and clinical workflows and protocols. The socio-technical aspects of safety are also important. The ONC often hears about how something as simple as an after-visit summary gives the patient an opportunity to make sure the doctor has their information right.

The IOM also focuses on another critical issue: making sure reporting of safety events takes place. The ONC is working on promoting reporting with EHR vendors, and have worked towards standards with the National Institute of Standards and Technology (NIST), but much more work is needed in this area. Mostashari appreciates IOM's recommendation on making sure that there is a coherent structure for reporting, analyzing, and acting on safety-related information by all the stakeholders. It is critical that this be followed through.

The IOM asked for a reporting and safety plan within 12 months. The ONC has already been engaged in much of this work. The Office will examine IOM's particular recommendations, and will also obtain input from stakeholders and will work with the Agency for Healthcare Quality and Research (AHRQ), NIST, and the Food and Drug Administration (FDA) as it crafts the surveillance and action plan.

The ONC has been receiving questions about whether the FDA should regulate electronic health care devices, and this is clearly a controversial issue. A key point is the recognition that a broader set of issues need to be addressed, not just the devices but the entire question of training, workflow, and how the systems work together. The ONC will work closely with FDA and other federal partners to craft an action and surveillance plan. The IOM report also mentions the need to balance an innovation agenda with concerns about the expertise needed to address this issue specifically, which may be different from device regulation in general.

Larry Wolf said that the importance of working with federal partners is key. It is an interesting notion to consider something like a transportation safety board for health care. He suggested that

the ONC consider the example of air travel regulations as they were formed. How could they leverage that experience?

## **6. Meaningful Use Workgroup Update—Report on Hearings and Preliminary Approach for Stage 3**

Meaningful Use Workgroup Chair Paul Tang introduced a report on the workgroup's latest hearing on October 5 about experiences from Meaningful Use Stage 1, and input towards Stage 3 strategies. Workgroup Co-Chair Paul Tang noted that he was struck by a notion in the earlier discussion on transitions—just because it is possible, it works, and it is feasible does not mean it will get done. There must be a program, some incentives, and a plan in place. He then reviewed the findings from the hearing, noting that there were four panels: (1) Meaningful Use—Supporting the Goals of Health Reform, (2) Providers—Working Toward Meaningful Use Stage 3, (3) Vendors—Developing Systems to Meet Meaningful Use Stage 3, and (4) Finding Solutions and Creating Outcomes.

Tang noted that the hearing's summary findings fell into the following categories: clinical quality measures (CQM), patient engagement, the lack of HIE, and other sources for feedback. With this feedback, the Workgroup is now focusing on the areas of quality measurement and specialties and has formed two small groups. The first will examine attributes that would be desirable for CQM. They have discussed the attributes of "ideal" clinical quality measures, including strategic attributes and technical attributes. The second small group is in the process of looking at specialties. Their work will include reviewing past hearings and testimony as well as an American Medical Association matrix of responses from specialty societies. The preference is not to have a separate Meaningful use track for specialists, but rather to focus broadly on all types of specialists. Specialists should contribute to EHR content, not just access. The small group may seek more feedback on options.

The Meaningful Use Workgroup is developing focus areas for Meaningful Use Stage 3 principles, and has created initial draft focal areas for Stage 3, focused on leveraging tools to support health. In closing the presentation, Tang reviewed the Workgroup's schedule and the strategy for developing recommendations for Stage 3.

### ***Discussion***

- Marc Probst observed that this work is moving from "things" to "outcomes" and how to influence those outcomes. Getting to exchange is what is important—more important than the particular vehicle.
- Gayle Harrell said that one of the key activities is to make sure this work moves forward at the specialist level. Specialist care likely accounts for 75% of the cost of care. Efforts are needed to ensure that there is enough flexibility with those quality measurements so that every specialty has the ability to qualify to meet Meaningful Use. This is absolutely critical for Stage 3.

