HIT Policy Committee
Final Transcript
November 9, 2011

Presentation

Operator
All lines are open, Ms. Deering.

Mary Jo Deering – ONC – Senior Policy Advisor
Hello, this is Mary Jo Deering of the Office of the National Coordinator. Welcome to the 29th meeting of the HIT Policy Committee. This is a public meeting. There will be an opportunity for public comment at the end. I would ask all of the members to identify themselves when speaking, as a transcript will be made of this meeting and it will be posted on the Web site. I will take the roll. Farzad Mostashari? Paul Tang? Dr. Agarwal?

Joe Francis - VA
Joe Francis for Dr. Agarwal

Mary Jo Deering – ONC – Senior Policy Advisor
Okay. David Bates? Eva Powell for –

Eva Powell – National Partnership for Women & Families – Director IT
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Richard Chapman?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Larry Wolf for Richard Chapman

Mary Jo Deering – ONC – Senior Policy Advisor
Adam Clark? Patrick Conway? Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Connie White Delaney?

Connie Delaney – University of Minnesota School of Nursing – Dean
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Paul Egerman?

Paul Egerman – Software Entrepreneur

Here, on the phone.

Mary Jo Deering – ONC – Senior Policy Advisor
Judy Faulkner? Michael Weiner?

Michael Weiner – Defense Health Information Management System – CMO
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Gayle Harrell?

Gayle Harrell – Florida – House of Representatives
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Charles Kennedy? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Deven McGraw? Frank Nemic? Marc Probst?

Marc Probst – Intermountain Healthcare – CIO
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Josh Sharfstein?

Josh Sharfstein – Maryland Department of Health and Mental Hygiene – Secretary
I'm here –

Mary Jo Deering – ONC – Senior Policy Advisor
Good. Latanya Sweeney? ...? Scott White?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Good morning. Here I am.

Mary Jo Deering – ONC – Senior Policy Advisor
And Steve Ondra?

Stephen Ondra – NeHC – Senior Policy Advisor
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Thank you very much. Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Thank you, Mary Jo. Welcome to all the committee members and the public and those on the phone. We have a very interesting meeting today. And by the way, we have a full and rich agenda in December as well, so we will be meeting in person. Today we're going to start out with an update from CMS about the recently released final rule for ACOs. It's been well received and I think we'll be very interested in hearing about that. We'll then have an update on something called "Putting IT in TransITions." We all know that transitions of care is a time when a lot of things can fall through the cracks and endanger patient safety, so one of the thoughts is to apply this technology in that situation, and we're going to hear an update from ONC on a project they have underway. After lunch Farzad will join us,

between 12:30 and 2:30, and update us, and some of his remarks will concern the IOM report that was recently leaked, because its official release was supposed to be tomorrow. Then the Meaningful Use Workgroup will update us on a hearing we had on October 5th talking about the experience in Stage 1 and looking towards Stage 3, and we'll conclude with an update on the consumer engagement strategy underway by ONC. We heard about the consumer health summit that was held, I believe it's last month, and we're going to hear about the plans going forward. And then we'll conclude as always with public comment. So that's what we have in store for today. Let's go ahead and get – first, let me entertain a motion to approve the minutes.

W
....

M
Second.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And any further discussion corrections? All in favor?

W
Aye.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any opposed or abstain? Great, thank you. Okay, let's have an update from CMS on the ACO final rule, please.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Good morning, everyone. Thank you for inviting me. My name is Terri Postma. I'm a Medical Officer and Senior Advisor at the Center for Medicare. I trained as a neurologist, but I've spent the last couple of years working on issues related to healthcare delivery system reform and I've been privileged to spend the last almost two years at CMS working on the development and implementation of the Medicare Shared Savings Program. Today I've been asked to give an overview of the program, a number of you may have already heard this talk maybe a week ago if you're involved in Beacon communities or are involved in some of our workgroups or sub-groups. Some of you may be more or less familiar with this program, so I'm going to try to cover all the bases, try to explain what the program is, where health IT fits in, and some of the changes that have been made since the proposed rule.

The overview today will be I'll start out by talking a little bit about CMS' vision and goals for the program, an overview of the program highlighting major changes in the final rule, and next steps. As many of you know, the Medicare Shared Savings Program was mandated last year as part of the Affordable Care Act. It establishes a voluntary incentive program. It incentivizes Medicare providers and suppliers to form what are known as accountable care organizations, or ACOs, to improve the quality and efficiency of care delivered to the Medicare fee-for-service population. The proposed rule was issued last spring. We received over 1,300 comments, and these comments helped refine our proposals and have contributed to what we believe will be a strong program.

As Dr. Tang mentioned, so far it appears that the final rule has been very well received in the community. Anyone who's been involved in our healthcare system, whether as a provider, a patient, or a family member of a patient knows that our healthcare system can often be very fragmented. It's developed in pieces, a hospital over there, a clinic over here, without any real conscious or well designed connection between those pieces. Fragmentation of payment, particularly fee-for-service payment, can often reinforce that fragmented care. So the Medicare Shared Savings Program we believe represents a new approach to the delivery of healthcare aimed at what our administrator, Dr. Don Berwick, refers to as the three part aim, that is: better care for individuals, better health for populations, and lowering growth in overall healthcare expenditures by promoting accountability for the care of Medicare fee-for-service beneficiaries, improving coordination for services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesign care processes.

As I mentioned, the Shared Savings Program is a voluntary program. It's built on the current fee-for-service system, so this is a little different than managed care collaborations and helps incentivize providers to reduce the fragmentation that's so often a part of that fee-for-service system. So participating providers and suppliers will continue to receive a fee-for-service payment as usual, but the ACO as a whole will be evaluated based on the quality and efficiency of care delivered at the end of each year. If the ACO has met the quality performance standard and has reduced per capita cost for its assigned population, the ACO will share in those savings with Medicare and in turn share with their participating providers and suppliers.

In addition to the overarching three-part aim that Dr. Berwick speaks about, he's always articulated his vision for the Shared Savings Program, which is largely focused on patient-centered care and reducing fragmentation by creating journeys for patients. So, for example, he believes the ACOs should promote seamless coordinated care by putting the beneficiary and family at the center of care; remembering patients over space and time; attending carefully to care transitions and managing resources carefully and respectfully; proactively managing beneficiaries' care, for example, through reminders at the point of care; evaluating data to improve care in patient outcomes; and innovating around better health, better care, and lower growth in cost; and also finally investing in team-based care in the ACO's workforce. This is the vision, and as you can see, the role of health IT can play a big part in many of these.

CMS conceptualizes a comprehensive ACO strategy, creating multiple pathways for organizations in various stages of readiness. We have the Medicare Shared Savings Program, where we've developed two tracks, one track with just shared savings only, and a second track which implements some performance-based risks for shared savings and losses. In addition, we have an advanced payment initiative to assist particularly small groups and physician-only groups in accessing up front capital in exchange for future savings, and then the pioneer ACO model is complementary to this effort. The pioneer model is designed to test and implement unique payment strategies with groups that are a little more sophisticated, and we're really looking forward to the results of that effort in implementing what we learn from that effort over time into the national program.

It was our goal in this final rule to both create different pathways for organizations in various stages of readiness, as I mentioned, creating a stronger business case for participation in this program. We also want to be a strong beta partner with the ACOs and help them to improve beneficiary engagement and implement robust quality measurement and performance monitoring as part of the program. We also wanted to maintain a strong partnership with the antitrust agencies with whom we worked very closely during development of both the proposed and the final rules.

Before going into this next set of slides, which I believe you have in your packet, it largely shows a side by side, the next five or so slides have a side by side of the proposed rule versus modifications that were made in the final rule to some of our major policies. But I want to put these in context rather than just reading through them in isolation. First I want to define what an ACO participant is, it's very important to the understanding of how the Shared Savings Program is operationalized and structured. An ACO participant meets two criteria: they are a Medicare enrolled entity, and they bill Medicare directly for services. So when an ACO is formed, it's formed by these ACO participants that are joined together and they're designated by a taxpayer ID. So when the ACO applies for participation, the ACO will write on its application who the ACO participants are that have joined together to form that entity.

A certain subset of ACO participants is critical for the formation and for the eligibility of the organization to participate. This subset of ACO participants are those who are both Medicare enrolled, who bill directly for services to Medicare but bill directly for primary care services to Medicare, and it's really important since the basis of assignment is primary care services rendered by ACO professionals. In the proposed rule we have talked about several entities that we thought would be eligible to participate based on those criteria, and those would be the ones defined in the statute, which are physicians and professionals in group practice arrangements, networks of individual practices of physicians and other professionals, joint venture partnerships of hospitals and physicians and other ACO professionals, hospitals employing ACO professionals, and critical access hospitals that bill under method two, those bill for primary care services.

In the final rule we have expanded that to include eligibility to meet that core requirement for primary care services to FQHCs and RHCs. Then additionally of course we use our secretarial discretion to allow any other Medicare enrolled entity to join with those groups to participate.

The final rule implements, as I mentioned, a two track approach for ACOs participating in the Shared Savings Program. ACOs have the opportunity to choose from one of two tracks. Track one is a minimum three year agreement of single-sided shared savings only. Track two is a minimum three year agreement of two-sided shared savings and losses. For a higher sharing rate and a higher sharing cap among some other slight changes in the financial models that reward groups for taking on greater performance based risk. This is a bit of a change from the proposed rule, where we had proposed that those in track one would transition during that agreement period to the two-sided model. So now instead we have a pure shared savings only model in track one, and a two-sided risk-based model in track two.

The first agreement periods will begin on April 1st and July 1st. This is also a bit of a change from the proposed rule, where we had proposed a January 1st start date. The reason for this is because we started to hear from groups that it was going to take them a little bit of time to get organized and they were concerned that they might not be able to meet the deadline for a January 1st start date, so we put into place these two start dates during the first year, 2012. After 2012 start dates will be on January 1st of each year, and each agreement period we're anticipating will be three years.

Similar to the proposed rule, after one agreement under Shared Savings only organizations who want to continue in the program and to renew their agreement must do so under the two-sided risk model under track two. We believe this two-sided approach provides an on ramp for organizations to gain experience and transition to performance-based risk arrangements, while also providing the opportunity for more experienced organizations to enter immediately into performance-based risk arrangements with the opportunity for greater rewards.

Beneficiary assignment is a real important part of this program and it's the basis for establishing and updating the financial benchmark, quality measurement and performance, and the focus of the ACO's efforts to achieve the three-part aim. Beneficiaries will be assigned to the ACOs based on a two-step process, and I want to make clear that a lot of people misunderstand beneficiary assignment in the context of the Shared Savings Program. What we're really talking about here is the operational necessity of determining what beneficiaries the ACO should be held accountable for to assess whether they've met the quality and financial benchmarks necessary to achieve an incentive payment. Beneficiaries in the fee-for-service and traditional fee-for-service Medicare retain full rights and freedom to choose their providers, there's no lock-in, there's no enrollment, so this is really very different than a managed care setting.

Beneficiaries will be assigned based on a two-step process. As you see on the slide, from the proposed rule to the final rule this is a bit different. We've implemented an assignment algorithm for beneficiaries that we've described as preliminary prospective assignment with retrospective reconciliation. What this means is that we've committed to giving ACOs up front information on the fee-for-service population that they're likely to be accountable for based on the beneficiaries that the ACO has cared for during the benchmark period. So we'll apply our assignment algorithm to each of the three years in the benchmark period and then each of the three years going forward into the agreement period, and what we know from modeling data from the physician group practice demonstration was a forerunner of this program. We know that when we apply that assignment algorithm from year to year many of the beneficiaries that are assigned in a year continue to see the same providers in the next year, so this gives the ACOs a very good look at who their assignment population is. The list of beneficiaries will be updated on a quarterly basis on a rolling 12 month assignment basis. So the ACOs will be able to see, from quarter to quarter, how that list changes over time. Then finally at the end of each performance year we'll reconcile that list and that's the list of beneficiaries that the ACO will be accountable for.

Quality is a very important part of this initiative. According to the statute, the ACO cannot share in savings even if they've been generated without meeting the quality performance standard first. So that was a very important part of our focus in the proposed rule. In the proposed rule we proposed 65

measures and 5 domains. This, we heard from a lot of stakeholders, appeared overly burdensome. We came and we looked back at those measures and we generated a list of what we believe to be core measures. There are 33 of them in 4 domains. Those domains are preventive health, at risk and frail elderly populations, patient and caregiver experience of care, and care coordination or patient safety. Because of stakeholders' concerns that they particularly mentioned regarding the EHR measure we had proposed as a condition of participation, we eliminated that as a condition of participation but we've retained it as part of this critical core set of quality measures and weighted it twice any other measure. So that remains a very important part of that core set. These measures, the finalized 33 measures align with current CMS measurement efforts and incentive programs and are consistent with the statute which suggested including measures that are process oriented, outcomes oriented, patient experience of care oriented, and these claims are just derived from claims data, survey data, and medical record data.

One of the major changes in the financial model that we've made is in the Shared Savings proposal, the statute talks about developing a risk corridor around the benchmark, meaning that we set a benchmark and then at the end of the performance year we do a calculation on the per capita cost and compare it to the ACO's benchmark. Around that benchmark there's a statistical corridor that accounts for normal variation and fluctuations of expenditures. That ... is called the MSR. In the proposed rule and the statute states that the MSR should be developed based on the number of beneficiaries assigned to the ACO, so that if an ACO has a small population of beneficiaries statistically speaking we'd expect the variation to be a lot more than if there's a larger assignment pool.

The MSR in the track one changes based on the number of beneficiaries, and I believe the range is something around 3.5 to 1.9, depending on how large the beneficiary pool is. In track one the ACO must meet or exceed the MSR in order to be considered to have actually done something to overcome the normal variation and have effected real change. They must meet or exceed that MSR, and once they do what we said in the proposed rule was that we would share in savings after that MSR. In the final rule we have modified that so that once the MSR is met or exceeded, the ACO would share back from first dollar to the benchmark, and that's a big change.

In track two, because the ACOs are sharing on both the upside and the downside, the MSR is a static 2%. The ACOs in track two also have to meet or exceed that MSR, but it's met or exceeded on both sides. If there are savings, they have to meet or exceed the 2% on the savings side, and that protects the ... run from normal variation. On the downside, they have to meet or exceed that 2% MSR, and that protects them from sharing in losses that are results of normal variation.

One of the things we've committed to doing with the ACOs, one thing we heard very strongly from stakeholders is how important data is for the ACO for managing their population and for understanding it, and for implementing appropriate redesign of care processes. One of the things we've committed to doing is to sharing beneficiary identifiable claims-based data with the ACO. We'll be doing that on a monthly basis. The ACO must enter into a data use agreement with CMS and make appropriate arrangements for security and privacy of that data.

Once they've assured us that they have done that, the ACOs may request on a monthly basis either from that list a preliminary perspective list, or the quarterly lists, they may request identifiable data from those folks, or they may request identifiable data from CMS for folks that they've seen in their primary care clinics, or that they deliver primary care services to. They may only do this, however, after notifying the beneficiary that they would like to request the data, and giving the beneficiary an opportunity to decline data sharing. While this isn't a legal requirement, we felt like this was a very important aspect to implement into the Shared Savings Program in the interest of beneficiary engagement and transparency of the program.

I talked a little bit already about the eligible entities so I won't go back into that. As far as the start date goes, I mentioned a start date but I want to give a little bit more background on that because of the staggered start in the first year those agreement periods are going to be a little longer than three years. The folks that are starting in April or in July in 2012 will have agreement periods of 3.75 years or 3.5 years respectively. That agreement is broken up into three "performance" years, so that the first

performance year is a little bit longer than a calendar year. It's going to be either 18 or 21 months depending on when they start. Their first performance year will end at the end of 2013 and they'll be synced up with all of the other folks that are entering into the program on the first of the year. So everybody's going to end up on a calendar year basis just in the interest of giving groups more options for starting in this first year we wanted to get them started as soon as possible and didn't want to penalize them for being early starters. In fact, having a little bit longer in the first performance year actually benefits early starters.

I already talked about the preliminary prospective list is going to be derived from aggregate data reports that we've put together for the ACOs. Those aggregate data reports are going to give them a lot of information on their benchmark and then each performance year going forward they'll include things like utilization measures, it will include things such as how many of your assigned population use the emergency department over the course of the year, how many had admissions to hospitals, that sort of data that can help them start to think about where they want to focus as a group redesigning care processes for their unique population.

I mentioned the EHR measure already, as I said, it's no longer a condition of participation, but we did retain it as part of our critical core performance measure set and weighted it twice any other measure for quality scoring purposes. The assignment process has changed a bit from the proposed rule. Initially, we had proposed a one step assignment process, beneficiaries based on the plurality of allowed charges for primary care services rendered by primary care physicians. So what we'll do is we'll take a look at those Medicare enrolled ..., those ACO participants that joined together, we'll pull their claims data for the last year, the last 12 months, and we'll say, okay, how many of the beneficiaries that they saw had enough visits with them to say that this group of providers should really be held accountable for these patients, and that's the theory behind the assignment process in a fee-for-service setting.

In the final rule what we've done, however, is we've expanded this assignment process. Instead, we're going to be implementing the assignment process in step one, as we had initially proposed, which is beneficiaries who on the basis of plurality have allowed charges for primary care services rendered by primary care physicians, and those are primary care physicians with a specialty designation of general practice, internal medicine, geriatric medicine, or family practice. However, in the final rule we've implemented a second step which would take the remainder of the beneficiaries and assign them to the ACO based on the plurality of allowed charges for primary care services rendered by any other ACO professional, so that will include any MD or DO with a specialty designation, and that will include MPs, PAs, and clinical nurse specialists.

Our marketing guidelines changed a bit from the proposed as well in response to comments. Initially we had proposed that all marketing materials must be approved by CMS before use. Instead, in the final rule what we've said is that as long as the ACO certifies that they have followed our marketing guidelines and have used the template language that we'll be providing for them, they may file their marketing materials with CMS and use it within 5 days.

There was a lot of inter-agency coordination going on. Particularly, we worked with FTC and DoJ antitrust agencies, as well as the IRS and the OIG. These agencies have concurrently released documents along with the final rule for the Shared Savings Program. The antitrust agencies released an antitrust policy statement that complements the final rule. It addresses stakeholder antitrust concerns and as a difference from the proposed rule we are retaining a voluntary review process for ACOs that are concerned of running afoul of antitrust laws, particularly those newly formed ACOs.

Initially, we had proposed a mandatory antitrust review for ACOs whose calculated primary service area shares were greater than 50% in their region, but in the final rule, while the FTC DoJ has retained those levels of concern with the PSA calculation and that data is still available for ACOs so that they can calculate that as they look to do their application for the Shared Savings Program, but instead of having it be a mandatory review the ACOs can take advantage of this voluntary review process through the FTC and DoJ. The IRS also released the response to comments for those tax exempt entities that wish to participate and the OIG jointly with CMS issued an interim final rule with comment regarding CMP

kickbacks and referrals for ACOs. This Web site is really important, it's www.cms.gov/sharedsavingsprogram/. On this Web site you can find information, fact sheets that are very helpful to share with folks who might think they want to participate or folks who are interacting with groups that are asking about participation. There's a link to the final rule. There are links to all those concurrent notices and statements that were put out by our friends in the other agencies. And this Web mailbox, aco@cms.hhs.gov and the phone number listed there are places where folks can go to ask questions of our subject matter experts.

I just want to mention that we have, on this Web site here, posted the notice of intent to apply. While that is a non-binding document, it is the first step in application and we are encouraging groups who think they might want to apply and participate to do that early. It's the first step in getting an ACO ID, which will be required for submission of an application. The sooner that a group goes ahead and does the NOI, gets their ACO ID, the sooner they can go about filling out the application, which should be available at this Web site soon. If folks are asking about that, please refer them to the Web site and have them check back often.

