

HIT Policy Committee
Final Transcript
February 2, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the 20th meeting of the HIT Policy Committee. This is a Federal Advisory Committee, so there will be opportunity at the end of the meeting for the public to make comment and a summary and a transcript of the meeting will be available on the ONC Website. Just a reminder for committee members to identify yourselves when speaking.

Let's go around the table and introduce those at the table, beginning on my left.

Jodi Daniel – ONC – Director Office of Policy & Research

Jodi Daniel, ONC.

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

Adam Clark, FasterCures.

W

... Department of Veterans Affairs.

Christine Bechtel – National Partnership for Women & Families – VP

Christine Bechtel, National Partnership for Women and Families.

Judy Faulkner – Epic Systems – Founder

Judy Faulkner, Epic.

Paul Egerman – Software Entrepreneur

Paul Egerman, Software Entrepreneur.

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

Paul Tang, Palo Alto Medical Foundation.

David Blumenthal – Department of HHS – National Coordinator for Health IT

David Blumenthal, Office of the National Coordinator.

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

David Lansky, Pacific Business Group on Health.

Deven McGraw – Center for Democracy & Technology – Director

Deven McGraw, the Center for Democracy and Technology.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Larry Wolf for Rick Chapman, Kindred Healthcare.

Gayle Harrell – Florida – Former State Legislator

Gayle Harrell, State Representative, Florida.

Marc Probst – Intermountain Healthcare – CIO

Marc Probst with Intermountain Healthcare.

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

Art Davidson, Denver Public Health, Denver Health.

Charles Kennedy – WellPoint – VP for Health IT

Charles Kennedy, WellPoint.

Jim Borland – SSA – Special Advisor for Health IT, Office of the Commissioner

Jim Borland, Social Security Administration.

Connie Delaney – University of Minnesota School of Nursing – Dean

Connie Delaney, University of Minnesota.

Judy Sparrow – Office of the National Coordinator – Executive Director

On the phone I believe we have Neil Calman. Neil, are you there?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I am. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Scott White?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director

Yes, I am. Good morning.

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning. Anybody else on the telephone? Okay. With that, I'll turn it over to Dr. Blumenthal.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Good morning. Thank you to everyone who braved the elements to get here or maybe if you're here it means you didn't have to brave the elements. It's always an adventure to try to get these Policy Committee meetings together and all of our working groups together, but usually everyone seems to find a way.

We are going to get a bunch of updates today and Paul will go over the agenda in more detail. Those reports will continue to show the progress we're making on the many issues that remain before us. I feel as though we are in a stage of planning for important next steps without quite the urgency that we had a year and a half ago to get meaningful use and standards and certification systems up and running and with that behind us, we are now experiencing meaningful use, experiencing standards. So we will be hearing from the Implementation Workgroup with very important feedback. We are trying to lay the framework for meaningful use stage two and for everything that comes with it. We are working hard on interoperability and the technical and policy basis for that.

Later on today, I will be leaving here early to go back to an event at the Department where we will be announcing the initiation of exchange using the Nationwide Health Information Direct option. It's now operational in two sites and will shortly be operational in five or six other sites. So that's an important addition to the armamentarium of exchange opportunities, part of the escalator for exchange interoperability, which is a sub-part of the overall escalator for meaningful use. We've got escalators upon escalators here. That, of course, has been developed with this very open, collective, communal, voluntary process of joint software development and informed by our tiger team, Deven and Paul and their work, closely integrated so that we could be sure that the direct solution was compatible with our policies on privacy and security for that particular case of exchange.

I think we're in something of a lull before another storm, but we should use that lull carefully to prepare for the tough decisions that will be coming. We are still, I think, accepting comments on the committee's ideas for stage two of meaningful use. We've already received, as you will hear later, many comments about the PCAST Report, so much work goes on in the background.