- Regarding the quality measures, Harrell commented on the need to review all of the various quality measures and coordinate them now, not in 5 years when this is set in stone and they will not be able to do anything.
- Harrell noted that licensure requirements in each state cost a tremendous amount of money. The Workgroup could obtain input from states related to state licensure, so that those quality measures that are already being carried out at the state level could be appropriately structured for re-use. It would save a large amount of money and empower the states in this process. The end result would be cost savings while creating that coordinated element that is lacking.
- Regarding quality measures, Bechtel asked how well connected this work is to other activities. One example is the Measures Application Partnership, which is making recommendations to HHS around alignment across programs. She also pointed to the test beds that the ONC is helping to fund, and the work of the Beacon Collaborative at Dartmouth. There is a need to consider how these efforts relate to HITPC's Quality Measures Workgroup.
- Judy Murphy asked about the definition of success as it relates to this work. Once they know what they have to achieve, they will do a better job of achieving it. As she looks at Meaningful Use Stage 3, she sees the need to analyze what happened with Stage 1, then build with Stage 2, and with Stage 3 identify what has already been achieved and craft recommendations relevant to these accomplishments. The goals should be clearly specified.
- The Department of Defense (DoD) and the Department of Veterans Affairs (VA) have come together in an inter-agency program to create one unified EHR. These agencies are in the process of standing this up, and it is an opportune time to take early thoughts and build them into the upcoming platform.
- Gayle Harrell pointed out that this Workgroup already held a hearing on specialties, and crafted very specific recommendations. In fact, the HITPC modified its recommendations based on this feedback. When the CMS issued its Notice of Proposed Rulemaking (NPRM), it did not include the Committee's recommendations on specialties. At the end of the day, when they have achieved the intent of the legislation, every specialty must have the ability to qualify for Meaningful Use.
- Neil Calman pointed to the need for reigning in the list of measures and rather than expanding the list, considering already-existing measures being required by other sources. He also suggested that the HITPC should call for a requirement for a flexible reporting system, specifying what the parameters are for vendors to make it possible to report on. For example, systems must be able to report by age, sex, principal diagnosis, etc.
- One Committee member commented that the most important quality measurement objective is one that is driven by the needs of the organization itself. The HITPC should be driving that process so that providers can indicate what their internal issues are (e.g., a problem with diabetic management).

## 7. Update From ONC on Consumer Engagement Strategy

ONC's Jodi Daniel introduced Lygeia Ricciardi to discuss the Office's work on consumer engagement. Elevating the role of the consumer is one of the five goals in ONC's Health IT Strategic Plan, which was published in September. The ONC is working to make the Strategic Plan a living document with significant public feedback that can be obtained interactively. Consumer e-Health could be a test in this regard. The Office has done a large amount of work since the draft plan was released back in March.

Ricciardi reported that in September, the Consumer e-Health Program released proposed rules on access to lab data (CLIA), consumer content on healthit.gov, and PHR Model Privacy Notice. They also established the Pledge Program, with 30 organizations taking the pledge. Since then, the number of pledging organizations has risen significantly among data holders and non-data holders. They have launched two new initiatives for engaging consumers via video/animation, and laid the groundwork for three new technology innovation challenges.

The ONC is working with several underlying assumptions about consumer engagement in health (e.g., personal behaviors and choices are essential factors in shaping individuals' health), powerful "megatrends" that support consumer engagement in health (e.g., communication technology is getting cheaper and more ubiquitous), and roles (e.g., ONC's role is to catalyze the change led by other stakeholders and "megatrends").

### *Discussion*

- It was suggested that the ONC distinguish between EHRs and PHRs. The Health Insurance Portability and Accountability Act (HIPAA) requires access to the HER; the case for PHRs is slightly different.
- Gayle Harrell pointed out that there is a digital divide in this country. There is a need to understand that there is a significant gap in terms of what people are going to be able to or are willing to handle.
- Larry Wolf likened consumer uptake in health care to the situation with MP3 players prior to the iPod. There were several devices on the market, and relatively low uptake, and then iTunes came out and shifted the model. Currently there are various PHR "players," but generally very little uptake. Wolf suggested looking at bright spots of consumer engagement. Some health care organizations say that they have very high rates of engagement. How can those be scaled?

Ricciardi continued the presentation and discussed ONC's strategic approach. Three areas of focus have been identified:

- Access: Give consumers easier access to their personal health information. Make "real" what is already required by law.

- Action: Support the development of tools and services that help consumers to take action using their electronic health information.
- Attitude: Support the evolution in expectations regarding access to and use of health information to engage more fully in health.

The Pledge program spans those three areas, encouraging public/private sector organizations to encourage greater ability by consumers to engage in care. The pledges are for organizations, not individuals, and there are two types of pledge. One is for data holders (primarily payers or providers) who are pledging to make it easier for individuals to get secure electronic access to their records, and to encourage consumers to do so. The pledge for non-data holders pledge is much broader, and relates to supporting consumer engagement in e-Health and HIT. The non-data holders pledge is about spreading the word, engagement and outreach, and developing tools and services (not just PHRs).