With that, I'd like to turn it back over. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Very good. Thank you very much, Terri, for a very informative update. At this time we'll entertain questions. While people are thinking maybe I'll ask the first one. Of interest to this group, the HIT Policy Committee, is the EHR incentive program in meaningful use, and clearly we noticed that the condition of participation of 50% in the second year being meaningful users was changed, and I'd be interested in hearing the rationale behind that. That was one of the ways we said CMS is reconciling the various programs it had. The second, you did mention that you doubled the weight. Does that mean just 2 out of 33, or is that what that means? I'd be interested in the rationale behind those changes.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Sure. Thanks for asking. We, as you mentioned, had proposed making the EHR requirement a condition of participation, meaning that an ACO, 50% of the primary care physicians in the ACO had to meet the requirement for meaningful use by year two in order for the ACO to continue with their agreement, otherwise the agreement would be terminated. We heard from many stakeholders that that just seemed far out of reach for them, they weren't quite there, and in addition I think a lot of them are looking toward the shared savings that they're hoping to achieve through the program in order to help build that infrastructure over time. So at the end of year two they will have only received one incentive payment at that point in time and they felt like it just was going to be a really heavy lift, especially for some of these smaller physician only groups or groups that have come together that are made up of very small practices, to be able to achieve that. They were expressing a lot of hesitation in participating because of it.

So in order to make this program available to groups of varying readiness, we decided to instead keep that as a core set because it is a very important part of this program and the path that we want to incentivize folks to go down. But we double weighted it, so that means, yes, it's worth twice any other measure, but that means in its domain there are requirements for meeting certain levels of quality within a domain, so an ACO has to pass 70% of its measures in each domain. In the domain in which the EHR measures sit, that means that the ACO could normally fail three measures or they would not achieve the quality standard for that domain if they fail three measures. But because that EHR measurement is weighted twice, if that EHR measurement is one of them they can only fail one other measure before they don't meet that standard for the domain.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Christine?

Christine Bechtel – National Partnership for Women & Families – VP
Thanks. I'm Christine Bechtel with the National Partnership for Women & Families. To follow up on Paul's question, can you just talk a little bit about what the measure is, the EHR measure.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes, thanks. It did change a little bit from the proposed rule. Initially we had said 50% of primary care physicians had to have met meaningful use. What we're going to be doing now is looking at the percentage on a sliding scale of primary care physicians who have met not just meaningful use but who have achieved an incentive payment through EHR incentive programs. So as you know, the practices, individuals can choose to enter into the EHR incentive program in either Medicare or Medicaid, but not both, so since the number of the practitioners who might be participating in the program may have chosen to do Medicaid, they're limited. They can't choose Medicare as well, meaningful use, and there are slightly different criteria for both of those programs. We expanded it a bit so that whether a practitioner was participating in Medicare or Medicaid EHR incentive program, if they met whatever criteria there were under those programs, if they achieved incentive payment then that would count. So we expanded a bit.

Christine Bechtel – National Partnership for Women & Families – VP
That's very helpful. I should have warned Paul I have a couple of questions. I guess I have two questions. Following up on that, is there a threshold that they've got to meet, because you had said that you must pass 70% of the measures in that domain, but that you also don't get to do the shared savings if you don't meet the quality measure targets. But I'm thinking year one and mostly year two also it's reporting only, right, so for the EHR measure you don't have to meet a target, you just have to report the number of primary care docs who received an incentive payment.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
That's right. After the first year there will be minimum requirements for each of the measures, and in the final rule we said that minimum requirement would be either the 30th percent or percentile based on for most measures we'll be comparing that measure to national performance standards, so whether that's if it's an MA measure we can look at what the MA national performance is on that measure, or if we use it in fee-for-service, or if it's a HEDIS measure that's how we'll be developing those minimum standards. But we have said in the final rule it would be the 30th percent or percentile and then it moves up on a sliding scale so that the ACOs, as we mentioned, in the first year, to qualify for the maximum amount of shared savings, which is 50% in track one, 60% in track two, in order to qualify for that maximum amount in the first year they just need to fully and completely report on all the quality measures. In the second and third year we're phasing that in so that the pay for performance is on about half the measures in year two and nearly all the measures in year three. So depending on the performance their maximum sharing rate is going to change. If they get 100% performance on all those performance measures then they get 100% of the savings for which they qualify. If they get 80% they'll get 80% savings for which they qualify.

Christine Bechtel – National Partnership for Women & Families – VP
Do you expect the EHR to have a performance threshold in year two?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
You do. Okay, and can you talk about your rationale for not including hospitals in terms of reporting the number of meaningful users if they're part of an ACO. That's a challenge, I think, for us.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes, and it is a bit of a challenge for the quality metrics overall when we were developing them for the Shared Savings Program because we recognize that there may be some ACOs that don't have hospitals involved, so the question became do we implement a standard and then apply it only to some ACOs, or are we going to have a standard that applies to all ACOs. So that was a bit of a challenge in thinking through which metrics we should choose. As the Shared Savings Program develops and grows over time we may find that most or all of ACOs choose to have hospitals. If that's the case, we might want to revisit that.

Christine Bechtel – National Partnership for Women & Families – VP
I think from my own perspective it's worth revisiting much sooner rather than later if for no other reason than at least from a consumer perspective the unique contribution of ACOs in our view is around care coordination, and you can't get to care coordination unless you're connecting the entire system, and there's an easy opportunity to get at least two provider types talking to each other in a way that also is consistent with other HHS programs. So I think it was a missed opportunity in that regard. I understand the logic and it makes sense, but I don't agree because I think we have lots of experience, and certainly CMS does, in the quality measurement world, with exclusions and exemptions and applying measures in a little bit of a different way.

Let me throw out my last question, which is a different part of this topic. You talked about notifying beneficiaries of the ACO's intent to request identifiable data, and you talked then later about template language from marketing. Are you giving them template language for the data request as well, and if so how are you developing that?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
In addition to notifying beneficiaries of the opportunity to decline to have their data shared, the ACOs are also required to notify beneficiaries that they're participating in the program. We anticipate providing template language for both of those things and I'm happy to talk with you about a template language or working with our CMS beneficiary, the group that specifically develops language for CMS for beneficiaries, to help us with that.

Christine Bechtel – National Partnership for Women & Families – VP
Terrific, thank you. This was a very helpful presentation, Terri. I appreciate it.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Judy?

Judy Faulkner – Epic Systems – Founder
I have two questions. I've been surprised that the healthcare organizations I have spoken with have more concern and hesitancy about this than I had thought they would. The two questions that seem to come up the most, maybe you addressed it and maybe I missed it, but the first is how do they get evaluated when patients don't participate; you have organizations and physicians who participate, but the patients can go anywhere, and that's the one thing that they've been fearful about. That's my first question.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes, it is something that comes up pretty frequently because I think most people are fairly comfortable in evaluating their organizations in the managed care setting, where beneficiaries have proactively enrolled in their system and they have a bit more control, or an understanding of who the beneficiary is seeing and what the limits are of their care. This is really a unique program that builds on the fee-for-service setting. Three-fourths of Medicare beneficiaries have chosen traditional fee-for-service Medicare. A quarter of those are in Medicare Advantage, which is a managed care setting, they've proactively chosen that setting. But a vast majority is in traditional fee-for-service, so the question arises then how do we implement an incentive program on a fee-for-service population when there are some of those challenges. We do view this program as sitting on a fee-for-service platform where the beneficiaries do retain their freedom to choose providers. One of the things we've tried to do to help mitigate that is the data sharing aspect, because while they've been the identifiable claims data sharing, because while the ACO may have an understanding of the claims that they're billing, they probably don't know what other providers are billing. So seeing those claims can be very helpful to them.

Judy Faulkner – Epic Systems – Founder
I think that it can be helpful to them in seeing what the patient has done at other places if they share that, but it isn't necessarily helpful to them in that they don't have shared care plans for how they will manage that patient's healthcare.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes, I think it's a real opportunity for the practitioners who are in ACO to more proactively engage with their fee-for-service beneficiaries. Patients, at least speaking from a provider's point of view I know patients tend to be very loyal to their practitioners, particularly the ones that they frequent often, and so building up that communication and that engagement is a real important focus of the program.

Judy Faulkner – Epic Systems – Founder
I think that's a real benefit of the participants to work more closely together that way. I think the big concern is when the patient is going to a non-participant.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes.

Judy Faulkner – Epic Systems – Founder
The second question that I've heard come up a bit is on the evaluation of how well they're doing. And I'm not quite sure when you were speaking of how you evaluate that what it's based on. One thing I have heard is that based on an average or some evaluation of what the whole group is doing, and you have to be in a certain tier to be seen as doing better, can you explain how you calculate that. Is it an average where they're competing against each other?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
No, the ACOs don't compete against each other. They compete against their own historical performance.

Judy Faulkner – Epic Systems – Founder
Okay.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes.

Judy Faulkner – Epic Systems – Founder
Thank you.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Sure. And I also want to say that we sometimes start to think of ACOs as a closed system. For the fee-for-service population what we really want is for providers to start to reach out and communicate, not just among each other, but also once they see from claims data that their beneficiaries may be frequenting a clinic in the area or a hospital in the area, reach out to that entity regardless of whether it's in the ACO or not and develop a communication strategy with them if the ACO finds that a high number of their beneficiaries, fee-for-service beneficiaries, are going there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good, thank you. Neil?

David Lansky – Pacific Business Group on Health – President & CEO
... get in the queue?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure, who was that, please?

David Lansky – Pacific Business Group on Health – President & CEO
David.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, thanks.

Neil Calman – Institute for Family Health – President & Cofounder
Thank you for the presentation. I just want to compliment CMS on how responsive you were to comments from the community. As an FQHC CEO we were extremely concerned at the beginning when the rule came out, and I think you've responded tremendously well to that, and to lots of other issues. I'd just make two comments, mostly about the comments my colleagues have made, maybe in a slightly different twist. When I saw that the EHR requirement came out and I was talking to one of our hospital folks about that they said that was really brilliant. And I said, why do you say that? And he said, because nobody can possibly do this without having not only electronic health records but really solid connectivity between different parts of the system. And it's about time we stop micromanaging what people need to do and basically put out the outcome. And if the outcome is really what we're talking about, I agree that I can't see how any system could actually create this level of integration with the kind of improvements we're talking about in quality and reduction in cost without health information exchange, not just electronic health records. So I think this is going to be a tremendous move and push for people to adopt and to really look at what information is being exchanged in these different exchanges that are being developed and whether or not that information that's being exchanged really has value in relationship to the coordinating people's care, and so I think that's tremendous.

In relationship to the second piece, which the providers are always critical about the fact that patients aren't locked in, and I think it's absolutely brilliant to not lock people in, because it's about time providers were held accountable for earning the kind of loyalty that this kind of program requires. And I say that as a provider we don't do such a great job at communicating with people, and to have to earn that loyalty I think is going to be one of the major side effects of the program. People are already talking about, okay, what do we need to do to get people to really engage with us in ways that maybe we haven't done before. Right now we have an open door, people come in and they go out, but we don't really necessarily engage them both in treatment plans, in long term goals, and really understanding the things that they need to be able to engage with us. So I think that's another major piece of this. It really says you need to earn what it is we're going to give you, and I think that those are really commendable.

So there are two questions I have, and the first really goes to the measures. I haven't looked at the 33 measures yet, but I'm wondering what you all did when you were developing them to look at what the primary care medical home measures are and the latest set of things that they're looking at for primary care medical homes in the measures that have come out around meaningful use and other kinds of things. The last thing we need is another set of measures, and CMS is very powerful in that regard so the first question that I'll ask is what kind of coordination do you see happening around the reportable measures?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Thanks for that. The measures piece of this program is probably one of the most challenging because, as you say, we didn't want to implement a whole new measure set that no one had ever seen before. We wanted it to be very relevant. We needed it to be very flexible because the groups that join together, we wanted to give them flexibility to join together in a way that made sense to them, so whether they have a hospital or they don't have a hospital. We really needed a measure set that focused on very core principles and some of the principles we used to develop that measure set was making sure that it aligned with other CMS quality initiatives and DHHS quality initiatives.

So particularly one of the things we looked at was the physician quality reporting system measures, the HEDIS measures that are out there in the private sector that are being used. We focused on measures that were really very central to chronic disease states in keeping with the priorities of DHHS and, for example, aligning with the Million Hearts initiative and things of that nature. And of course patient experience of care was a central focus as well, so that's how we ended up cutting things down pretty much in half. We definitely wanted to retain the survey as an important piece, patient experience of care survey, and so most of the other measures are very focused on chronic disease state, high cost states

preventive care. So that's essentially how we did it. It was looking to see how aligned these measures were with other initiatives so that it's not just another measure set.

Neil Calman – Institute for Family Health – President & Cofounder
I think for us that's going to mean taking a really close look at those and seeing whether we want to do some sort of realignment. I think we just all have a responsibility of reducing this burden for the community. It's the number one thing we hear back. And for somebody that's been doing lots of reporting, as we have, on measures, I can tell you that people just become immune to this. You just start measuring everything and you lump all the measures on top of it, and it just becomes another pile of papers that somebody does. And it really doesn't allow you to drive focus on the really critical issues that are important for quality, so we're going to all have to look at this together.

I just want to ask one other quick question, and that is, you talked about, you don't call it the Triple Aim anymore, you call it the Triple Play or something?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Three-Part Aim.

Neil Calman – Institute for Family Health – President & Cofounder
The Three-Part Aim, thank you. It's clear what the ACOs do in terms of improving quality of care for individuals. In terms of trying to address cost it's not clear to me what they do in relationship to improving the health of populations. In fact, what I understand from this new rule is pretty much everybody that's ever seen a doctor in the past year is going to be eligible to be at an ACO, right? It used to be you'd have to have seen somebody in primary care, but at this point if you've seen anybody – did I get that right – in any specialty and that person is in an ACO, that provider is in an ACO, then the patient could be eligible to be in that ACO. Did I get that right?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Any Medicare fee-for-service beneficiary that's received a primary care service could ultimately be aligned, but they have to have the plurality of their allowed charges with physicians.

Neil Calman – Institute for Family Health – President & Cofounder
That's primary care. But even if you've not seen a primary care physician you fall into that other bucket, right, the new bucket that says if you've seen another provider for care and you've received the plurality of care from them then you're in the ACO through that relationship.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
It's still based on the primary care services rendered, and so those would be office-based services. So, yes, the first step is primary care services rendered by primary care physicians, and the second step is still primary care services the plurality rendered by any other ACO professional.

Neil Calman – Institute for Family Health – President & Cofounder
What are we doing for the people that are outside of that system? If you're talking about health of populations we have to be paying attention to the people that aren't connected to providers. How does the ACO rule help in any way? Have you considered measures that look at the health of the community? Is there anything like that to try to hold these large organized entities in some way accountable or drive incentives that would incentivize them to reach out in their communities and bring new people in?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
The program focus obviously is on the traditional Medicare fee-for-service population, some of which are dual eligibles, so as far as the assignment algorithm goes, one of the reasons we implemented the preliminary perspective with retrospective reconciliation approach is that by retrospectively reconciling we feel like that incentivizes providers to pay attention to all their fee-for-service beneficiaries, not only the ones who are definitely assigned or preliminarily prospectively assigned. I think folks that participate in this program will have to have an eye toward their Medicare fee-for-service population.

One of the things that we've done to help incentivize ACOs to participate in their communities is to encourage them to add community members to their governing body and also as a part of the individualized care plans, it's a requirement that they have to take into account community services available to beneficiaries. So our expectation is that they will be reaching out in their communities to understand what services are available and that can help impact the care of this fee-for-service population. But while this program is focused on that fee-for-service, that Medicare population, at least the FTC and DoJ are anticipating that these ACOs will reach out to other private payers as well as a group and say we're a group and we're an ACO, we'd like to negotiate with you as well, so one of the required processes of the ACO that they have to show us on the application is that they have internal processes for monitoring quality of care and within their system for their population. So they're expected to develop that capability as they go along in the program. That's going to be a very important part. Beyond metrics that we're assessing for quality, they're expected to develop that skill.

Neil Calman – Institute for Family Health – President & Cofounder
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Gayle?

Gayle Harrell – Florida – House of Representatives
Thank you very much. This is extremely informative. I share a little bit of the concern that Christine expressed on the hospital situation. I think for the coordination of care that is going to be an extremely part to make sure that they are on board with the EHRs and we can have that coordination of record, and for the continuity of care, especially in those care transitions. So I share her concern on that and I hope that as we move forward we make sure that that becomes a component of things. But I do have a couple of areas that I haven't been focused on. First of all, what ability is there in the process, and do you see it as a potential problem is being able to cherry pick. Will providers have the ability to look at that kind of data that they're going to be getting, or claims-based data that they're going to be getting, and be able to cherry pick and eliminate from their model, from their ACO, certain high cost patients? Does that have you address that issue? Also, I would like you to expound a little bit on what do you see the role of specialists in this, and how are they going to fit in and why would it be to their benefit to become part of an ACO?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Those are great questions. The first one regarding the ability to cherry pick, one of the reasons, like I said, that we implemented the assignment process that we did with retaining the retrospective reconciliation was for just that reason. We will be giving the ACOs information along the way about who, on a rolling basis, is being assigned. But at the end of the day they're going to be held accountable for the beneficiaries who receive a plurality of their primary care services from those providers. We think that retrospective look helps mitigate that in some respects.

The other thing is that we've implemented a very robust monitoring system. One of the things that the statute talks about is monitoring for avoidance of at risk beneficiaries. We define at risk beneficiaries as those who are high cost, for example, those who, and we've talked a bit about in the final rule who those folks might be, so for example, they might be folks with chronic disease states that are high cost, or they might be folks who have just recently received a diagnosis that is expected to be high cost in the coming year, and those types. So as part of our monitoring process we're going to be looking very closely at whether ACOs are cherry picking in order to make it look like they've driven down costs compared to their benchmark when they actually haven't.

The other thing is that our risk adjustment methodology, we risk adjust the baseline dollars and we also risk adjust the performance year expenditures. That risk adjustment will take into account concerns regarding up coding or cherry picking, so for example, we're going to be using CMS ... scores to risk adjust the benchmark expenditures. We're going to be looking at in the performance at the end of the first performance year, who were the beneficiaries who left the assignment poll from the benchmark, who were those that joined, is the ACO adding beneficiaries that are higher risk scores? If so, we want to

make an appropriate adjustment for that, but does it look like they're dropping a number of beneficiaries with very high risk scores. And if that's the case we're going to take that into account as well and adjust based on the risk scores of the population. So we will be looking at that very closely.

Other things that OIG has brought up as concerning is over utilization of services, we'll be looking out for that, and unnecessary care delivery, and the reasons that they're concerned about that is because of the joint waiver that was posted, which gives the folks participating in the ... program waivers from some of those C&P kickback and referral laws. So, we'll be looking at both the care stinting and avoidance of that risk beneficiary end of things, but we'll also be looking at the over utilization of care and unnecessary care provision side of things.

Gayle Harrell – Florida – House of Representatives
Would you address the specialist issue?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Oh yes, thank you. The role of the specialist I think is really important. As a neurologist I put myself in the shoes of a neurologist that might want to participate in the Shared Savings Program. And while it is very primary care-centric, there's an enormous role, I think for specialists to play in an ACO. ACOs have the freedom to choose the participants they want to join together, whether it's a hospital or a primary care clinic or a multi-specialty clinic or whatever, but oftentimes a lot of opportunity is lost in lack of coordination or lack of communication between primary care providers and specialists. A lot of specialists become the primary care providers for patients. For example, in my clinic I had a lot of Alzheimer's patients who are otherwise healthy, and they came to see me fairly routinely but they didn't have a real primary care physician following their care. But we want to make sure that whatever participants are joining together that they are focused on primary care, preventive care, that's going to be part of the quality standards, so if I have a specialist who wants to retain being the primary care physician for a particular beneficiary, it's incumbent on me to make sure that they're getting the preventive services that they need too. If that means I need to get them connected with a primary care physician, if we'll be doing that or if that means that I make sure that they get that themselves, the flu shots and whatever, then really it's very beneficiary focused. I think there is a big role for the specialists.