With that, one other thing I wanted to share with you: Over 14,000 providers have registered for meaningful use, so it's very much a reality here in early February, just a month into the opening of the registration process.

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

Thank you, Dr. Blumenthal. I think I'd like to take this opportunity in our 20th meeting and about two years into this journey to acknowledge the absolutely tremendous effort and leadership that you've shown in directing this country through all of this. You and the staff have just done a terrific job. Three years ago, no one imagined we would be even contemplating what we're doing, let alone accomplishing it. Really, the nation owes you a debt of gratitude, so I really want to thank you for that.

To the many volunteers, not only on the committees and the workgroups and the rest of the country who submit comments, we're going to hear from a number of workgroups. We haven't met for about six weeks on this continuing agenda. I don't know what you mean by a lull. So we'll open up with the Quality Measures Workgroup. They've been hard at work and they'll be summarizing their comments and looking at many of the good concepts and quality measures that are really going to be part of the persistent legacy from all of this work. We'll go on to hear a summary of the hearing on the implementation where we heard from a number of groups as they embark on this journey. After lunch we'll hear from the Privacy & Security Tiger Team talking about the patient matching, another extraordinarily important topic in terms of getting information not only within one record, but exchanging them throughout the whole system. The Information Exchange Workgroup will also give us an update and finally, the beginnings of the work on the PCAST Report and how this group, what kinds of comments and recommendations can come out of this based on the PCAST Report. We'll conclude with public comments, as we always do.

I need to do one thing, which is to approve the minutes. I did notice a couple of things, which I submitted to Judy, one of which is the MU Workgroup talked about the thresholds of stage two as being something between stage one and stage three.

Any other corrections or comments about the minutes? If not, I'll entertain a motion.

W

I move we adopt the minutes.

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

Okay. Thank you. Any opposed? Any abstentions? Thank you. I'll turn it back over to Dr. Blumenthal.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I would like to encourage or ask David Lansky if he would take over and lead us through this discussion.

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

I don't know that I'll take over, but—

David Blumenthal – Department of HHS – National Coordinator for Health IT

I can stay here. That's fine. Yes. Thank you.

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

Good morning, everyone. Thank you, Dr. Blumenthal, Paul, Judy. So this section of our agenda, I want to report to you on the process we've been going through on the Quality Measures Workgroup, in particular, the response we received to the public solicitation for input about the kinds of quality measures that might be needed for stages two and three.

Just to refresh your memories: We've essentially been operating on a parallel path with the Meaningful Use Workgroup, which, as David just said, released its Request for Comment concurrently. Our Request for Comment concluded a couple of weeks ago and the staff worked really heroically. I just want to thank them very specifically for the amount of time and work they put in in a very fast track to try to condense

what ended up being more than 1,000 proposed measures into something that we could have a reasonable conversation about here today. They really did a great deal of work and I'll try to synthesize that. As you'll see, 1,000 got compressed down to a couple of handfuls so that we could try to have that conversation. So I'll review what we think we received from the public comment and the process we have in mind to go forward.

The ONC wants to work very quickly, in the next month or so, to put into the development pipeline or the refinement pipeline, perhaps, some of the best suggestions that came out of this public comment process. So I think the urgency of our discussion today is to give them some feedback as to whether this looks like the right path so that they can put in motion the processes. Which will get us to usable, clinical quality measures consistent with the direction we've given them by the end of this year in order to be part of the stage two process. So I think our purpose today is both to review the public input, but really to get your comments. As to whether this feels like we're on the right path or any redirection you want to suggest to the staff and the committees over the next few weeks so that they can put the rest of the work into motion for our use and the use of the program as a whole.

I think there are a few kinds of contextual things just to keep in mind as we go through this. We were asked, as a workgroup, to stretch the program a little bit, to go outside of the existing battery of measures that are relatively familiar, some of which are being retooled for e-health applications, but to really take some of the domains that we defined meaningful use around two years ago. Including patient engagement, efficiency, patient safety, care coordination, where many of us felt there weren't adequate measures currently in use to really get the best benefit of health IT as it becomes implemented. To take those domains that were a little bit under populated and to see if we could very rapidly, within a year or 18 months, put some measures into the field that would help shape the successful applications of health IT.