She then reviewed the group's short-term objectives, as follows:

- Establish baseline metrics for success and update them regularly.
- Via the pledge program, get data holders that serve a significant proportion of Americans to commit to make health information easily accessible electronically to individuals.
- Encourage data holder pledge participants to make a clear statement regarding individuals' right to access their health information.
- Incorporate the group's messaging into existing public outreach campaigns or publications reaching large numbers of Americans.
- Increase transparency about which providers make health information easily accessible electronically to individuals.
- Significantly increase use of ONC's Model Privacy Notice by PHR companies, and provide ways for consumers to more easily compare them with each other.

Longer-term goals include changing expectations, learning from and updating pledge organizations, developing a community of peers, and providing tools and materials to support pledging organizations. Additional longer-term goals include contributing to a shift in public attitudes through a series of video contest challenges for the public and an animation explaining HIT. The group is also striving to better understand and act on policy, technical, and other dimensions of the following areas: (1) integration of "patient generated data" into EHRs/clinical care, (2) use of social media for health, (3) enabling proxy access to personal data, and (4) integrating information about costs/quality of care with clinical info to help consumers understand context.

## *Discussion*

- It was noted that for several years, the VA has been deploying a PHR, my HealthEVet, which is now integrated with secure messaging. The VA funded an implementation study that was a partnership between the research community and VA's IT/informatics operations. Some offline assistance in connecting Ricciardi with this was offered. There is a need for this type of evaluative-oriented research, rather than new knowledge discovery.
- Gayle Harrell reiterated the stratification in the levels of knowledge and comfort with technology in the country. A lot of it is age related, and the Medicare population is not going to be as technologically savvy. Outreach is extremely important to make this population comfortable with it, and they have major privacy concerns as well. Ricciardi acknowledged Harrell's concern, and said that they have been debating whether to stratify by age or by health engagement level, which is another area where there is a big divide.
- If this is structured around the concept of access to information, it might not be nearly as attractive for the user as if it is structured it around the actions and tools that a user could have. The outcomes and the actions are important. The main reason veterans use MyHealthEVet is that they can get their prescriptions filled, their appointments scheduled, etc. Mobile device applications should also be considered. For example, something focused that works well on the iPhone could make a very positive connection.
- Bechtel noted that there are data demonstrating that online access is a factor in choosing a provider. However, it depends what kind of online access they have. Functionality is important.
- Bechtel also noted the importance of considering who is delivering the various messages that the ONC hopes to send with its outreach campaign. Physicians are enormously trusted messengers. She encouraged Ricciardi to think broadly about how to deploy all of the messages that were outlined in the presentation, but through different channels. She also warned about creating demand for things that do not yet exist.
- Neil Calman discussed data on the 15,000 people who use Institute for Family Health's patient portal and what their usages are for the different components of it. Lab results come out as number one. He suggested that they could segment the video contest by functional areas. For example, one category could include videos showing how important it is to be able to make appointments online. Allowing consumers to generate these activities will be powerful. He characterized it as "putting the ME" in Meaningful Use. Of all the things ONC is doing, this is by far the most critical, he said.
- Larry Wolf suggested that the ONC look for examples of where people are trying to support their own health outside the usual stakeholders of those who do it as a profession. He mentioned various electronic health tracking devices as an example.
- Another Committee member mentioned the benefit of more convenient access to one's health care provider. Another area to consider is patient-generated data, with home monitoring and

other kinds of physiological data and information about symptoms that could come from outside the office.

- Bechtel suggested that they consider the importance of consumers understanding the information to which they will have access. They are hoping, through Meaningful Use, to unlock a lot of information, but it cannot simply be a data dump. People will need help interpreting the information. The proposed rule that would allow people to directly access their lab results is the perfect example of this.
- Bechtel also said they need to understand the impact of the ONC pledge program and the consumer education campaign from a patient's viewpoint. She offered the help of her organization and noted that many other organizations would be willing to help through surveys and focus groups and other ways to understand the value and impact of these programs.

## **9. Public Comment**

Carol Bickford from the American Nurses Association (ANA) asked about outreach to the organizations that have signed onto the Pledge Program to bring them up to date about resources available. ANA's expectation when they signed on was to provide distribution for materials from the ONC. Ricciardi said that they will receive some outreach shortly about surveys and upcoming webinars.

## **SUMMARY OF ACTION ITEMS:**

**Action Item #1:** Minutes from the October 12, 2011, HITPC meeting were approved by consensus.