The other role I think that's important is that a lot of times there's lack of communication between a referring primary care physician and the specialist and back again. This program really incentivizes that transition to go very smoothly. There's a large opportunity I think for ACOs to focus on avoiding duplicative testing. It annoys the patients to have to do the same testing over and over and it annoys both the primary care doctors as well as the specialist physicians to have to repeat tests or they don't know which tests have been done. I think there are a lot of opportunities for that collaboration to take place.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. David Lansky on the phone?

David Lansky – Pacific Business Group on Health – President & CEO
Thank you, Paul. Thanks, Terri. Two questions, both in the measurement arena naturally. Obviously the ACOs give us an opportunity to align the measurement strategy that will drive some clinical redesign and payment redesign. We're in the business also, in the Meaningful Use program of putting out measures over the next several years, so there's an important opportunity to try to align these. My reading of the measures, I understand some of the choices you had to make in proposing the 33 measures that are out now and it's a reasonable package, but I'm wondering, the first question is, over the next three years or the first three year cycle of the ACOs it doesn't appear, from what I read, that you anticipate modifying the required measures. I know they have often reporting to payment in some categories, but what do you have in mind over a three year or say five year period for the measures to change, and what's your advice to us in how to do our work in the meaningful use program so that the measures we're advocating to CMS will be compatible with or leading the development of measures for ACOs over time?

My second question really I think goes back to Neil's point. We've had a desire in our work, looking at 2015 measures now for Stage 3, to see that the measures we advocate pull through certain practices around care coordination and patient engagement and patient safety and so on. So to the extent that health information exchange or sharing information across the continuum or pooling information for registries, quality feedback, clinical decision support, all those we think desirable attributes we want to help use this program to build the infrastructure for that, which will in turn help ACOs be successful. I'm wondering, is there an opportunity, as you've relinquished the strategy of requiring a certain number of primary care EHR users it does seem to increase the importance of outcome measures that pull through certain kinds of behaviors around care coordination and patient engagement, and so should we be thinking about our measurement development in meaningful use in a particular way that would support the National Quality Strategy goals that you want to achieve through ACOs. Those are my two questions. Thanks.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Thank you. Over the next three years we anticipate that this measure set will probably remain fairly static, with some minor changes. There may be instances where we have to make changes in the basic specifications, for example. If a measure steward determines that a measure is no longer a valid measure then we'll have to look at removing that measure and replacing it. But we do anticipate that we'll be learning from the ACOs over time some of the measure gaps that we have that we would like to work on in the future, are looking at more outcomes-based measures, the care transitions measures that you mentioned, is something I think that we want to see from the ACOs and maybe want to give a little more direction or guidance on how to do that through the quality measures. Those are big areas for us to think through where the direction that we'd like to move and to the extent that we can collaborate and communicate with you all to help develop and implement some of those in future rulemaking we would truly appreciate that opportunity. We're asking a lot of ACO participants to coordinate and to communicate better with each other, and I think that we in the federal government should be the leaders in showing how good collaboration and coordination and communication can take place among different agencies or different groups within the government. I am looking forward to those collaborations and looking at where we can fill in some of those gaps.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Judy, final question?

Judy Faulkner – Epic Systems – Founder
Terri, how will you define success?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Boy, if that isn't a loaded question. I have my own definition of what I think to me would be a success. For now I'm happily, for the short term, resting on the laurels of having produced the final rule; to me that was short term success and having it well received in the community. But other people think of success in different ways. Success for an ACO may be improving quality or showing that they're improving quality through the quality performance standard. Success may be getting very high patient experience of care scores on their survey. Success might be getting large incentive payments through which they can put back into developing their infrastructure.

Judy Faulkner – Epic Systems – Founder
Let me be a little bit more specific.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Okay.

Judy Faulkner – Epic Systems – Founder
Given the number who could apply for this, what is that number, how many would you like to see, or think should sign up for this, and how many should then achieve reimbursement through this? In terms of quantity, what would be success?

Gayle Harrell – Florida – House of Representatives
I would add to that how many patients are impacted?

Judy Faulkner – Epic Systems – Founder
Yes.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Those are things we're going to be evaluating as the program gets started. Our actuaries have estimated that approximately, they've given a range of 50 to 270 organizations that might be participating, I think, in the first three years. So that's the actuarial estimate. They've also estimated, I believe, I don't have it right in front of me, it's in the impact statement, in the final rule, if folks are interested in those numbers I believe they've estimated somewhere in the range of 1 million to 3 million Medicare fee-for-service beneficiaries touched by ACOs, so those are actuarial numbers that we're looking at right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, Terri –

Gayle Harrell – Florida – House of Representatives
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
If it's really short, we're behind.

Gayle Harrell – Florida – House of Representatives
Oh, we're running behind, I do apologize. I just want to ask, and this is kind of fundamental, does CMS have the capability at this point to deal with what this is going to open up, the number crunching, the amount of data that this is all going to require, the reporting mechanisms, everything that is going to be required to make this program truly successful, do you have the wherewithal at this point to do that?

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
The short answer is I believe we do. As you mentioned, there is a lot that goes into this program but we have a very excellent team at CMS that's working on excellent leadership and Dr. Berwick and Secretary Sebelius that are leading this effort are very supportive in every way. We've been working toward this for two years now, so we're not just starting now, we've actually been working on putting the infrastructure in place to be able to implement a successful program. So we're looking forward to that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
On the ONC Web site there's a cross-walk between the measures, just see here, and unless I'm reading this wrong, maybe there's somebody here who did that cross-walk, but there's only 16 of the 33 measures correlate with measures that we have in meaningful use. So there's a lot of MU measures that don't carry over to the 33, but there must be 17 of the other measures, of the ACO measures, that don't have a corresponding measure in meaningful use, so that gives you a sense of what we're dealing with. But it's on the Web site.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we'll be talking about quality measures this afternoon as well. Terri, I want to thank you so much for a very informative presentation and very thoughtful responses to all the questions here. Thanks also to the department for its responsiveness to the public comments to your NPRM, because I think this is very different. These are all journeys and as just a FACA Policy Committee we share your pain and are sensitive to what it takes to write something for an entire country, so thank you so much for all that effort and for being here with us. And we'd like to invite you back in terms of this ongoing dialogue, I think quality measures, well it's the way EHR feeds the data and the quality measures into this program and

other seamless programs where it's so important that we try to collaborate and stay as close in touch as possible. So we'd love to have you back and continue that dialogue.

Terri Postma – Center for Medicare – Medical Officer and Senior Advisor
Yes, thanks so much for having me. It's a real treat. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you, Terri. Okay, our next topic is going to be a new program called "Putting the IT in TransITions." And we have a couple of speakers from ONC.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
My name is Janhavi Kirtane. I'm the Director of Clinical Transformation with ONC ... Community Program. Thank you for having us here today. I'm also here with Leah Marcotte, who's part of the Meaningful Use team. We wanted to share with you some of the output from a public private meeting called "Putting the IT in TransITions," that happened on 10-14, and share with you some of the highlights, share with you some of the results, and then get your feedback on what it might mean from a policy perspective as we move forward and seek to get to action. As I said before, we're going to quickly go over the context of why this convening came to the forefront of one of the things we wanted to focus on, look at the results because actually we had several different types of stakeholders and asked them to go through a prioritization exercise, and Leah will share some of that data. And then we'll have some time for your feedback based on these results.

"Putting the IT in TransITions," and it was convenient that the IT was in fact in transitions, we saw tremendous opportunity as we walked into the first year and beyond of high tech. And we started to learn more and more, not just within the ONC but this growing level of focus around hospital to post-hospital transitions, and that's been historic in the last couple of years, from some of the work that you'll see here, the CMS ... scope of work, led by the QIOs, the STAAR initiative, Project RED, and Project BOOST. We have a stabilizing payment environment where we see more penalties coming down so we're seeing more activity across the country of organizations focusing on this. And of course then we have the HHS Partnership for Patients 2013 goal of a 20% reduction in readmissions, so a lot of focus on this hospital to post-hospital transition.

Also then through a lot of our ONC programs we've been learning a lot of how technology can really drive this improvement around care transitions. We have about 14 of our 17 Beacons who are focusing on IT enabled care transitions, whether that's through thinking about care managers in an HIE environment or wrapping around technology, around, say, an Eric Homan model for care, so a lot of different experiences. We have four Challenge grantees, we of course have our S&I work on transitions of care, and the recommendations around Meaningful Use Stage 2. We also have seen a lot of activity on the innovation side, most recently from a challenge actually that's going to be due November 17th, I think, almost 20 applications, a mobile app competition on safe transitions from hospital to home. So basically we saw a tremendous opportunity, given all the activity on the field, all of our experiences in a stabilized payment environment, of what can we really do to define an IT agenda around transitions of care to drive near term improvement.

The important part also as context is ... ONC, there's a policy agenda put forward of course. One of the things that we're seeing, though, is a big gap that still needs to be closed to get to implementation. So we're hearing a lot, for example, about just a lot of noise as a lot of this activity can represent, and a lot of still not enough detail of how do I translate what I'm trying to do and infuse technology into it, so a lot of noise, but then also a lot of need to get more detail around the how-tos to get to some of the action. We were particularly inspired for this meeting. It's not yet determined of the arc of what will happen post this meeting, of our role as Government 2.0, so our power as a convener and our power as a signal to the market of what might be important.

One of the important things to consider when we think about the transitions world is that depending on who you ask of course the problem looks very different. And our commitment out of the gates, and this image was a central part of our meeting, was that the patients and the challenges faced by patients and

caregivers were going to define our problem statement. And so, for example, you ask a care provider what is hard about a transition and he or she might have a very specific answer. Sometimes it very much translates to patient care, but we were very committed to focus on those intractable challenges for patients and caregivers at the time of transition. One of the important things, I don't know if you can see the detail of these three patient stories, there's an elderly frail woman who is in her 80s taking 10 to 15 medications, there's a child with asthma, and then there's someone suffering from mental illness, so very different types of stories but all very challenging from the point of transition. One of the interesting pieces here that people talked about again and again is these are clinical factors, but these are also some of the important social and psychological and non-clinical factors that we wanted to consider and keep in the front of our mind.

We got to then this concept of the meeting, and this in front of us shares what our focus was. Farzad actually was there, and one of the things he said out of the gates was this is a "do" meeting. This isn't a session of plenary, this is where we're going to get together and we're going to get to some real results of what can we do to inform this agenda to drive change and action. You'll see that, again, we focus on the notion of what are those intractable changes for patients and caregivers. We then actually had five concurrent workgroups. There were about 200 people in the room, so we broke out into five groups, two on information flow and feedback, one on discharge process, one on patient and caregiver activation, and one on medicine reconciliation. And we asked individuals to really go deep and say what was it in terms of IT that could help us be successful today when we think about transitions from the hospital to post-hospital setting, and where is it that opportunities for innovation still exist, and then of course what do we need to do to encourage spread in uptick. Because one of the interesting pieces we heard quite a bit about is that there's actually not a lack of technology to see some results. We have often what we need. It's that we don't always effectively know how to use it. We don't often know how to translate what someone's doing as a winning example into my market, etc.

The other piece, just to bring some flavor into the information flow and feedback, we also heard a lot that technology historically has been talked about in terms of information exchange or simply focus on EHR adoption flow style, and individuals and care providers, and investors alike were looking at technology well beyond that, so how does technology really help to bring solutions to scale that historically were existing absent technology, but the technology, if wrapped around, say, the Grace model, how could that, if you infuse it with technology, could you more rapidly go to scale. And finally, we then took all those outputs and put them into a group prioritization activity to figure out where were those real opportunities to get to change.

Here's a quick visual to give you a sense of who was in the room and again our commitment to have this be a "do" meeting. You'll see three foundation partners and organizations at the center: the Gordon and Betty Moore Foundation, the Johnny Hartford Foundation, and Kaiser Permanente. The ONC and HHS Partnership for Patients were key of course partners in the room. There were vendors, there were hospital leaders, there were policy makers, foundations, leaders from community-based organizations, so all the different types of payers, different types of groups, when we think what does that agenda need to have included, they were all part of this conversation.

I'm going to now turn it over to Leah to go through some of the standards and interoperability that we covered in the meeting, and then some of the results.

Leah Marcotte - ONC

Thanks, Janhavi. We know that this group is very well informed of the standards and interoperability framework work and goals, and particularly the S&I initiative for transitions of care, but it became readily apparent to us that a lot of the people who are doing on the ground work to improve care transitions from multiple perspectives were not as in tune to the goals and progress of the S&I ToC work. So we wanted to, as one of the main goals of the meeting, to socialize the S&I work toward Transitions of Care in a way that someone who's not necessarily technology savvy can understand, appreciate, and get excited about, but also reaching the people who are more technology savvy and wanted to engage in the work and who are ready to engage in the work to form more partners in the S&I goals.

There were three things that we specifically tried to call out in the meeting aims, the first being the convergence on a single standard for electronic transitions of care. The second that all of this work has been done specifically with an eye toward the clinical needs of both the patient, of the providers, what different providers need, and that's critical clinical information in a transition of care, and then building the technology standards around those needs rather than the other way around. Lastly, we highlighted the unprecedented amount of engagement by vendors collaborating with on the ground clinicians to pilot this standard to make it clinically effective and toward the goals of Stage 2, Stage 3 Meaningful Use.

Some of the questions or discussions that arose from this group was, first of all, the need for attention to high impact transitions such as transitions to long term care and post-acute care, as well as the need for aligned efforts of a number of disparate initiatives to achieve electronic health information exchange, including the great work that's been done by the multi-state collaborative led by New York, as well as the consortia of systems including Geisinger, Kaiser, Intermountain, Group Health, and the Mayo Clinic. So how do we make sure that all of this terrific work that's going on around the country toward electronic health information exchange is really aiming toward the same goals so that we achieve interoperability.

Some of the immediate work that has come out of this meeting specifically related to the S&I Transitions of Care initiative and other S&I initiatives is that the formerly known as LT PAC Workgroup has now changed to the Longitudinal Coordination of Care Workgroup, which is significant because they have reoriented their goals toward the development of standards to allow for the transmission of care plans, assessments and transfer documents.

We also mentioned that this is a "do" meeting, this is a working meeting, and we had, as Janhavi mentioned, five breakout sessions during the meeting for people to, in smaller groups, hash out what were the important priorities related to the problems, the intractable challenges and problems that we need to solve that may have technology solutions. The current IT solutions that exist to approach some of these problems, the opportunity for innovation, as well as what the enablers for spread and uptick were. And it was really incredible, we had a report out by each of the five groups and during this report out we took all of their top priority statements and included it into a survey monkey, and we then did a prioritization activity that was IT enabled with the entire group of participants in the room, but also with the people listening in via Webcast.

There was really incredible convergence on a few main topics, and this really came out of a total of probably 15 different topics, these were the four main themes that came out, the first being this vision of plan of care, and not only a plan of care that reaches across settings, that can be accessed by all providers in the care team, but also that seamlessly incorporates the social and the medical needs of the patients and importantly reflects the patient and caregiver goals. This is very important, for example, so that we can link patients to community-based organizations to meet their transportation and nutrition needs, as well as their medical needs to make sure that all of the providers are on the same page with respect to a shared plan of care, and with respect to treatment of the priority medical conditions and consideration of all of those conditions.

The second theme that came out was the importance of figuring out the medication reconciliation, specifically in an IT-enabled environment, how do we get providers to have a shared list of medications, not only medications that are prescribed but also medications that patients are taking. And this has several implications. First of all, for medication error prevention of course, but also to mitigate polypharmacy and to make sure that you have a working med list for a patient that works for the patient.

We also heard a lot of discussion about IT-enabled feedback loops and the potential opportunity for IT-enabled feedback loops to improve care, for example, to make sure that patients make their post-hospital visit appointments and to make sure that medication lists are shared, to make sure that diagnoses and what happens in the hospital is shared and received. And finally the most popular enable for spread and uptick was the idea that we need to shift from this hospital-centric model when discussing transitions of care, and the realization that the probability that a patient's going to be admitted to the hospital largely depends on the patient experience and care that that patient receives outside of the hospital, so the focus

on the primary care physicians and the specialists who are taking care of that patient and also all of the social services, the community-based organization access, resource access, etc.

We thought these results were really great and encouraging, especially because we found that they were very much aligned with the recommendations from this committee regarding transitions of care, so that was very exciting. On the right is just a graph showing some of the results from the prioritization activity, and as you can see, the results add up to more than 100% because people were allowed to pick their three top priorities. But there are common themes with respect to the fact that problems include no shared care plan, the inability for all providers and all care team members to see the plan of care and what happened to patients when they were inside the hospital or in the care of another provider, and the lack of effective feedback loops is obviously something that's really important.

Secondly, we also displayed the innovation opportunities and the results from that. Again, people found that the feedback loops overwhelmingly were a huge opportunity that could be met with the support of information technology and again medication reconciliation and merged medication records and then just the optimization of existing technologies, so the idea that there are actually a lot of solutions that exist out there, but that we need to then figure out how to take those promising solutions and be able to spread them across the country.

The other thing that we did, and this is kind of post-meeting, we were very focused on making this a working meeting and making these goals and this vision actionable after our convening, and we posed a two week challenge to all meeting participants where we asked people to report back to tell us what they were going to be doing differently as a result of this meeting, what have they done in the last two weeks, what their goals were, and we had over two dozen responses, and really detailed and exciting responses. And while I would love to read them all out to you, I respect there is a time limitation, so I did want to highlight a few, though. For example, Siebel listed opportunities within already funded interventions, for example, the community-based care transitions project. There was one person who had helped the community to develop an application that included meaningful information tracking and a clinical information sharing platform.

Secondly, with respect to innovation that's going on in the field, Siebel reported to us that they were releasing an app within the next couple months that's specifically focused towards geriatric nurses and to help them with transitions of care to prevent readmissions. There is a multilingual medication reconciliation module that has been developed for electronic health records by the company, Polyglot, and there also has been ... health success in transmitting retina scans, fundoscopy, EKGs, ultrasounds, and color Doppler to not only desktop EHR computers, but also iPhones and iPads.

We also had a few really exciting partnerships that were forged from the convening, or we would like to think from the convening. Our leaders in the Transition of Care initiative, MedAllies, the health system, had conversations with the New York Visiting Nurse Service, and they are now going to partner in the Direct Project, so figuring out how the Visiting Nurse Service of New York can utilize Direct in their work. They've done a lot of IT enabled transitions work in the last five or ten years. Finally, we also heard from people on this committee. Dr. Common reported that he is working with state public and private partnerships to help move health information exchange to new levels in New York City, where all providers can share information more freely.

So with that I'll turn it back to Janhavi.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
Great. Thank you, Leah. What does this mean? One of our commitments was that we were not wanting to start a new program or a new government-centric activity. There is a lot already happening. Our desire was to create some focus on where could we see some real change and real momentum around Transitions of Care from the hospital to home and IT knowing what's already in play and knowing what the gaps in innovation might be.

Before I get into the slide here, I did want to make two points that I don't know that we made as clearly as we could have. Number one, we made a decision to focus explicitly on hospital to post-hospital knowing full well that that's not where all the action resides, nor that's where it should be. There are a lot of other transitions that are important. There are a lot of other providers who need to be engaged, but given the payment environment and our desire to see real results and get to some focus, we thought providing that precision would be helpful for the sake of a meeting.

The second thing just to call to attention is that we clearly excluded a lot of important pieces in the story. We didn't talk about payment. We didn't talk about measures. That was a decision because again given the stakeholders and given our authority we wanted to focus on technology and then pass the question of what does it mean around measures and payments to our federal partners and private partners as appropriate. So keys to success and rapid action, we are focused on doing things like we are today, socializing this agenda generated by 200+ individuals around technology and transitions to be able to translate this to action. So what does it mean for us as ONC, what does it mean for vendors, what does it mean for hospital CEOs, and what does it mean for social workers out in the field. We want to be able to find the most important agendas to get in front of and informed.

One of the examples that just came across our desks was an NPR interview from Ann Degy, I'm going to mispronounce her name, she was unable to come but had tuned into Webcasts and we had been in touch with her and basically there was a discussion among the venture community of what is it when we think about venture investments in healthcare that can be very effective, and Transitions of Care was cited as a key opportunity. And that was very exciting, because our desire is to activate different parts of the market to be able to focus on this important transition to improve outcomes for patients and caregivers. Implications for HHS, and this is something we'd like to focus on with you more, there's a lot of activity already happening, so our desire is, again, how do we translate these priorities articulated to different people in the field to what the policy agenda already is happening.

Leah mentioned clear alignment with what's already been put forward with Stage 2 Meaningful Use, and we're curious about what could that mean in terms of future stages and what does that mean for some of our other federal partners within CMS, within the AOA, and not just individually but perhaps through shared scopes of activity that could be new. We've also done quite a bit to understand and thread this activity through CMMI payment pilots, best practice harvesting from groups like the Beacon communities, and of course we're considering additional challenges like the one that we've already listed from the challenge of hospital to home, potential road blocks and things that we do want to consider and would appreciate your feedback on, this notion of an information gap that's hindering progress. During our opening remarks one of the things we said is it's been our observation that despite incentives, despite a lot of focused activity and attention on things like transitions, it's very noisy still, and number two, there's an information deficit when people want to link the technology to real improvement.

So I'll give you a few examples that we heard about. One, we asked people what is a technology solution that you think could really be helpful today and where do gaps in innovation still reside? I was in the discharge planning group and it was very frequent that people had listed interventions or ideas for innovation that were already fully in effect just because of lack of knowledge. So how could we hope to know what's in the market? Now, I don't know, we are not proposing what the role of government would be to address that, but this is a clear limitation when we think about rapidly getting to scale, particularly around technology, which is costly and very customized.

The other piece that we heard a lot about is what's truly believable when we want to get to scale. So, for example, we heard a lot of people say, well, we're already doing risk stratification. We know how to do that. We know how to identify the social factors, the clinical factors, etc., to find our patients most at risk. Well, the next question becomes, are we really there yet, because if we are we should be moving this across the country quickly. The consensus that we're getting to is we're not sure, so getting very clear with technology partners of what's believable now so we can push that agenda out through the right partners is still an area that it's a little bit murky and we need to define better risk partners. Of course I've mentioned the noise in the system, we are competing in a very crowded place and our hope is that if we

do this right we in fact will discipline ourselves to focus on the two to three most important things to get to the results that we want.

With that we've proposed a few questions here, but would certainly welcome your other questions or feedback on this topic, knowing that we just want to get to results and better inform our ONC agenda.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good, thank you very much. It was a very interesting agenda and also of course dovetails with our programs that we talk about. Can I open with one question on the things in transition? You have a number of objectives that address it and three of them include the summary of care transition document, the care plan that you mentioned, and the med rec. And in the summary of care document you talk about an HL7 standard, CDA standard, does the group already have or is working on the content standards for those documents, either care plan or summary of care transition document?

Leah Marcotte - ONC
This group, or the workgroup?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
The S&I framework?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Leah Marcotte - ONC
If I'm not mistaken, and Josh and Alan can help me on this, I believe that they're starting a workgroup around the summary of care plan. Is that correct, they're starting a workgroup but they don't have –

M
(Inaudible.)

Leah Marcotte - ONC
Is that for the ToC standards, or summary of care?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It sounds like it's a work in progress.

Leah Marcotte - ONC
Yes. I think the ToC work, the Transition of Care work specifically is in the piloting stages, and I think that they have several sites that they're going to be piloting those standards.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Thank you. That was very exciting. Overall, I would say you're more positive about where we are than I am personally, and I'm usually a glass half full kind of person. I do think that we need some more support for research in this area, and it would also be really useful to have some measures. We would like to be introducing more measures around this, but it's been challenging to do that because we just basically haven't been able to find measures. If you look at the 2011 meaningful use criteria that relates to this area, they're basically the ones that focus on data exchange and we couldn't go past that because there was just no place where we had anything that we could note that was solid. We really need the standard that Paul just mentioned, that is something that – I mean, I agree that that really is the priority. It's very nice that that came out clearly. But the vendors, understandably, have come to us and said we would

really like a standard for this if you're going to require us to include it in a record, which is a reasonable request.

In terms of priorities, just another thing which I think is really valuable is just the ability to have two-way communications between the various partners, so anything that improves that will make things much better. One other thing that I would note is that what information should be exchanged at the time of the transition depends a lot on what the patients' conditions are, and HIT can allow you to use branching algorithms for that. Working out what some of that would be could be very valuable. We've done a lot of this in our own network. For example, if somebody's on Warfarin and they go to a next setting of care there's a whole set of things that you just really want to know but we found that when we looked at that ourselves we hardly ever communicated those. And there are some specific scenarios like that that it would be very valuable to exam and to create some agreement around.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Christine?

Christine Bechtel – National Partnership for Women & Families – VP
Thank you, really very exciting work that is desperately needed. I'll put a finer point on what I think Paul and David are saying, which is that we really struggled when we were working on both the Stage 1 and the Stage 2 Meaningful Use criteria to define what's a care plan, because we're collecting a whole lot of information through view and download, through discharge summary, through lots of the different individual criteria, but there isn't broad agreement about, forget the standard, what's the information that belongs in there. Just at the National Partnership Eva Powell and I did some work to look at how do people define this, and we looked at the Canadian experience, which started out with an 11 page care plan, and nobody would read it so they got it down to two. It's that kind of very practical, very hands-on stuff that I think we really need and we need a group of folks to do that. I know the ToC work that was done, and I think it's a really good start. I don't know if it's an observation or a warning, but I think there are two issues. One is, what is the information? But the other is getting agreement around that. I think that's almost more where the challenge is, because it's like the Supreme Court's definition of pornography, you know when you see it, but it's different to everybody. So we're challenged on that one.

The second thing is the question, and it is about the care plan, are you envisioning consumer access to the care plan? And if so, does it include things like how do I know what to do if certain symptoms, after I've been discharged, come up. What I'm thinking of is there's a program that was begun by actually the QIO down in Louisiana that's had some really great results around transitions and care coordination, and their approach is very simple. And it has an electronic but it also has a paper version where as a patient I get a red sheet, a yellow sheet, a green sheet when I'm discharged with a particular condition and it tells me if you're experiencing a symptom on the red sheet here's who you call. If you're on the green sheet you don't need to go back to the hospital. It's a way that is almost a branching off of the care plan in that it's a way that I can know how to interpret the information on the care plan, which is not just what the goal is that I am trying to achieve but what the pathway is and how I need to get there.

So my fundamental question is, do you envision consumer access to the care plan, because at least with our discussion I think in the Policy Committee has been it often ends up being two different documents that the clinical team might need versus the consumer, but I see you have a lot of very appropriate and very important things in the care plan like connection to community resources, so can you help me understand what you're envisioning?

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
One thing I would say from the convergence from the meeting, the first part of your question is absolutely yes, that the input from patients and caregivers to that care plan, visibility of that plan and translation of that plan back to patients and caregivers as appropriate was articulated as very, very important. I was actually thinking of the Indiana towns grant, I think they gave an example around a PHR linked to their health information exchange to basically help with transitions and give patients the appropriate information, or their caregivers' appropriate information. But the question of what would we recommend, it still depends and I think we're still trying to find, given the concerns you mentioned of we're seeing so

much diversity still of who defines what as a minimum data set that they'd want, at any given type of transition, depending on the transition, depending on the user, is so variable I think we're committed to saying the consumer and the caregiver is part of that network and the central part of that network but this is the newer area so we're going to have to potentially decouple them for now to try to make some incremental gains. But I –

Christine Bechtel – National Partnership for Women & Families – VP
Excuse me, to clarify. I wasn't as much asking a question as saying that area of defining the content needs work and it's going to need both the work of what is it and the work of agreement around it. So I just was really supporting and encouraging your focus on that piece. My question was really about do you envision the care plan as being something that's very consumer oriented, very provider oriented, or is it both?

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
I think it's both, because the language that, again, the group would use, and as we've been talking more people use is the distributed care plan, so something that's here that depending on who you are and what you need you pull different things from it and your ability input is also similarly somehow connected.

Christine Bechtel – National Partnership for Women & Families – VP
Maybe your view is different too.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
Yes. So –

Christine Bechtel – National Partnership for Women & Families – VP
That's great.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
Leah, I don't know if you have another –

Leah Marcotte - ONC
Yes, just to say that I think there is an emphasis that this reflects the goals of care from the patient perspective, and I think that's really important.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
But I think everyone in the meeting really agreed that this is something that was for the patient and included the patient inherently. And also your input is very valuable too because obviously this is a day-long meeting so we didn't get to individual elements of the care plan, but just the urgency to work on this and that this should be a very top priority.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We have a number of questions and we're over time. Could we limit both the question and the response to a minute per, and I think Larry was next.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Let's see if I can keep this short. First off, thank you for the presentation. I thought it was a really great summary. I especially liked slide eight, you summarized the results and some key takeaways. It was also really great to have been there for the day. It was a great immersion in something that's part of my daily world, but to do it in that broader context was also really good. A couple of things I think are important in the conversation, particularly as we start to look at what makes a successful transition. I've been using the notion of push versus pull, that historically the site that's been providing care is pushing information to the next place care's going to happen, whether that's at home or another care provider.

And while that can be really good, there also is a pull component of when someone gets to the next setting what's needed, either it's needed because we've discovered something here, and I have a recent example of actually working with HIE in Indianapolis, of a patient who was in our care, we noticed

something, it looked like it was a new condition, we started working it up and wound up transferring the patient back to an acute care hospital. Hindsight is always 20/20, so we said we're in the HIE what could we have learned from the HIE that in the moment of providing care we didn't. So we went back to the HIE and spent some time looking at documentation in the patient's record and there was a consult note from two back hospitalizations, so not the immediate discharge transfer to us, but two prior, that actually addressed that particular condition, what was agreed upon as a plan, and it would have been really, really helpful to have known that at the point when it suddenly became an issue, and maybe as a good news piece of that the HIE is planning to implement that content-based search in the next few months so that we could have searched for that condition and might have had an assist from the computer in finding it. So I look at that as an example of it wasn't clear from the site sending the patient this was important to tell us, but it turned out to be important in our care.

The other piece is that the different sites of care, whether it's an acute care hospital ... acute care settings or home really are working on a different timeline and a different set of goals, different set of resources, so it's not like we just have to move the plan along and continue carrying out the same plan. The plan actually shifts because the goals shift. And maybe depression is a good example. If you're in the hospital for a fractured hip and you have depression, well, the depression might affect your ability to do rehab once you're home and needing to do rehab on your own, but it's not something that really can be addressed in the couple of days you're in the hospital having your hip reset. But it becomes an opportunity if you're going to be in a rehab setting for a month, they might actually begin to address the depression. It certainly could be key for home health, who's going to see you at home. It might be key for what you do for post-hospital outpatient care when you're more ambulatory, and part of the feedback of then are you doing the things. So I think the different settings are inherently different in the kinds of things that they're doing, so this notion of creating a shared care plan is more than just a hand-off, there actually needs to be intelligence in how we do this. I can probably say more, but that's probably plenty.

One final note, this is the problems of a mixed mode world, so using the HIE or using technology to look at the history can be very good because it gives you ways to slice and dice and zoom in on things, potentially gives you search capabilities. But where we get information in a paper transfer out of a system with an EHR, we're now getting 200 and 300 pages worth of printout, and that's really not helpful because there's not time to assess what's in those 200 or 300 pages, so we really need to have the electronic tools to help us find what we're looking for. Okay, plenty for me. Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think Gayle was next, please.

Gayle Harrell – Florida – House of Representatives
The only thing I want to address, and as you move forward with this project certainly care transitions are probably the pivotal point where things can fall apart and that coordination is so important. However, on the other end of it you have entities, especially when you talk about home healthcare and nursing homes, who don't have the capabilities, the electronic record capabilities that the hospitals have or perhaps the physicians have. So you have a real issue here on the ground level on how do you make that all work when you have entities who are going to be dealing with that patient who don't have that capability and probably won't have that capability, especially when you go into the home health world, which of course is a different issue totally and the amount of fraud and abuse that goes on in home health is very significant. So how would you address that, and where can you focus in your deliberations as you move forward into that ground level view of what the real world is out there?

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
Quick answer on that one, I absolutely agree. We actually had questions of HIT adoption and non-hospital providers and a lot of other community-based providers as a key barrier. We are, perhaps it's not uninformed optimism but it was interesting to hear from many different home health providers, and maybe these are the tip of the sphere, how much they're doing, granted it's very much jerry-rigged systems to put things like iPads in the hands of their nurses who are going into homes, to then figure out how to build the interfaces that bolt on to their partners in care. So perhaps the answer here is that in the near term what we'd like to see happen as we wait for adoption to pick up and not exactly knowing how that arc will

go, is to identify those bright spots much more deliberately and use them as a model to figure out how can we rapidly translate what they're learning to other home health agencies, or whoever those other providers are, so that those other providers, who may not have the dollars or grants, etc., to pursue those, could rapidly adopt them. But I left feeling that there was some movement that we weren't as aware of before.

Gayle Harrell – Florida – House of Representatives
I think this is an opportunity for those venture capitalists and also vendors out there to truly address, because Medicare, CMS has a vested interest in this entire endeavor and if you don't deal with things down at that ground level people are going to wind up back in the hospitals. I think this is an area that needs to be focused on and needs to be addressed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks for being patient, Marc.

Marc Probst – Intermountain Healthcare – CIO
I promise, Paul, I only have about 20 or 30 minutes. I'm kidding. These should be very quick. Thank you for doing a very positive thing, I think. This has really been a good presentation.

Two quick things that I think maybe can be helped with a policy type committee like ours, one is, you showed some road blocks, but I'm assuming you've got a list of barriers to achieving what you're doing and those have to align fairly tightly with the barriers we have been working through as a group. It might be nice to see more explicitly what those are and how those align, because I think that's something policy can help deal with. Then secondly, priority, transitions of care is a huge issue, it starts when the patient gets ill, or hopefully doesn't get ill, all the way through what you're talking about in discharge and post-acute care. Any focus on prioritizing what you might go after that has the most benefit, is that chronic disease, is that cardiac, cardiac care, that's pretty simple on the discharge side what you're supposed to do and how you track it and there are some cool technologies that could support it, make a huge difference for the country, so again not trying to do everything associated with TCO, but looking at the priorities that might be most effectively helped with the technology you're looking at. But again thanks for the work you're doing.

Janhavi Kirtane – ONC – Director of Clinical Transformation with ... Community Program
And quickly to that point, I think there are several opportunities to focus. The way we have been talking about this all along is we wanted to figure this out for the most complex patients, the patients who have multiple co-morbidities, and how do you get it right for them first. But also to your point of focusing on heart failure or cardiac care, I think that there's ample opportunity within the Million Hearts initiative, for instance, to focus some of those efforts to improving care transitions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Very good. This obviously struck a chord. We're very much in tune with it, and really we understand you just had one day and it's not like you were able to solve the whole problem, so thank you very much. Farzad's going to join us at 12:45 for his remarks, so we'll reconvene after lunch at 12:45. Thanks.

Mary Jo Deering – ONC – Senior Policy Advisor
Okay, ladies and gentlemen, take your seats. This is Mary Jo Deering. We're reconvening the HIT Policy Committee, and I'll turn it over to Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you for coming back for the afternoon session, and we're going to start out with remarks by Dr. Mostashari, who unfortunately couldn't be here but is on the phone. Farzad?

Farzad Mostashari – ONC – National Coordinator for Health Information Technology
Hi. Sorry I couldn't be there in person. It's been, as always, a busy week in the land of health IT. I wanted to in particular talk a little bit about the report that came out. We had not thought it would be something we could do a presentation on today because the embargo was due to be lifted tomorrow, but

the news got out early and so we have the fortune of being able to talk about the IOM report that just came out on better systems for better care. I wanted to give a little bit of my perspective. There have been some different reports and each report seems to have a little bit of a different angle on it, so I thought I'd share with you my thoughts about the report itself and about the issue, really, of how do we keep patients safer through health IT.

As everyone who's been part of the committee knows, better patient safety has been one of the key motivators and drivers and important reasons for switching from paper to electronic health records, and we all know that there's lots of different ways in which electronic health records can and do every day make care safer, having the patient's information available, having the ability to spot drug interactions, having the patient be more informed and engaged and able to be a part of the care. And this has been obviously something that didn't start with us, didn't start with this Policy Committee, the ... in itself going back two decades has consistently looked to health IT as a keystone, really a cornerstone in helping create a safer healthcare system. In the report that just came out, health IT in patient safety IOM, we affirmed their faith in the potential for health IT to improve safety, but they also made some important recommendations for making sure that health IT's potential is fully realized. We commissioned this new report as part of a longer term strategy for building in safety from the beginning, as adoption of health IT moves forward. We asked IOM to examine the topic because of their ability to assemble really some of the best minds and the experiences in the field, and to have the time to really generate a thoughtful, consolidated set of recommendations.

But we also asked IOM because of IOM's long history of looking at safety and looking at it comprehensively as part of a comprehensive approach around safety, and I think that they certainly made a very important point in that respect, that of course the EHR systems, the software needs to perform reliably. But they point out that it's not about, as one person said, safety is not about any one point, it's not about a gadget, but safety is not just about product performance, safety is a system. And successful use of health IT means that we have to understand safety as part of a systemic approach. So it means, yes, use system usability issues, it means the relationship between having the right relationship between the design of electronic health records and the workflows, and this calls on vendors. And frankly, I think we have seen, just yesterday, new movement on the part of the EHR vendor association and HINs to really collaborate on reporting of safety events and I think an engagement is necessary in terms of, as we've discussed, on usability issues and good design.

It also, I think, calls on providers to take the time to implement the systems appropriately and particularly the importance of training and the close connection between making the right connection between the computerized workflows and the clinical workflows and protocols. As we mentioned, we hear all the time about how something as simple as the meaningful use requirement to give patients an after visit summary with their medications on it and their diagnoses and so forth, gives patients an opportunity to make sure their doctors got their information right. The IOM report describes these all broadly as the sociotechnical aspect of safety and underline the way that patient safety, including health IT, is a shared responsibility. So the question really was how do we ensure that health IT is going to improve safety on all three of these levels, and proper functioning of the product, in its clinical use on the part of providers, and ultimately in supporting safer practice across all of medical care.

What we've been doing as we supported ... EHRs obviously is, and the meaningful use framework that this Policy Committee has helped provide pertains closely to attaining the higher quality and improving safety. We also recognize that there's a workflow and training issue in our community college and university programs that included components around safety and helping to educate those health and IT professionals needed. Our regional extension centers are helping ensure safety by assisting providers when they choose and they install systems, helping to fit the EHRs to the practices' needs and their workflows. Our SHARP research program is supporting some of that research to look at usability and decision support and some of the system wide improvement issues.

The report really focuses on one issue, though, which has been, I think, a critical issue, which is how do we know what's going on. How can we make sure that we have the information? How can we make sure that we have the reporting of safety events when they occur? We've been working with the Agency for

Healthcare, which is a quality AHRQ, as well as the FDA on promoting reporting by EHR vendors on adverse events through patient safety organizations. We've talked about and worked towards with NIST on the development of standards to facilitate the measurement and testing of usability, but I think a lot more work needs to be done, and we really appreciate the IOM's recommendations on making sure that we really do have a coherent structure for reporting, analyzing, and acting on the information about EHR related safety. They call for the freer flow of safety related information and the action by all the stakeholders, and I think it's really critical that we follow through on that. They ask for a reporting and safety plan within 12 months, where we've already been doing a lot of this work and we're going to have that report out a lot sooner than the 12 month target adjusted by the IOM. We're going to look at the particular recommendations from the IOM, but we also are going to obtain input from stakeholders and in particular are going to be working very closely with our federal partners with AHRQ and NIST and importantly with FDA as we craft the surveillance in action plan. I think we're appreciative of the IOM's reports. We think it's going to be a significant help in bringing stakeholders together and motivating all of us to do more to make sure that the health IT improves quality and safety of care, and I think this committee is going to be an important part of that conversation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you very much, Farzad. Any comments, questions about what Farzad talked about? We know that the ONC and HHS take safety very seriously and have already, as Farzad mentioned, have a number of programs underway to make sure that we promote it, understand it better, and as Farzad pointed out, the reporting, analyzing and acting on is an important part of the IOM report.

Farzad Mostashari – ONC – National Coordinator for Health Information Technology
I think we've been getting a lot of questions about the recommendations around FDA and whether FDA should be regulating the devices that ... and the report notes a descent, and they had a formal appendix that laid out the arguments of one member who felt that it should clearly be regulated by the FDA as a level three device. And I think it clearly was one of the most controversial issues that the committee struggled with, and my understanding of, and, Paul, you may have some perspective on this, but my understanding from reading the report is that one of the key issues was the recognition that a broader set of issues needed to be addressed, not just the devices but the entire system of how care is delivered, how training is done, how workflows are done, and we at ONC are going to work very closely with FDA and with our federal partners on behalf of the department to craft this action and surveillance plan.

The report mentioned the need to balance the innovation agenda and some of the concerns that they expressed around the expertise needed to address this issue specifically that may be different from device regulation in general. So I imagine there's lots of richness in that discussion, but at this point I think all we can say is we're going to be working as a department to look at the IOM recommendations and make sure that we have the best plan in place for helping achieve really the improvements in health and healthcare safety that are possible through health IT.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good, thank you very much. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Farzad, a quick comment as you head into this. Thank you very much for all your comments and the summary of what the IOM report has to say. I think the importance of working with other federal partners is key and I was intrigued with the suggestion from IOM that something like the National Transportation Safety Board be set up for healthcare. So perhaps as you're looking at other federal partners they might be a partner to consult with and also to be asking the question about so where was air travel in the '50s and '60s, so let's not necessarily look at where they've gotten, but how did they get here with the level of safety we now take for granted in air travel, what were the early days and things they learned and what we could learn and leverage from their experience.

Farzad Mostashari – ONC – National Coordinator for Health Information Technology
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, any other comments or questions? Farzad, you'll be staying on for a little bit?

Farzad Mostashari – ONC – National Coordinator for Health Information Technology
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wonderful, thank you. Okay, so next on our agenda is a report from the Meaningful Use Workgroup about hearings and some initial plans for Stage 3, so George and I will wander over to the table.

I wanted to remind every one of the members on the workgroup, this is a hard working workgroup over the past two and a half, going on three years, and the latest thing we had was a hearing on October the 5th where we got some information from the field about experience of Meaningful Use Stage 1 and input towards our strategy for dealing with Stage 3. And George is going to cover the topics that were covered and the participants, and I'll summarize the findings from that, and then start just the glimpse of where we're headed in terms of working through Stage 3. So these are not even draft, what we're calling focus areas. We just want to get your input in terms of where we're headed, how we're approaching it and have time for discussion. The first?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Thank you, Paul; George Hripcsak here. Before I begin, I was struck at the transition talk this morning. Judy Sparrow recently retired from ONC, was my project officer on a project to give out what was then iPads, there were tablet computers, to the visiting service of New York, use them in the home and it connected them to the hospital so they could fix Transitions of Care in 1994. It worked very well and it was published 17 years ago, so the importance of the Meaningful Use program is that just because it's possible and it works and it's feasible is not enough to get it done, you need the incentives, you need a whole program, and that's why we're all here today.

Let me whip through the definition of the panel, because you're soon going to hear the results of it. We had four panels that day, the first one supporting goals of health reform. We heard from the federal, CMS, state, and private payers' experience with meaningful use talking about adoption rates, challenges, recommendations for supporting accountable care and alignment, and as you can see we had representatives from CMS, the state, and private payer.

The second panel was from providers hearing both eligible professionals and hospitals, their experience with meaningful use on experience with the objectives, quality measures, and certification, the costs and challenges, how is it going with the care teams and their definitions of the value and types of quality measures, types meaning the difference between, say, an absolute threshold versus a delta threshold for an organization. Patients response to the providers' use of meaningful use and the effect of this whole program on their other activities, including patient safety activities, and on their achieving accountable care, and as you can see on the right we had a broad range of providers from professionals and hospitals.

The third panel was from vendors' experience with meaningful use, which objectives were most challenging, development and implementation time, what approach their customers are taking, how are they doing with health information exchange, how are they implementing the sharing of data with patients, how are they doing images, and how is this affecting their other initiatives that they would have been doing if it weren't for meaningful use. And as you can see, we have a diverse group of vendors.

The fourth and last panel was called "Finding Solutions and Creating Outcomes." This was a more broad-based panel addressing two questions, both really around data, key data challenges to improving America's health system. The kinds of things we were looking at were quality measure development, certification of healthcare professionals, consumer use of comparison data, and coordination of care. The second topic was solutions to make the acquisition analysis and use of healthcare date more effective and efficient, looking at things like standards, architectural approaches, workflow changes, and policy changes, and as you see on the right we had a broad representation from several groups for that panel.

Let's talk about some of the findings from that hearing, and it really was a rich hearing, a lot of good information, and we tried to summarize them as follows. One, the top of the hit list was quality measures, as you heard about this morning, so it was the most popular thing to talk about, not necessarily the most popular thing. People certainly do believe in quality measures, they do believe in getting more meaningful and more accurate measures of what they do as clinicians, so that wasn't the point. The point was there were a number of challenges when trying to report on these things, even though in fact there are only 6 for provider groups and 15 for hospitals. One panelist characterized his experience and his hospital health system as when he counted up all the costs for complying or qualifying for meaningful use, three-quarters of it went to extracting and reporting on quality measures.

There are a number of reasons for that. One is the lack of clarity in some of the CQM definitions. When they sought out answers to some of their questions it wasn't clear, who do they ask. As you recall, most of these things were retooled from the existing measures to fit or come out of EHRs, so who is the owner, who is the maintainer of these, and who can answer their questions. Now I'm just reporting what they report to us. We're not saying that this is the workgroup's opinion. The second piece is just a definition of the case, so that's really the denominator problem. Is there a clear way of defining how you identify people with a condition, for example, diabetes. Third was actually just a technical error in the CQM definitions. From that people surmised that the retooled measures were not necessarily field tested because there are these glitches in the way they were calculated, so those are things that got in people's way. Then the whole notion of exclusion, and certainly we've talked about this before as well, that oftentimes exclusions can cause people to revert back to a chart review, which is undermining the notion that we can try to get all these things automatically and in more real time from EHRs. So those are some of the things that got in the way that made it a more costly venture that took up more time when people are trying to fulfill the quality measure objectives of the Meaningful Use program.

The second kind of a problem was the whole certification program, not the whole program but the notion that in order to report the quality measures they had to come out of certified EHRs. Most systems do take the data out of EHRs, but then they process them in another system, not necessarily part of the EHR, they may buy other databases, other analysis programs, yet the program calls for the output to come from a certified EHR. One of the implications is that means the vendor has programmed something to test, to certify, and the vendor then makes decisions on where do the data elements reside in their system and that has implications, again, going back to this latest ... that Farzad talked about, the workflow, is it impacts the workflow. In order to use the vendor certified calculation of the quality measure some of the health systems in provider groups had to redesign the workflow to make sure they populated the right fields in the vendor system. You can see that's an unintended consequence deriving from the assumptions that a vendor makes in order to put through its calculation for certification of these quality measures. The flip side of that is because you must have this data reported out of a certified module of the EHR, either a complete EHR or module, that means people who did do the processing and the reporting outside of the EHR, even though they're using EHR data would actually have to get their processing, their reporting module, certified in order to qualify. We may want to re-look at this whole thing, ONC may want to look at this whole thing and see how can we facilitate the best way of using data as it comes out of an EHR and reporting accurately on these quality measures.

Next is the actual certification process itself for reporting on CQMs by vendor systems. The certification, at least as was reported to us, is that a vendor only needed to certify that they could report on 9 out of the 44 potential quality measures. Well, what about the other 35? And they're not really tested. In fact, what was told to us is that the certification process doesn't actually test the accuracy of the report even of those 9. So people were left a little bit hanging in terms of if there were some problems with one of these other measures how do they work through that, they have to work through it with the vendor, etc. So the certification program is not complete in that respect, and that caused some challenges.

Then finally we heard this morning the concern over the volume CQMs. There's a CQM for this program, there's one for that program, there's programs in the private sectors, and Neil brought this up, people are really concerned over well, is this just going to keep being a cumulative effect rather than harmonize and align QMs. The goal of course of putting in the EHRs is, one, to have more real time measurement; also

to be able to have these things come out as a byproduct of taking care of patients and then satisfying some of these requirements and not being driven by different definitions of these quality measures. This is really a mouthful, but these are the challenges of this very good theme, this very good requirement, of reporting on your quality, but we need to try to find ways to help these systems facilitate this process and make it easier and hopefully harmonize with other requirements of other programs.

The next area, still under CQM, is the lack of alignment, and this is a lot with what I just got done talking about, the lack of alignment or harmonization of all the CQMs. The additional piece is, and not all of them apply equally to a health system or a locale, so healthcare is local, the needs and the issues of a region are local, and the ask was can we make sure we maintain some ability to select the things that are most relevant to the health priority conditions of this locale. Some of the notions that David Lansky's Quality Measurement Workgroup had menus in six different domains so that that would seem like that's an approach to being able to pick the things that are most relevant. Then they wanted also to focus more on the outcomes rather than the process, because sometimes if you're actually achieving good outcomes through your processes you may actually have to take a step back to go measure the process pieces.

Another kind of feedback is we're asking providers to do more to get this information into the system in a coded way. Wouldn't it be nice to pay them back right away? Well, one way to pay them back is to let them have access to their real time basically quality reports, so a lot of times, let's say, in a P-for-P program you'll get information 18 months late, and it just doesn't do anything for what do you do today with these people that you're going to see today. So it would be nice if we could work towards and the benefit of providing products that would give almost real time access to their own personal ... reports about their patients and lists for them to do something about. In a sense it's dashboard versus just retrospective reporting to some administrator. Likewise, the publicly endorsed quality measures are therefore reporting versus quality improvement, so not every reportable measure, measures designed for public reporting, is as helpful for quality improvement. If we exclusively focus only on the publicly reported measures, we may miss the capabilities in the EHR to provide ongoing support for QI projects. Then, as we all know, the smaller providers, so we've talked about the 75% of the cost and quality measurement for a larger health system, well the smaller providers just have those issues magnified because they have fewer resources to deal with this.

Patient engagement is another area where great idea, really well intentioned, but here are some of the challenges that came up. Part of Stage 1 said that there's a 50% threshold of giving people clinical summaries at the end of an encounter, a good goal and good intentions, but it turns out not every encounter necessarily, maybe there's some encounters that are a check in and nothing really changed, so in the patient's mind, according to the report to the panelists, they didn't necessarily feel like they even needed this. And what happened then was people ended up with pieces of paper that they had to do something with, which could mean throwing it in the trash can in the organization. So not only is that a waste of paper, it's certainly a privacy risk, again, unintended.

Second is, gosh, this group works intensively with both information and health information technology, and the public doesn't necessarily understand either the value and all the tools available to them to deal with this information. More could be done, and it would help if we could educate the public on the value and use of this information, and of course we'll hear more about that from ONC in the consumer engagement programs.

The notion of flexibility, if the goal is to make sure patients and their families have the information they need to take a more active role in their health, let's try to get them a personalized approach to that rather than say do this specifically at this level. So the ask there was can we have a little bit more flexibility in achieving the goal with different patient populations, as an example. I think all this input we had was very helpful and illustrates when you have good intentions and ask people to do such-and-such, let's make sure that we're achieving the goal we've set out to do.

The next topic was really health information exchange. We know what a challenge that is, what we heard back from panelists is it's still a challenge. There is no clear business model for HIE as communicated by these HIE organizations, versus exchanging information. People naturally have a motivation and an

interest in exchanging information, and we already are seeing that they're starting to go do that anyway. Usually it's on a one-by-one basis, in other words you work with your frequent clinical trading partners. Those solutions organically are arising. What's been a bit more problematic is what about these more centralized or regional clearinghouses that help exchange information. The business model question just keeps coming up. There was a recent article out of the University of Michigan that sort of reinforces that point. Another point that came up is speaking of these regional organizations, now the payers are starting to own the technology that used to be the way that these regional organizations exchange information.

Finally on this list is just the whole notion now in Meaningful Use Stage 1 we said we're basically trying to create requirements for the HIT vendors, and so we asked the providers to test it, just test it. Well, that actually tends to be pretty hard. Let's say, in public health it may be hard to find somebody who can receive it, can cooperate with your test. So that's again one of the things that just came up in terms of experience from the field.

Other sources that were suggested for feedback, one is the Beacon communities, that's what they're hired to do, they're beacons in this field, try to get more systematic feedback from them. The others we've been hearing from the folks who have attested successfully, we wanted to know about that process, what about the people who have not yet and are struggling, that's another source of information. Then the third suggestion is crowd sourcing, the blogs, other ways of getting people to give us more continuous feedback. Not necessarily under this heading, but one of the ways that maybe we can help answer these questions, remember we said one of the complaints was that we don't really have an owner to go to, to ask these questions, clarification questions, and CMS does provide FAQs, is there a way to speed that up even though there's an approval process, a way to speed it up so that people can get the answers while they're in the trenches trying to crank this stuff out can they get answers to the questions in a more centralized and more timely way.

We took this feedback and we've summarized these high level things for you from that hearing and already started working on a couple of areas. One, no surprise, is the quality measurement area. And the other is specialty. So we formed two small groups, one on the CQM, and in that small group we looked at attributes of what might be an ideal, or at least a desirable CQM. We divided them into two kinds of attributes; one strategic and one more technical. Under the strategic objectives, above all else if they're going to influence behavior they've got to be really meaningful to the people you're trying to influence, and those would be the providers and the patients, and we do include patients very deliberately. The second is we confirmed our initial approach with Stage 1, which is instead of having 500 objectives, having exemplar objectives and measures that would exercise the system and be able to add more things as needed for any given organization.

Third is, loud and clear we wanted to try to keep these things aligned, particularly with where the ... going in these future payment models. The ideal is for people to work so hard on these quality measures, these reports, make sure that that's also satisfying their need in dealing with their businesses in the new reformed world. And then these measures should be more outcomes oriented. We reiterated the need for flexibility, so the menu approach is something that sits better with folks than having everything be core, and that EHRs be more capable of reporting the needs of the in the field clinicians, so give them help with the QI projects as well as the public reports and a real time dashboard. Clearly we want to get this stuff as a byproduct of care, not as a reason for spending your time, so really the goal has always been to minimize data capture burden. In a sense there's a value proposition for quality measures. Just like value is quality over cost, well, there's a quality over cost of even calculating one of these quality measures, and we should think of that as well, almost uniformly simple measures that are going to get you much further than these complex things with lots of exclusions and hard things to capture in coded format.

It was very important, particularly as we move into Stage 2 and 3, and working on ACOs, to make sure that these measures include the need and the act of exchanging health information. That's where we get the care coordination, that's where we deal with the transitions of care, etc. So these are some of the strategic attributes of an ideal CQM. On the technical side, one is it needs to be very well, it's pretty self-

evident, it needs to be clear and well specified, the definitions need to be. That would mean also you can almost never get it right the first time, these definitions should be field tested and the glitches worked out before they're put out in the field. And ideally, and a couple of people mentioned this, it would be nice to have a test bed of exemplars and perhaps hosted by ONC, but anyway, somewhere where both the vendors and the organizations and CMS can test some of these measure definitions out as one part of field testing.

Data capture must fit the workflow. The more it consists among providers, which can be a part of the definition, for example, it's metadata for the data elements, so there's a data element, the metadata might say who captures it. Is it a licensed professional, is it home, etc.? These are things, the more specified they are the better it is, the easier it is to capture. A suggestion came up of since none of what humans do are rarely perfectly right, right out the chute, can we get some feedback mechanism so that people who have to captivate these things with real data in real life can feed that back to the measure developers. It just makes a whole lot of sense. So in a sense there's a yellow button to provide feedback.

Ideally, right now the state of the practice is a lot of these measures are hard wired, so the customer, the provider organization has to take it as is. What we really need is a more flexible, more easily updated QM module that essentially plugs into a platform. That will be true for, I think, all of these measures that are used by CMS program, by this program, by quality measures, etc. It would be much nicer to go towards a platform where you have these plug-ins so people can plug in with standard definitions rather than everybody doing the same job over and over again, and to consider other reporting options besides saying it must come out of a certified EHR. One possibility is however you get the numbers you're always subject to audit and it has to be traceable back to the data that comes out of an EHR, but perhaps the reporting doesn't have to come directly out of an EHR. These are just some thoughts to play around with.

The second small group we had, this is truly a work in progress, even the slide is a work in progress, the progress is a work in progress, so this is to reexamine, re-explore how well we're doing with specialties. We've had a couple of hearings on it. The small groups are going to review those past hearings. The AMA supplied a very rich matrix, they've dealt with a lot of those specialties in their society and had input from them. We're going to study that in depth. The small groups would prefer not to have separate tracks. That's their current thinking. Otherwise you just get down, and how many tracks are we going to have. To the extent possible we'd like to keep it in one track. There may be certainly a menu approach, but not have to have multiple tracks. We want to focus more broadly on all types of specialists rather than individuals one at a time. And the notion, a lot of requirements, particularly the quality measures have to do with primary care, and we want to make sure that it's a bit of an even playing field, that specialists are contributing, like their primary care providers, to the content in the EHR, so that's one of the principles being considered. We want to seek more feedback from specialty societies about options to implement the above. ....

What we're trying to do is make meaningful use objectives be a common infrastructure that's saying by definition the thing that underlies all the specialists and the quality measures there may make more sense to have it designed for the specific specialists. We understand and we've heard from people at the hearings that there's a problem if you're a specialist that doesn't do most of it, do you need an EHR that does all of it, and we've heard that and we need to address that. However, separating meaningful use into a large set of tracks, I think the tracks from our desire to have a common platform where there's health information exchange, medication reconciliations, care plans, and so on, so much of what we do requires that integration that we're afraid of separating it, will actually take us in the wrong direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Now we're moving towards the strategy for Stage 3. We first came up with some principles, and this, as I say, really early work in progress. One we did reaffirm with the group, we took a look at those five goals again, the five categories, and they hold up really well. So we developed those before the National Quality Strategy and they seem to fit with the National Quality Strategy. So we're really in sync with the current policies. Here are some of the principles for focal areas. We wanted to align with the emerging payment policies and the National Quality Strategy; second, to consider some kind of harmonized

qualification, is there some cross-credit between some of the CMS programs like ACOs and meaningful use, or vice versa. That's why we asked the question this morning of CMS about they used to have a cross-credit with meaningful use, for good reason, but continue to think about that kind of thing. And as we move towards ACO and other things that are more population based we need to be able to have capabilities in the EHR to support that collection and analysis. We want to, as we move into the later stages, be able to support innovation in these technologies. So that's almost a theme or a principle is to make sure that we're not at all disturbing it. In fact, we're encouraging innovative approaches to these developed by IT to improve health, and that's the same theme as the next bullet, which is the flexible adaptive platforms rather than essentially hard wired functions.

We certainly don't want to penalize success. That was one of the reasons for our recommendation about that timing glitch for early attesters. If people are finding ways to use this technology to achieve good results we don't want them to have to backtrack and say well, prove to us that you do this, this, and this process. So some of the initial draft focal areas, just to give you an idea of how we're thinking for your feedback, one is, essentially rewarding the folks that are in this process of improving health and healthcare, so give more real time information back to the point of care, whether that's to the clinician or the patient or the family ... how can we get them information that would shape and color their decisions. One could be, as an example, this clinical performance dashboard that's there every day and is updated every day with every patient, not 18 months in arrears. Another is proactive adverse event prevention, a detection, a mitigation reporting thing so that we can catch these things before they happen, prevent them, catch them while they're happening, mitigate them. It's in the culture of safety and the culture of quality. And while we're on that subject, the continuous learning health system, that's one of the strategic objectives for ONC and for the country at large, and that's something we want the EHR system to essentially be a front and center tool.

Second is to reinforce and empower this patient partnership, the partnership between the professional health team and the patients and their caregivers. So we've worked really hard on access to information, we want to start moving in these later stages to their direct contribution to their health record, support of the caregivers, and making sure they get feedback in measures that matter to them. That probably means, and we forecast this basically back in the Stage 1 phase, capturing emerging sources of data, home remote devices, patient reported outcomes, new ways of getting a more total picture of an individual's health and the determinants of their health. CDS, we always said from Stage 1, clinical decision support, is one of the key tools we have in EHRs and personal health records in influencing decisions that are made around health, so prevention, disease management, safety domains of clinical decision support are some of the targets for Stage 3. And reinforcing the population health assessment analysis and surveillance, really making sure we have the eye on the whole community, not just each individual.

This is where we are in our work plan for developing recommendations for Stage 3. We had a hearing, we've been meeting in the workgroup and small groups, we're providing this sort of feedback, this briefing to you to get your feedback, and we'll go in and continue our deliberations in the workgroup. We're planning to use the same process we did for Stage 1 and 2, which is get a request for comment out to the field, get public feedback, I mean, this is like an ANPRM kind of thing, and before we revise our recommendations and get it before this full committee again for your feedback before we go through the process to final recommendations to ONC and CMS.

Our goals, really we found that our initial approach, the framework, we've reconfirmed that that's the thing that is working well, that we do have some major challenges to address. They're not insurmountable and they're not unexpected, but they're things that we're working on. We're introducing some of the ways we're thinking about Stage 3 in much more of a proactive, outcomes oriented way and we're open to your questions and comments and input. Thank you.

So we're open for discussion, and Marc's the first one up.

Marc Probst – Intermountain Healthcare – CIO
That never happens. Thanks, Paul, a really good discussion and good information. It looked like on your thinking around Stage 3, and I think we've had this discussion before, we're moving more from things to outcomes and how we influence those outcomes. A couple of things that came up in the discussions, the panels you held, which sound like they were really useful, in HIE it has been difficult to take hold. And really with all the things that we discussed this morning around transitions of care and what ACOs are doing, really the drivers are there for people to exchange information. And whether that will happen through a statewide exchange or whatever, the drivers are there. I don't know, I guess my comment is more of a focus on getting that exchange than the vehicles to do it. And it would the same thing around dashboards, I'd hate to see us try to find specific dashboards, and that kind of goes to clinical decision support. That's a great area. It is the advantage of having health information technology like this, but it also is a constantly evolving area in how to influence the practice of care, provide aids to clinicians, and it really requires a fair amount of local expertise to actually understand, define and tailor those clinical decision support type protocols.

So I guess my overall statement is this is great. I really think you've done some good assessment in getting that information, and we just have to be careful not to get too it or thingy about Stage 3 but let's look at what the outcomes could be. And I think we've put some good pieces in place that allow those outcomes to happen, so thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Gayle?

Gayle Harrell – Florida – House of Representatives
Thank you so very much, and I too want to echo the impact of holding these kinds of hearings. I want to encourage ONC to continue to do this. This is an evolving process and we're learning things every single day as people are implementing the problems and challenges that they're finding, but we have an opportunity now to get Stage 3 right. We kind of did a minimal Stage 2 and we need to look at this as the evolutionary path and learn from what is going on in Stage 1 and as we move into Stage 2. I think one of the key things we need to do if we really want to get our bang for the buck and make sure we're using these incredibly large amount of money wisely and get really out of it what we all want, is to make sure you move forward on the specialist level. I know I've spoken many times about this, and so much of the care and the cost of care is done, probably 75%, by specialists. So we need to make sure that whether we're not going to go down a track from meaningful use for specialists, at least make sure that there is enough flexibility with those quality measures and those basic meaningful use measurements there so that every specialty has the ability to qualify and that they will be able to meet meaningful use. I think this is absolutely key to where we go in Stage 3.

Also, when we're talking about quality measures I know I hear this from my hospitals again and again, and as a public official I tend to be the repository of all the public comment, everybody calls me up and talks to me or my office and I get all these e-mails, so I think we need to really look and make sure we are very careful in how we integrate. And this needs to be more than just ONC, that partnership with CMS, in order to coordinate the quality measures and the cross-walk, and Neil's example today on 17 out of 35, is all we are able to match. We need to look at PQRI, we need to look at meaningful use, all the reporting mechanisms that we have for CMS. And we have the ability to do this now. In five years, when all this is set in stone, we're not going to have that.

Also, I would say as a state official this is a dream I have that we could also coordinate with the states. When you look at licensure requirements for hospitals and what they have to go through in each state and the quality measures and the things that they have to support, this all costs a tremendous amount of money every time you run one of these reports. And if there was a way, again, to look at the big picture and get some input from states, maybe do a little workgroup or something where you involve the states in state licensure so that those quality measures are already being done over here, why can't they be used if they're structured appropriately, be used for other things as well. So you can save a huge amount of money as we move forward and really empower and engage the states in this process as well. I think the end result of that will be not only we'll be able to save our entire system a whole lot of money, but we're

also then going to have that coordinated element that is so lacking across the nation to really improve the ultimate outcomes that we're all looking for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Joe?

Joe Francis – VA
Again, a nice summary. I wanted to amplify a point that I think was implicit in your slides on clinical quality measures, but bring it forward because it has implications for public accountability reporting and value-based purchasing. Even a reasonably well specified clinical quality measure good enough for value purposes when implemented across all the local implementations of a certified EHR system may present difficulties in rolling up data so that the roll up is comparable. And if you use the methodology like a rank ordering and that rank ordering defines cut points for either payment plus-ups or payment subtractions, all of those things come into play.

And I can say that because there was an article in this month's *American Journal of Medical Quality* looking at how Yale New Haven Hospital had worked their electronic health records to address the data issues, the data quality and the standardization issues, to make it work at their site. And in my system, where we have 128 different implementations of our Vista system, people have done the same thing. I can't, at my level through our corporate data warehouse, come up with reliable metrics because with all the little subtleties and how things are specified or defined, and some of those in fact you can relate to practice patterns that even in our system vary, so I think the whole concept of saying let's look at this from an end-to-end process, let's consider that the corporate data warehouse that is used to generate a measure is just as important as the EHR alone, and there has to be some global oversight, again, as the measures are used for hard ball as opposed for just local QI a noisy measure works just fine locally, because you're hopefully making the same mistakes consistently. And I know you had that in your bullets, but the technical challenges are quite significant.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Very good. Christine?

Christine Bechtel – National Partnership for Women & Families – VP
My comments are also about the quality measures. I think this is a terrific start. I like the principles. My question really is how well connected it is to a couple of other streams of work that are going on that I think are really important to connect to. One is the MAP, the Measures Application Partnership that NQF has convened, and it is making recommendations to HHS around alignment across programs, for example, CMS participates in it, we do, and a number of other folks, I'm sure, around the table do, but I think it's really worth paying attention to. And I would probably start with the measure selection criteria that they have, actually we just agreed to at the meeting last week, to inform our thinking. I think this really is, to Gayle's point, about we can't have completely different quality measures across all the federal programs and in fact that to me seems to be the easiest and most parsimonious way to thread that needle. So that's really more of a comment, but I'm just wondering if it's also connected to the test beds that I think ONC is helping to fund, at least I know that they're supporting some work, I think it's through the Beacon collaborative, with Dartmouth around patient reported measures and collecting that electronically. I think we need to be informed by that work. And then my last connection is how this relates to, I'm not sure who's on this small workgroup, but how it relates to the Policy Committee's own Quality Measures Workgroup and how that work is coming together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
David Lansky, for example, is on the small group; all good points. Larry?

Christine Bechtel – National Partnership for Women & Families – VP
(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes?

Christine Bechtel – National Partnership for Women & Families – VP
... on the Quality Measures Workgroup is, I don't want to get confusion about which workgroup's working on what. And so I don't know what the small group is doing versus the big group or if they still exist, but they were separate before and I'm worried about crossing wires.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why I mentioned David Lansky, who's the Chair of the Quality Measures Workgroup, which is a little bit dormant after there's a contract out to get some of the measure concepts that that workgroup developed. And so this is a little bit coming at it from here's some input from experience from the field, and now that's going to be fed back to the ... workgroup. Anyway, we're awaiting the activities as a result of that contract –

Christine Bechtel – National Partnership for Women & Families – VP
That's very helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... additional ... that.

Christine Bechtel – National Partnership for Women & Families – VP
Thank you very much. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're trying to deliberately keep these things coordinated. Thanks. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Three cheers for the progress we're making against the timeline. It will be really exciting to have our final recommendations come out next summer. Obviously the counterbalance of that, of we're really just going to be in the swing of uptake on Stage 1 at that point, so obviously we know that problem so it kind of reinforces the messages of ONC continuing to get feedback beyond what we're going to be able to deliver in the timeline you've laid out.

I completely support the notion of quality measures as a byproduct of care and the feedback you're getting on how it's either tough to do that reliably or where things have been hard wired into applications, partly because of the crunch timeline, but also partly because of the history of things getting hard wired. So I'd like us to further explore notions around e-measures as a platform, and so don't just take in the 6 or 20 e-measures that we've defined, but actually looking to vendors and the feasibility of generally implementing e-measures as electronically specified measures that can be executed, if you will, computed by the EHR, or by supporting technology, and to start the ... feasibility of actually seeing that as a platform. Because I think that gives people a much richer tool kit to actually implement the quality measures that make sense for them and it gets us out of the business of micro managing which quality measure makes sense for an organization.

Finally, some feedback I've been hearing about some of the problems with Stage 1, particularly around information exchange, and that the requirement to be able to create a care summary really was a very low bar of the certification, it just said can you produce it, and that the providers just have to be able to test against it if they choose that measure. What I'm hearing from the health information exchanges is they're basically getting blobs that don't have a lot of structure in them and that vendors on the ability to receive them and do something with them mostly can display them, but they're not yet at a place where they can take action. Now clearly some vendors are ahead of that curve, but broadly speaking it seems like the vendors haven't gone very far in being able to do something useful with the care summaries, and that these would be areas that if we can start to get further down that road would be really, really helpful, that we could have a platform out there that can both do the e-measure piece and do the care coordination with some structure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me just follow up with something that Larry brought up, which I didn't expand upon. If you remember, the timeline, the lead time we're trying to create is this so-called 18 month lead time. It's a combination of the vendors want lead time, the providers want lead time, the quality measure developers want lead time, everyone wants lead time, so the number that's been given to us is 18 months, a year and a half, and you know that the regulatory process from the creation of the NPRM and the final rollout is a year, so that's how you get two and a half years from 2015 and you know the other side, which is the final rule for Stage 2 even comes out around the same time of mid next year. So that's where we're at, but we're trying to honor all these multiple competing timing issues. Neil, you were going to say something specific on that?

Neil Calman – Institute for Family Health – President & Cofounder
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I've got Judy and Tom and then Neil.

Judy Faulkner – Epic Systems – Founder
Through this whole day I've been thinking about the inconsistency that I'm feeling here, and that is that we are having groups measure things. So the healthcare organizations have to do 9 out of 44 of this, or they have to improve that by 2%, or "X" percent of the patients have to have access to whatever, and the part that strikes me is that is an inconsistency and it makes me feel like we're not holding ourselves to the same standards as how do we set up what we should measure ourselves to, and how do we have similar standards, how do we define success, whether it's the ACOs, the Beacon communities or Meaningful Use. Remember in the very beginning of Meaningful Use somebody said, and I thought it was very well said, if too many can successfully attest we haven't succeeded, and if too few successfully attest we haven't succeeded. How do we step back a little bit and define what is success for our group as we're defining all of the stuff for everybody else?

And I think it's a good list, but my concern is, we aren't saying this is success, this is the goal that we should have, we're not going to be using our time well in all these meetings here. So, for example, the ACOs, if it's 50 to 270, is that a good number? And what number within that range should we pick and say this is what we have to achieve? I think that once you know what you have to achieve, just like we're setting up for the healthcare organizations, you do a better job of achieving it. I don't think we've set the standards for ourselves that we need to set as I listen to this, and as I look at Stage 3 I'm thinking those are good lists, but don't we have to analyze where we've gone with Stage 1, then set standards for Stage 2, and then maybe for Stage 3 look at what we've achieved with Stage 2 and vary it, depending on how we need to adjust from the success, or lack of success, that we've had.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good proposition. Is Farzad still on the line? We'll ask him in terms of, what is the definition, does anybody from ONC know?

W
I'm thinking it should be numeric. It's not just general stuff.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is there such a number? No?

W
And we should all know it, too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

W
It sure is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Let's follow up on that very interesting comment. Tom?

Michael Weiner – Defense Health Information Management System – CMO
This is Michael.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Michael, sorry. .... It's just like the color red, if you make it red you can't –

Michael Weiner – Defense Health Information Management System – CMO
I'm just going to chime in for Stage 3 and go back to Stage 1. The Department of Defense and military health remains committed and we believe we were one of your first adopters and supporters and we plan to continue to do so. Since Stage 1 came out the Department of Defense and our VA colleagues have come together for an inter-agency program for one unified electronic health record. I say that because we are in the middle of standing that up together between the two agencies and this is the perfect timing to take these early thoughts, build them into requirements into our upcoming combined platform, so we'll take those and we look forward to continuing to work with you and at the end of the day I think between our two agencies we see 10+% of the population and we hope that that will help create the critical mass needed to move this forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thank you, Michael. Let's see, I think Kate and then Neil.

Kate Goodrich – ASPE – CMO
Hi, Kate Goodrich from CMS. A lot of you don't know me. I'm in the Office of Clinical Standards and Quality. I work for ... Patrick Conway and I thought I crafted it so CMS would get the last word, but apparently not. This conversation has been really fascinating, really helpful. All of the comments here have been marvelous, the presentation obviously very helpful to us, particularly some of the details of the comments that you heard, and I'm going to get to one of those in just a minute. I want to first address the comments that many people have brought forward related to alignment. This is something that we are very focused on now within HHS, not just across CMS, but we very much look to groups such as this and of course the MAP, who Patrick and I both work with closely in that effort to ensure that we are going the right path and incorporating all of the views of the various stakeholders. So we thank everyone here for their work on that. It's been an amazing journey so far and there's a lot more to do.

As we drill down internally what it actually means to align, it turns out there's all of these really complex overlying issues that often compete with one another. So we continue to seek counsel and advice from everybody on that as we work towards it internally. I wanted to get to the issue, really kind of throw out a question a little bit and then see if there were specific comments on this, on the issue of specialty measures that you brought up. We've been talking a lot about this, not just for meaningful use, it's obviously very important there, but across value-based purchasing programs and PQRS of course, and this is a big issue and we hear a lot from the specialty societies on this, and it's really important that those folks are also able to participate in not only the meaningful use program, but all of our programs.

And so one of the things that we've been thinking about is what should the right, first, thinking about parsimony, right, which is super important, but what should the right balance be, or how should we be thinking about specialty measures. Should we be thinking about them as individual sets of measures for every single different specialty, or should we be thinking about them more as cross-cutting measures that actually apply to all providers, so patient experience measures, care coordination measures, maybe overuse measures, that sort of thing. I'd be interested to know from you all if there were any comments specific to that, and certainly either now or if we run out of time off line, if people would be willing to provide their thoughts about what that should look like for specialties. I'd be very interested in hearing that. Thank you.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's what that small group is working on as we speak.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just a couple of comments on where we had been, so one is this small group we've been reaffirmed trying to keep it all in one track, and it's more on the cross-cutting side. And just an example that we thought about in Stage 1 even was specialty referral feedback once you've referred a patient, that's cross-cutting. It's highly desirable. It's not that frequently supplied in today's world, and the HR should help us. That's a little bit of what we're thinking. As George mentioned, we have this small group that's going to try to still hunker down and try to talk about that subject more. Thanks.

Gayle Harrell – Florida – House of Representatives
Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Gayle?

Gayle Harrell – Florida – House of Representatives
... also address that as well. I think specifically we held a hearing from specialties and they were very specific recommendations. In fact, this committee came forward and changed its recommendations as a result of that when CMS came out with the NPRM they did not take our recommendations on specialties. So that would be certainly a starting point to go back and look at those specific recommendations that this group did come forward with and certainly the working group that is now in existence is a very critical group. But there needs to be the ability at the end of the day, when we're finished, I don't know that we're ever finished, but when we at least have achieved the intent of the legislation that there's the ability for every specialty to qualify.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Neil?

Neil Calman – Institute for Family Health – President & Cofounder
I'd like to propose that we establish a 12-step program for all of the people who develop measures, and part of it is to ask for forgiveness for all of the past things that we've done to everybody by making this list longer and longer and longer. I appreciate the fact that we all lament this, but we keep doing it. We just came out with an ACO rule that very well could have just limited its measures to those that are in use in other places. But instead they established new measures, we're in the process of establishing new measures, we all recognize that it's a problem, and we all keep doing it. So I think the first way to do this is we have to break this cycle somehow, and so one of the things we should look at in our own work, I think, is the possibility of pulling back and looking at measures that are already being required by other sources, whether they're primary care medical home or the ACO, I mean, I believe that the ACO rule is going to dominate what happens in healthcare for quite a while and everybody's going to be going to their vendors right now and saying, we need to be able to report on this kind of stuff. So we should look at that, but if we're going to add those other measures into the things, not necessarily that we require for meaningful use but the things that the vendors are working on that the providers are going to have to report on, we're being complacent in this process. One point is, I think somebody's got to call a halt to this and we should think about being the first to do that. I think that would require us to take a few steps backward, but that wouldn't be the worst thing that we would need to do.

The second thing is I think that if there's anything that we ought to be calling for as a policy committee, it would be a requirement to develop a flexible reporting system that says what the parameters are that the vendors have to be able to allow providers to report on, so to be able to say that all certified products need to have a flexible reporting system that allows providers to go in and report by age, sex, race and ethnicity, principal diagnosis, put the list out there, would cover a lot of ground in relationship to what people are going to need to do as some of these other requirements come down the road. What I hear from my colleagues is that getting information into the system is not nearly as hard as getting it out of all these systems, and yet what we've been doing is we've been building up a list of specific reports without really requiring a general reporting mechanism that allows people to get information out the way they would want to see it. I think that would deal with a lot of the specialty issues.

That would bring me to my third point, which is, and I've raised this before, the most important quality improvement activity that can be generated in any organization is one that's driven by the needs of an organization, a recognized problem that the organization has identified through looking at the work that it does, and saying we need to improve on this. I think what we should be doing is driving that process so that people have the tools to be able to say within their system, we have a real problem here with diabetic management, or as happened to us a few years ago, when one of our nephrology specialists said you guys have a real problem. You're referring your patients too late for renal consultation, your diabetic patients, and we're getting them too late. To be able to take that, develop a report to figure out what to do with it, to develop a quality improvement mechanism, and to flexibly be able to do that within your systems, I think that's what would lead us to a place that would solve a lot of these issues. So very concretely what I'm saying is I think that we ought to look at our general reporting requirement, and I think that that would cover a lot of ground for us and we ought to figure out a way to limit what we're doing to be a subset of what's required elsewhere and to try to see if others are willing to do the same thing in their development, and then to try to figure out how to really be parsimonious, not just looking at what meaningful use is, but parsimonious looking at the entire spectrum of what providers and vendors are required to develop.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good points. Is David Lansky still on the line?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I'm here, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you want to respond a bit to Neil's quality measure proposal?

David Lansky – Pacific Business Group on Health – President & CEO
It's probably best not to get into a debate on this whole scope of strategy here. I don't agree that we should consolidate down to the lowest common denominator measures that are already in play. Our strategy and the outcomes priorities we've identified are not adequately met by the measures that are already out there, so we either, in effect abandon a big part of our health outcomes goals, or we have to encourage alignment with other programs like CMS as they also move forward to expand their reach. I think the key is to align across the programs in a consistent and a thoughtful direction and also allow local sites to implement the strategic direction in a way that's flexible to their local needs and where they get a lot of value. So I think it's a complicated matrix in effect just to think through, including the specialty goals that several people have raised, and I think the question that was posed, I think Kate suggested it, of whether specialty measures should be generic and commonly used by all specialists or whether they should be tailored to the specific areas of service they're providing is another complex question, and the answer to me is obviously who's the user. Lastly, I'd say I think our question as a Policy Committee on health IT is actually in some ways easier, which is how do we verify that enabling capabilities are being adopted and used rather than are they generating increments in quality and so on, which is someone else's job who's involved in payment or recognition or certification programs.

All of these points are very well taken, but it's a complex area and hopefully these small subcommittees can begin to dig deeper into them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, David. Thank you very much for your feedback. I've written them down and we will bring that back into the workgroup and deliberate on this further, and I'd be expecting to get back with you on some initial recommendations later on, in the late winter perhaps.

Next on the agenda is Jodi Daniel, and I think Lygeia.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
I'm right here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, on the consumer engagement strategy.

Jodi Daniel – ONC – Director Office of Policy & Research
Good afternoon, everyone. I'm just going to kick this off and really turn the substance over to Lygeia, who heads up our Consumer eHealth Program, as most of you probably know, to talk about our consumer eHealth strategy, and just to get some feedback from folks on what we're thinking as we're in the throes of developing this.

I just was going to give a little bit of context before I turn it over. We've heard Farzad talk a lot about how we need to make sure that all of our work is really focused on putting the patient in the center and that that should be motivating all of our thinking and be embedded in all of our programs. This committee was wise when they gave us feedback on our strategic plan by coming up with a framework on highlighting the need for elevating the role of the patient, elevating the role of the consumer and as I had mentioned in the past, we took that not only to heart but made it one of our five goals in our health IT strategic plan, which we released this past September. What we are thinking about now with our strategic plan generally is that we want to figure out how to make this not the very thoughtful document that everybody, it was a snapshot in time and that sits on a shelf, and that we look at three years or five years down the road, but really make it a living document and figure out how we can do that in an interactive way with a lot of public feedback. We're still working through the details of that. We're trying to come up with a way that we can have real time, here's our thinking on a particular strategy, an update on what our thinking was when we first put out the plan, and be able to get comments in a live, interactive way, and we're looking at tools and approaches for doing that right now.

I don't have anything to announce on how we're doing that yet, but that's our intention. What we're thinking about is starting with consumer eHealth as our test of our interactive strategic plan and making this a living document, because we've actually done a huge amount of work and thinking and progress in our program since we drafted that, which we released in a draft form back in March of this year. So we thought that since this is something that was active that we're discussing right now that it's essential to the work we do, that we wanted to, as we're thinking about our consumer eHealth program and our consumer eHealth strategy, figure out how we can marry these two efforts and keep our strategic plan, live and up to date, with input. So today our goal is to get input from you all on our strategic thinking on our consumer eHealth program, so that we can develop something that we would then put up live for folks to interact with, engage with, comment on, share their thoughts with us, etc., as we're thinking through our strategy.

With that, I'm going to turn it over to Lygeia to walk through our thinking, our assumptions, our short and long term tactics that we've got in place, and then we'd really like your input and thoughts on what we propose.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Thank you, Jodi. First of all, thank you all for being here until the end and giving us some input and attention, it sounds like it's been an incredibly long and stimulating day. I've heard part of it but not all of it, and already my head is swimming. What we want to do here is do a couple of updates on what's happened in the very recent past, then step back to the very big picture and talk about some of the thinking that underpins our strategy in the consumer eHealth area, and get your input on some of those guiding ideas. We then want to focus in on a couple of particular things we're doing and get your input on those. Some of them are short term objectives, and some of them are longer term initiatives, so a lot to cover.

I think you last heard a real update officially from Jodi soon after our September 12th official launch of the program, during which we released the CLIA rules related to access to lab data, we released a whole lot of new consumer geared content about health information technology online, we released a PHR model privacy notice, and we had more than 30 organizations, public and private, getting up and making pledges in support of engaging consumers in health via IT. That was exciting and it was officially the launch of our program. Since then we've really done some work in pushing the pledge program forward,

and we'll talk about that more, but the numbers of participants have gone up dramatically. We've launched a couple of new contracts, they're specifically related to the media outreach piece, so we'll talk about that. We've also laid the groundwork for several innovation challenges and laid out some of the particular goals that we're going to talk about today.

Stepping back to the super big picture and what we're trying to do here, the mission of our program is to empower individuals to be partners in their health through information technology. We deliberately chose the word "health" rather than "healthcare," although healthcare is embodied in it and we want it to be broader. We chose individuals because it was one of the broader ways of saying consumers and patients. There are a number of assumptions that we start from as we think about not only that general mission but what we're trying to do to achieve it, and so we wanted to take the opportunity to walk through them with you. We've already gotten input from a number of sources, certainly including ONC's senior leadership team, as well as a number of outside organizations, including the Consumer Partnership for eHealth. Christine was nice enough to include us on one of their calls so they could give feedback, but we really see this as an evolving body of thought really. So we'd be interested in your input too. Broadly speaking, this first set of assumptions is really about consumer engagement, and it essentially says this first point is that personal behaviors and choices are essential factors in shaping an individual's health. There are many other important factors too, but we really need to not forget the really essential role of the individual in defining his or her own health and well being.

The next point is that actionable information, the right information at the right place and the right time, really contributes to the ability to effectively engage in health, and that's really where health information technology can come in. Actionable information for patients or individuals can contribute to people's well being in several different ways. The first here is your ability to potentially coordinate your information and your care among multiple providers, so it's linking you to your care system. You can also forge stronger partnerships with your providers and helping them move toward more patient centered care. And you can also better manage your own health and your own well being, which may take place largely outside of the traditional care system. But all these different components are important.

When we talk about consumer engagement, the next assumption here is that it's not that we want necessarily more engagement by consumers in their care. That might be good in some cases but it's more effective engagement. So it's not that we want a higher proportion of people's time to be spent thinking about management of their health and their care, but that they really engage at the points where they can have the greatest impact. The last point is that attitudes on the part of both patients and providers, not just technical and financial considerations, are really important here in impacting an individual's ability to use information to engage actively in their health.

I want to go on to a couple of other kinds of assumptions that we're working on and then I'm going to stop and see if you have any comments to add. So a couple of other categories of assumptions, this next one is largely about larger outside forces, both technological and policy, and it essentially is talking about the fact that information and communications technology is getting cheaper and more ubiquitous, the Internet, cell phones, online communities, social media, these are changing all aspects of our society and lumping together several of these, but the net result is that people engage more fully in many aspects of their lives and healthcare is, in some ways, beginning to be part of that trend, although it lags behind some other areas.

The other point is that market forces and policy forces are likely to require consumers to take ever greater responsibility for their health and their healthcare. The underlying point in that whole section there is that there are these huge outside trends that are really moving us toward greater individual consumer patient engagement and health. Then the final point down there at the bottom is about ONC's role, and we want to underscore the point that we don't see us as leaders who are going to forge this whole new world, but rather as folks who are observing these powerful mega trends and shifts and important factors and trying to catalyze them and support them.

Those are a lot of the basic ideas and assumptions that we're working on. We want to take a second and just see if you had any input, if there's anything that you think is missing or that you disagree with or that

you might phrase differently. And if not that's okay too because we have many other points of discussion. But it looks like Joe has some input.

Joe Francis – VA
I'm Joe from VA and I think you know we have both an electronic health record and a personal health record and we distinguish between the two. And one of the questions that I have, or maybe it's a suggestion, is trying to understand the boundary of these two entities. You make some mention about giving consumers access to the health information that they're entitled to under HIPAA, and I say technically HIPAA refers to the electronic health record, and the medical record in our space, the PHR, is a little different and I think trying to understand and manage that convergence so there isn't a distinction might be a useful discussion to have.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
I think actually it tees up nicely into some of the issues that we'll get into a little later about the frontier issues that we're going to want to look at more, so hold that thought. I totally agree. Any other comments on assumptions? Yes?

Gayle Harrell – Florida – House of Representatives
I think one of the things you've not put into your basic assumptions is that there's a digital divide in this country.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Excellent point. You're absolutely right, and we need to articulate that in here.

Gayle Harrell – Florida – House of Representatives
We need to understand that we have a very with it society that's got cell phones, maybe cell phones not so much, because that seems to be pretty universal. Even my 94-year-old mother has a cell phone. But when you talk about really personal health records, we have a real digital divide in what people will be able to, or are comfortable using and being able to really glean the information that they need that's going to be beneficial to them. So you need to put that into your whole basic assumption as we move forward.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Excellent point to emphasize. Thank you very much, Gayle. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Thank you, Gayle, for inspiring a thought here. I'm a little bit reminded of a situation with MP3 players prior to the iPod and that we have personal health records ... in the world and various organizations make them available to their patients, or people who set up their own personal health record. Microsoft has been in this business for a few years, Google got out of the business, and there are other players, niche players that are out there, I don't want to just cite those two vendors, but generally speaking there's been very little uptake. And then a new device came out that was cool and we had iTunes come out, which actually shifted the model, that those of us who didn't want to be stealing music and only doing file share had a method to actually buy a single song for $0.99. And that wasn't enough of a barrier to stop anybody, so suddenly they were selling players and music like crazy. So I suggest as you look at consumer engagement and start looking at bright spots of where things are taking off, to start to look at where is there an echo system that actually gets people to actively engage their records. I know we have some healthcare organizations that say they have very high use of their PHRs, so what they're doing is actually engaging people in using it and how do we scale it and how do we go from it's a cool technology that a few people use, to it starts to be everywhere. And it's not just cool, it's helpful.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
That's a great point. I also think it's important when we talk about looking at bright spots and we think about sometimes admittedly a little bit depressing uptake rates for PHRs, for example, that if we think about health information technology, or eHealth even more broadly, there is tons of consumer use of the Internet, for example, to do search on health information, online communities, and there are certain

wellness related programs like Weight Watchers and things like that that are actually doing really well. So that's a really good point.

Jodi Daniel – ONC – Director Office of Policy & Research
One thing to add on that, and I ... highlight what Lygeia is saying is that our consumer eHealth program is not looking just at how we provide access to their information through PHRs. We are able to aim much more broadly than that, although inclusive of that, so we are looking at where the trends are and how we support consumer engagement through technology broadly, including access to information, which is a huge part of access to your own information and PHRs in the world to play there, so it's a part of what we're doing. But I think that the scope is broader than –

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes, that's actually a beautiful segue. I'm going to move on to the next part to talk about, and if there are other comments that you want to make on any part of this and we move too quickly, please feel that you can follow up either after the meeting by e-mail, etc. But when we look at what's the strategic approach that we're taking, building on what Jodi just said, there are three basic prongs that we're looking at here in terms of areas where we're involved. The first is about access and giving consumers easier, safer, faster access to their personal health information. It's really about making real through technology what is already required by law by HIPAA. The second piece is about action, believing that if you give people access to the information it doesn't mean a lot unless you enable them to take action using it. So we want to support the development of tools and services that enable people to use this information that we've suddenly made more available to them in positive ways. The third piece is about changing attitudes, which includes all of our own, not just people out there, but those of individual patients and consumers and also providers. In terms of just expectations it's more assumed that people are going to get access to their information and really be partners in their care with their providers. I think that's ultimately going to be healthy for everybody. Those are the three areas we're working in.

We have particular initiatives in each area. I did want to take a moment and do a little bit of a review of our pledge program before we go into some of our specific goals that we're setting for the short term and the longer term, because our pledge program in particular spans across those three A's, the access, the action and the attitude pieces. This pledge program which we officially kicked off in September, has to do with encouraging both public and private sector organizations to work with us as part of a community to encourage greater ability by consumers to engage in their care. There are two different kinds of pledges. Pledges are for organizations, not individuals. So there are two different kinds of pledges that organizations can take. One is for data holders. This is primarily for payers or providers, certainly some other kinds of organizations like personal health records, for example, who are pledging to make it easier for individuals to get secure electronic access to their records. A second part of that pledge that they had to agree to was to encourage them to do it. So it's not enough to say, hey, we're going to blue button our data or we're going to use Direct, and we do specify that there are some parameters around what giving access means. But they have to agree that they're going to actually get the word out about it, they're not going to silently turn on this capability and wonder why nobody comes. So that's the data holder's pledge.

The non-data holder's pledge is much broader and it's generally about supporting consumer engagement in eHealth and health IT. A lot of folks are fulfilling it by really spreading the word and doing engagement and outreach in this area, although some are doing it by developing tools and services. So it's mostly about education and outreach, but then we've also encouraged folks who are developing, not just PHRs but a whole variety of eHealth or Health 2.0 tools to participate in that one.

With that bit of background, I want to jump into a few short term objectives that we've set for our program, and this is going to be an area where want to get a little bit of feedback from you as well. The first is that we want to, certainly among ourselves and perhaps for the general public, establish some baseline metrics for success and talk about how we as a nation, we as a country are doing over time toward meeting them. I think in particular an area we'd love to get your input is exactly which of those metrics we should focus on. We've certainly put thought into it, but we want to bounce ideas off you. Is this about — well I won't get stuck on that one yet. We'll go back to it.

Some other short term objectives are essentially to maximize the pledge program. Number two is about using the pledge program to really up the proportion of Americans that have easy access to their information electronically and potentially setting a number and saying, I mean, ultimately what we would love to do is align with President Obama's goal, he said that in 2014 he wants all health information, every American to have an EHR. That would be terrific. We would also like every American to be able to access their health information electronically. Whether that's totally feasible exactly in 2014 or not, I'm not sure, but depending on various forces, including hopefully our pledge program but also HIPAA mods and other factors at play certainly meaningful use is a big driver in this space, and that may be possible as well. The third point here is more about education and encouraging these data holders to make it very clear to all of their patients that they have a right to access their health information. So again I was thinking about ways that we could really push that forward.

The fourth point also involves consumer outreach and education, and really drives toward our inserting some of the messaging and work that we've been doing, which I can get into a bit a little bit later, into existing outreach campaigns rather than just trying to roll out our own. So for example we recently submitted a lot of materials to the Dr. Oz show. We want to use that. We want to use the Care About Your Care campaign through Robert Wood Johnson Foundation, which Farzad has participated in, and other vehicles, whether in the government like AHRQ or some of these private sector forces, to integrate these ideas related to access to information and use of health information within broader campaigns that are about health more generally.

The last points are about, number five is really about increasing transparency about which providers make health information easily accessible to individuals. What we would really like to do here is be able to take data about who has attested to meaningful use and make that public. So that if an individual is seeking a new provider, he or she would be able to go to whatever resource they would go to anyway, maybe it's *US News and World Report*, maybe it's Yelp, maybe it's through their provider directory, and see, as they choose a doctor or a provider, whether or not this is a service they provide.

Then the last one, as I think you heard about, we released this model privacy notice for PHRs so that individuals can comparison shop among several ones. And we want to make it really an industry standard that anyone that offers a PHR will comply, will basically use this tool and we're also thinking about developing a tool that will help people easily make a comparison among several products, rather than having to go to different Web sites.

Those are a number of short term objectives and we'd love to take a second and get your feedback, thoughts. In particular we'd love some help, as I mentioned, on thinking about the metrics for success and whether we should be looking for examples about how many people have access to their health information, or how many people are actually downloading it, or whether there are differences in health outcomes or what. Yes, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So in Stage 2 we went from offer and provide, which is ... thing into 10% access. That doesn't mean have a code, they literally have logged in. And that may be a good, because, like you said, there's a sequence of events that has to happen, you have to make them even aware of it, those are the benefits of it, and so on and so forth all the way down to authentication and then motivation for them to access it. In a sense it demonstrates an activated patient of some sort. That's one of the things that we use.

Another thing we talked about is just the whole reaching out in the outreach campaign. ..., I don't know maybe a decade ago, had this campaign called "Got EHR?" and in a sense that might have been the clearest quality metric you could ask a physician, because at that time of course it was all on their own dollars they had to go do it, so they clearly believed in something. In a sense it's along the line of your being pleased. It really does prove something I think to the consumer.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes. Any other comments? Joe?

Joe Francis – VA
This is not so much a comment but maybe an offer for some assistance off line. Again, we, for several years, have been deploying a personal health record called My Health eVet, which now is also deploying and integrated with secure messaging. But we realized about a year ago that there was a lot about this that we didn't understand. We didn't understand what were the things that made users use it. We also didn't understand what indeed should be our metrics for the use of this, so we actually funded, through our research program, an implementation study of this, it's a partnership between our research community and our IT op and informatics operations, and I can connect you with that off line, Tom Houston, who's at the University of Massachusetts in Worcester, and also a VA physician is engaged in that. But I would say that the need for this kind of research particularly implementation research and evaluative oriented research rather than new knowledge discovery, is critical here.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
That would be very helpful. I should add, as you may be aware we're pretty well connected with, for instance, Peter Levin and others at the VA, but there's obviously a wealth of knowledge residing in several different VA minds, and I hadn't heard about that particular work. We've asked them about the metrics question and I know that they're toying with some of these same issues too.

Joe Francis – VA
And maybe because we're operating really at the level of the weeds, right at the provider patient interface, which is where the rubber meets the road.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes, great. We'll take you up on that. I think we're going to keep moving. Oh, I'm sorry. Gayle?

Gayle Harrell – Florida – House of Representatives
I just wanted to make one more comment. I think as you look at your outreach you have to realize that there are stratified levels and a lot of it's age related as to how you reach out to people. And certainly our Medicare population is perhaps not as technologically savvy, at least in the upper ends of it, as our general MP3 players. So you have to have things that are age related to that, but I think the whole outreach to that population is extremely important in order to really make them comfortable with it. Because a lot of them don't tend to be particularly comfortable with technology to start with and they have major privacy and security concerns in addition. So as you develop your strategy for reaching out to them and pulling them in and first educating them, because a lot of them don't even know about this, and secondly, a lot of them have basic fears about anything of this sort, so it's going to be a major challenge in order to do that and you need to look at the various strategies for different ages.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
That brings up a lot of interesting points, Gayle, and I am going to move ahead. I'm going to switch the order of my own slides to respond to what you're saying a little bit. We have developed a number of basic materials on HealthIT.gov right now about what health information technology is, what eHealth tools even more broadly are, what the benefits of these things are, what some of the privacy and security issues are, those kinds of things. But we definitely recognize the need to go deeper in what we've done and also to stratify somewhat. We've had some debates among ourselves about whether it's best to stratify necessarily by age or by health engagement level, for example, which isn't necessarily pegged toward age. You have some people who are very active in their health and healthcare who may be in their 80s and other people who are not so involved who are in their 20s, even though they may be tech savvy. So there are a lot of different ways to place these issues. I did want to make you aware of a couple of interesting new projects that we've just started. There are two things related to online media. One is we're going to be issuing a series of video contests, crowd sourced video contests, to the public, which is going to ask them to give their own short clips, a minute, a couple of minutes at the most, talking about information technology and how they've used tools or information to engage more fully in their care. We're going to run 50 different little contests, probably released in clumps, not individually, but the idea of having so many is not only that we can have many winners, but we can really stratify the categories of folks who can participate. So, for example, we could have had a category for people over 60, or something like that, or under 20, however, you want to – see, I knew no matter what age I gave someone

would giggle somewhere. But the idea is we'll be able to reach populations, again, not stratified necessarily by age but by other kinds of considerations too, like health status. Maybe you want to particularly reach out to folks who are managing diabetes and then you can take the winning entries and really use those as advertising for those groups. So that's one tool we have.

We also have just launched some work on putting together an animation related to health information technology. And here's one of the things that we're struggling with, the messaging piece of that, there are a lot of different ways we can take this, particularly the animation, because I think the videos are allowing individual people to tell their stories and what worked for them, and hopefully inspire others, which builds, by the way, on some individual stories that we already have on our Web site. But the animation allows us to go deeper, I suppose. There's a diagram here of a bunch of different options. We could just drive toward awareness, help people understand what health information technology is, and why it's preferable in many ways to the status quo, or we could move to something that has more of a concrete ask, like that next second sort of square over is about asking people, and this goals back to this goal around transparency, like go choose a provider who uses health information technology, or ask your provider why he or she, if they do, and if not when are they planning to. So that might be another ask.

Yet another ask, which you could argue is further down the line and more sophisticated, is get a copy of your own health information electronically, have a look at it, and do something specific with it. Check to see if there are errors. Maybe just check your meds list, see if it's right. Another approach that we could take if we decided, for whatever reason, that we weren't ready to go with any of those approaches or something like that, would be to give a more general message about eHealth tools and how there are a lot of things that you can already do. You can obviously search for information, you can use a Fitbit to monitor your activity, all those kinds of things.

Do you guys have any thoughts? I think a few years ago, if people had looked at this array they would have said there's no way you can ask people to go and get a copy of their record, because many people don't have the technical capability to do that right now, for example. But the environment is shifting, thanks in part to meaningful use. Where do you guys think we should focus and in particular the messaging of the animation, do you have any thoughts on where we should follow along this continuum? Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A couple of things. One, when we worked with our patient portal back in 2000 we were in a beta test and we had a list of providers who were using the patient portal and who weren't. We literally had people asking, oh my provider's not on the list, can I change, literally that persuasive. That's point one. Now I forgot my second point, so go ahead and react.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
I think that's right. I was just going to say I've seen data that 60% of people, whether a provider had, I believe it's whether they have health IT not whether they could directly access their own records, but that would be a factor in their choosing a provider, if they knew that information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that could be very potent, actually, just to have some kind of emblem. Maybe meaningful use comes up with a logo and people can voluntarily choose to use it. I think it would make a real difference if, not even with the patient, their children may think it makes a real difference. There's all kinds of fallout from that.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Any other thoughts on this one? Joe, oh, and I'm sorry, Christine?

Christine Bechtel – National Partnership for Women & Families – VP
We'll let Joe go first.

Joe Francis – VA
One thought is that I think if you structure this around the concept of information or access to information it might not be nearly as jazzy for the average user, particularly a younger, healthier user. It is structured more around the kind of actions and the cool things that you can possibly do. I think we care a lot about health information because that's our field, but really it's the outcomes and the actions. I think the main reason veterans use My Health eVet is not because they have access to the health information or Blue Button, but it's more because they can get their medicines refilled. They go online, they click a button, and something happens and they don't have to wait in line or go through a call system that may take more time. We want to offer to them appointment scheduling and other types of things, so that's why I think it may need something to be fleshed out and then you can get into the concept going to the previous presentation from your group, is what sort of mobile apps might be out there, very focused information technology, that does something very well, can be done on a thin client, on our iPhone, and that connection I think can be very positive.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Let me just ask a follow up question. There were a couple of things that you said, and I'm wondering what your experience has been at VA. Is it that patients care about this because some of the convenience parts of it, so getting prescriptions refilled, appointment reminders, etc. Have you seen much, and maybe this is a question for the folks who have done this research, but do you know, is there data about folks, about veterans caring about having access to your information or using PHRs or I guess the providers have an EHR, because of their ability to be more engaged or because of safety issues or quality of care issues, or is that too far afield for most folks and it's not really a motivator?

Joe Francis – VA
I think there is data, but I don't have it in front of me and I'm going to have to connect you. I think a lot of it is a combination of some numbers but also a lot of stories, so it's really mixed qualitative and quantitative. We do have focus groups. We have a lot of engagement with the veteran consumer, and also with the providers at the other end. I can see it every night from my wife, who still is a full time PCP and actually is doing secure messaging with one of her patients who's deployed overseas. So those kinds of opportunities I think speak to the value. The amount of use, even in our system, I mean, we have eight million enrolled veterans and I think probably the number of regular users right now is somewhere around 100,000 to 150,000. So you don't see the system performance measures push yet, but boy we think we're getting to an inflection point where some of the numeric performance may actually change.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Christine and Neil? And then I just want to ask one more question which you guys are uniquely qualified to answer, I think.

Christine Bechtel – National Partnership for Women & Families – VP
A short answer to Jodi's questions, we do have data and you guys are actually going to get briefed on it at the end of the month because this is the survey that we keep saying we're going to release and we don't release it because the deeper we dig the richer the data gets. But in a nutshell we have some really good numbers that basically say it is a factor, online access is a factor, and your choice of provider in staying with the provider and that these consumers, their support for a provider who uses an EHR generally is much more strong because they have online access. The kicker, though, and the caveat is it depends what kind of online access they have. And what we heard, because we did an open-ended narrative response, was, I only can get lab results, or I don't have the ability to correct my record online. A lot of support is really driven by how robust the online access is in the functionality of it.

But with respect to the boxes here, I think it depends who the messenger is. I think these are all terrifically valid messages. I think the issue is who's delivering them. So if I think about the first box about getting an upgrade, it would be brilliant if through the RECs and the general meaningful use community every provider had a brochure that was like an under construction brochure, I'm getting an upgrade and here's what's happening. Because what we know is that physicians are enormously trusted messengers, and that would be a brilliant channel. I think consumer groups and actually employers are

brilliant messengers for the second two boxes and the third probably depends a lot on the segmentation of the audience that we would be trying to reach. I guess I just wanted you to encourage you to think broadly about how you deploy all of these messages, but through different channels, because I don't think the "Got Milk?" campaign is going to work, in part because it is still early enough that it ends up creating demand for something that doesn't exist. I don't mean the message "Got Milk?" I mean the distribution of here Super Bowl ads and all those, it's not so much, but where it's targeted and focused through the right channels I think it makes a lot of sense. Then the last thing I wanted to say is just to commend you guys for the terrific thinking that has gone into this, how open you've been and how engaging with the consumer community and open to our input with our consumer colleagues. The leadership that you, Lygeia, and of course you, Jodi, have provided has been terrific on this, so we really appreciate seeing the evolution in your thinking.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Thank you, Christine. I just want to say you personally have been an immense force in this area too, are an immense force. Thank you. Neil, I think was up next.

Neil Calman – Institute for Family Health – President & Cofounder
I would just like to say we do have data too on about 15,000 people that use our patient portal and what their usages are for the different components of it. So I'll be glad to send you that.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
That would be great.

Neil Calman – Institute for Family Health – President & Cofounder
Labs come out as number one, people looking at their lab data, and I think that one of the ways of looking at this in terms of your video contest would be to segment it by the functional areas so that we end up with videos that basically show how critical it is to be able to make appointments online. There's a great video that I saw at our user group meeting of somebody who's trying to make an appointment for obviously a sexually transmitted disease while they're calling their provider from work in a cubicle, and you basically see and then the little thing that comes up and says if you could book your appointment online or whatever you wouldn't be sitting there in this cubicle trying to say you know I have a rash down there and have the provider talk to you over the telephone. But I think those kinds of things and allowing consumers to be able to generate that kind of stuff is going to be really powerful, and I'll bet you get some absolutely incredible testimonials from there. I think we should call this putting the "me" in meaningful use.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
I love that.

Neil Calman – Institute for Family Health – President & Cofounder
I'm just putting it out there for –

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
That's great.

Neil Calman – Institute for Family Health – President & Cofounder
The last thing I'll say is I think of all the things that we're doing and this is by far the most critical because otherwise we're just going to end up with systems that sit in our office and I think the work that you guys are doing on this is fantastic. I didn't really know that you were doing all of this stuff, but it's amazing. Whatever we can contribute we'd be glad to.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Thanks, Neil. Gayle?

Gayle Harrell – Florida – House of Representatives
I just want to first say how important, I want to echo what Neil just said. I can't tell you how important this is. If we really want to be successful you have to have consumer engagement. That is absolutely key to making the entire system work. If you want better outcomes, if you want to improve population health, every goal that we have when you enumerate things has to do with being patient-centric. And to be patient-centric you have to have patient engagement, and I think Neil's going to win the first contest here, which is an STD ad. ... this, as you move forward I think you have to realize that you have to gear the message to the individual patient and patients are in different places on the whole thing. So you have to have a broad approach and if your contest is just going to be held on line, a lot of people aren't online. People in Florida, when you look at Florida's population and who consumes healthcare in Florida, 65% of hospital admissions are 65 or over. So you have a senior population and you have to gear your message to your population that are the consumers of healthcare if you really want the big bang for your buck. So you want to balance that out. It's cool to go and do all these terrific online kind of stuff, but you need to educate the population to help move them in the direction we hope that they will go.

And the next thing I want to say is it's a push-pull. All advertising, all marketing is a push-pull. You have to get have your provider there engaged in that whole process and he or she is the best educator out there, encourager, but you also have to have the other side on the consumer side asking the physician you know I would really like to access my health records, do you have a portal? So it's a push-pull. You have to do it on both sides of that as you move forward and devise your entire strategy with all the different components, and I want to say good luck to you. I think it's fantastic.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Thank you. We want to just beg your patience for a moment to ask you one more question, which is about the frontier. One of the things that we wanted to do is put irons into the fire for the future and think about issues that we think are going to be important from a policy and other perspectives, technical perspectives, etc., going down the line. And this is great following the presentation on Stage 3 of Meaningful Use. Here are some areas we've identified that we think are really important that we're trying to understand better, just get a snapshot overview of how do we make sense of this and are there things we should be doing to encourage them. I just want to familiarize you with this list and ask you is this the right list, are there things that are missing from this list, would you prioritize it differently?

The first one on there is essentially it connects very nicely to what Paula was saying earlier in the presentation about the integration of all this patient generated data, whether it's from a monitor or handwritten from a PHR, typed in or whatever, into the clinical care process. What are the policy and technical barriers to that and then what do we need to be doing to support that integration. That's step one, and that's actually the first one that we're actually biting off. These other three we haven't yet done but we're thinking about doing.

The next point is about the fact that social media is totally exploding, everybody's using Facebook and Twitter and everything else, and already sharing health information on it. Are there things we need to be doing, either to look at privacy issues or other issues to enable support, control, I don't know, affect that process in some way.

W
Guard rails, or guidance on how to use social media for health information.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes. Either it could be in the form of guidance for consumers or it could be working with providers of these services to talk about their privacy practices, for example, or their transparency. The third issue here is about enabling proxy access to personal data. This is not just about enabling your daughter or son or mother or father or spouse, whatever, to access your information on your behalf electronically. It might also be about you giving access to a third party, someone outside, a service, a company, a healthcare coach or a navigator, somebody who's going to help you navigate the system. We want to just look at whether any of our policies, HHS wide are in any way potentially road blocks in that area and see where we can encourage it.

Then the last point is pretty broad. It's about this issue of we focus so much on enabling access to clinical information and one's own personal information, but how can we think about integrating that with contextual data for consumers about the costs of their care and the likely outcomes of their quality data that's associated with that. So, Larry, it looks like you have some input.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'll go back to some of your earlier comments, this is about health, not healthcare.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So as you look at this broadly people have a lot of interest in their own health, and they do a lot of things to take care of themselves that may or may not touch the healthcare system, if you will. So the obvious things, I just want to mention, fit this. The obvious things are all consumer technology that's showing up for tracking my personal sports performance. The latest devices you don't have to have a gizmo in your shoe anymore, it's a pedometer that figures the stuff out, ties into heart rate monitor, may be tied into the bike you're riding, ties into your home scale, ties into your computer, and you can start to get all kinds of very cool graphs about your performance. Maybe it's a 1% niche that's actually interested in tracking that data, that's looking to hack their own lives, but I guess I would say look for those examples of where people are. In fact, looking to provide their own health, support their own health may be outside the usual stakeholders, if you will, of those of us who do it for a profession. So it really sort of broadens around that.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Okay, other thoughts? Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you're on precisely the right track. We have two-thirds of our patients are online with us; one-third of them are logging in on any given month, and the most popular, like Neil was saying, is lab. That was something we owed them. We just weren't really good at getting back. They have a vested interest. The second one is secure messaging with providers. So that's the getting a much better, much more continuous, much more convenient access to their professional source of information and you're going into the third area, which is the data outside of the trivial amount of time we spend in the office. So that is the patient generated data, whether that's home monitoring, that could be for glucose and diabetes or weights in heart failure patients, etc., the other kinds of physiologic and symptoms that come from other than the office. I think you're on the right set.

The next one that we're looking at is we already have proxy access, and that turns out to be really important at both extremes of the age continuum. The social media, I think they want social support, and we're struggling with how to provide that in a safe way because there are plenty of ways to connect. How can you do it in a safe and essentially an accountable way? They don't need to know who the other person is, but they want to know that somebody else does know who. So that it's a much safer environment. But I think you're really on the right track with these things, and probably your first one is one of the ones that's the high priority for our organization, and I think we've already identified it in meaningful use as something to look at for Stage 3.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Okay. Christine, I think was first and then we'll move to Joe.

Christine Bechtel – National Partnership for Women & Families – VP
I agree, these are some terrific areas. I would suggest three things, two of which are areas, one of which is sort of a process. The two areas are, and I have to tell you I have heartburn thinking about making these long term objectives, so I'll preface it by saying –

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
It's all relevant.

Christine Bechtel – National Partnership for Women & Families – VP
But one is understanding information. One of my concerns is that we are hoping, through Meaningful Use, on the pledge program to really unlock a lot of information. But it's not enough to just go here's a data dump. We need to contextualize it. We need to help people interpret it. We need to pair it with the kind of information prescriptions that I know Josh used to work on and things like that, shared decision making tools, things that are going to really help people use it. I think that's inherent in your big picture that you talked about earlier, about making it usable, but it's not just through sort of Mobile Health 2.0 .... I'm just thinking about the care process, and when I think about the proposed rule that would allow people to directly access their lab results, that's a perfect example of where it's not going to be enough just to say here's the information, here's the data. I've got to figure out what to do with it. That needs to happen in a way that builds a strong partnership with the care team.

The second area is patient activation so there's a big theme appropriately in your slides around empowerment and enabling me to improve my own health. I think there's a paradigm shift happening right now away from the let me tell you why you need to get off the coach approach, which absolutely may be true but doesn't work to activation, and developing the belief for me that I can change and then developing the skills and the ability and it's really this recognition that knowledge alone isn't enough.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
I think technology could actually help a lot in facilitating the self-efficacy approach that needs to happen to get patients activated, because information is only going to do it for maybe 20% of the population.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes, a totally great point. A lot of it is community and that kind of thing.

Christine Bechtel – National Partnership for Women & Families – VP
Exactly. The third thing that I would say is not really an area, but it is a process. I think as I sit back and think about your approach that you've described today and with us before, we need to understand the impact of meaningful use from a patient's viewpoint. We need to understand the impact of the pledge program, of all the changes in the privacy policies that are happening now and of the impact of the ONC consumer education program. We need to see what's going on and I think that will actually point us in some new directions for the longer term. So I want to offer our help and I think there are a lot of organizations who are willing to help through surveying and focus groups and lots of ways to build the feedback loops to patients and to understand are we delivering value through these mechanisms and where do we deliver the most and the least value so that we can really refine and target. And I think there are a lot of us in the VA I'm sure too who could really help with that. But I think it's something that we need to establish a robust, ongoing monitoring strategy for.

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes, thank you for your help with that. Joe?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can we make this really short?

Lygeia Ricciardi – ONC – Head of Consumer eHealth Program
Yes.

Joe Francis – VA
Mine was going to be very short. Just two areas of specificity, under patient generated data there's a huge gap in patient reported outcomes and patient centered quality metrics, so it's not just heart monitors or physiologic measurements, but just getting people to validate physical and emotional symptoms, particularly in certain chronic disease states. And then under social media for some specificity peer to peer is very important. We've had a tradition of doing that in the realms of PTSD in mental health, where veterans help other veterans get through some of the emotional concomitants of their past combat experience. We're finding it works for diabetes almost as well, if not better, and can be part of that activation piece that Christine mentioned.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you very much. Obviously everybody is very interested in this subject. It's extraordinarily important. It's all about the patients. It's all about individuals. So thank you so much for engaging in this. We'll be totally supportive .... Thank you.

At this point we'll go to public comment, please.

Mary Jo Deering – ONC – Senior Policy Advisor
Operator, would you open the lines and give instructions for offering public comment? And if anyone is in the room would you please come forward to the table and identify yourself?

Operator
(Instructions given.) We have one public comment from Carol Bickford.

Carol Bickford – ANA – Senior Policy Fellow
Carol Bickford from the American Nurses Association. I was very impressed with the presentation by the last two presenters and would invite outreach to the organizations who have set up for the pledge to bring them up to date on what resources are available. Our expectation when we signed on was to serve as a further distribution mechanism for some of the materials that ONC has generated, and that connection would be very helpful. Please let us know who we need to speak to. Thank you.

Lygeia Ricciardi - ONC
... for reiterating that. As a pledging organization you should be receiving some outreach very shortly with a survey getting your input, and also talking about some upcoming Webinars.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, no further questions? Thank you, everyone for another productive meeting, a rich discussion and rich information, and we will see you in December.

Public Comment Received During the Meeting

1. One of the committee members mentioned a crosswalk available on ONC's website that compares ACO measures to MU measures. Would you be able to provide a link or pathway? I cannot find it, Thank you. I was hoping there would be something more recent now that ACO rule it out.

2. One of the emphasis I see for stage 3 rule is "Emerging Sources of Data" , what is the thought of capturing specialty data like Electrophysiciology(Cardiology group) , and link into EHR. I am a patient with implanted device, I have seen my complete interrogated device data is not saved to my medical record in EHR and used later. Do you have any thought on some recommendations in stage to attach such data at EMR level in structured manner, and some thought on specialty Information Management System (like Cardiology clinical Information Management System).