Given that it's somewhat untilled soil, the question is can we find seedlings that are ready enough to be put in the ground and flower by the end of this year. I'll stop the metaphor there, Gayle.

Gayle Harrell – Florida – Former State Legislator

....

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

And not have the storm blow them over. Thank you. Yes. So given that context, part of the sort of circular challenge we have is that many of these directions we all want to go in will stress where the existing health IT products have been. For example, some of these call for longitudinal measures, multiple snapshots of data over time. Some of them call for multiple sources of data, for example, how do we combine claims data with EHR data to get at, say, readmissions. Some of them require data from the patient and family, as well as data from the clinical setting. How do we capture that data? How do we combine it with the EHR data? So the more we go into these domains, like care coordination and patient engagement, the more we stress the existing IT product portfolio. We, as a Policy Committee, need to give some thought to what's a reasonable set of stress tests in the short time frame this program is operating under. I'll ask you to think about that as we go through the suggestions that have come forward.

I do think these really are policy issues. I think we've now heard from the measurement community what they think is desirable and feasible. Our job now is to put some boundaries around what is important from a policy point of view. Let me go through the material we received and then we'll try to take a few minutes on each of the major domains and get your reactions to where we should go.

The RFC was put out, the Request for Comment, was put out in December. We, I think, gave people about a month to respond. As you see, we had 134 respondents, of which, 112 were organizations and 22 were other individuals.

Just in case you can't read all of the small print on this slide—if you're on the phone, I'm on the Organizations slide, but—this just gives you a flavor for the very wide range of people interested in this process wanting to contribute their expertise to what we're doing. It was really a wonderful, very diverse

and very expert set of respondents ranging from researchers to consumer organizations to state entities and federal agencies, all of whom gave us just great input. Here is a little more of this very long list and very wide-ranging participation we had in this solicitation. I think it was a great success from the point of view of getting the kind of input we all want to make this process reflect the broad capabilities of the country.

Just to remind you, the criteria that we had used to select measures for stage two and stage three include these: Whether the measures are ready to be deployed in a rapid time frame, whether they are HIT sensitive. We didn't say they had to be dependent or directly produced by an EHR, but they had to reflect the effectiveness of adopting EHRs and the related technologies. We wanted a parsimonious approach, which, for us really meant could we find some measures that touched upon multiple domains of importance so that we didn't have just a big library of measures, but we found an elegant few. That we hopefully would not be creating any additional— We would try to minimize preventable burden of illness by the selection of measures that we target. We would want to put some direction, as Paul has often encouraged us; to measuring outcomes wherever we can.

In that sense, the meaningful use criteria that is now out for comment gets at functional capabilities, at processes that are desirable to the health IT platform. Our challenge in the quality measure side is to see whether it makes a difference in clinical outcome. So wherever possible, we want to tilt in the direction of outcomes and then finally, to begin to capture the longitudinal performance of case across a condition over time. So we're trying to tilt in these directions.

Again, to remind you, there were five domains that we've had tiger teams working very industriously on: Patient and Family Engagement; Appropriateness and Efficiency; Care Coordination; Patient Safety; and Population and Public Health. These are all areas we collected we felt had not been adequately addressed by the previous availability of measures. We received, as I mentioned, more than 1,000 recommended measures. With the help of the staff and a consultant we synthesized that to 491 unique measure concepts, some of which were very highly specified as ready to go measures and some of which were just ideas that were formulated for our consideration. Nonetheless, overall, on the whole we had 491 measures to consider.

On the right of this slide, you also see that we have 113 measures that have previously been around and through our previous discussions. NQF and others are beginning to retool them for e-specifications so that while they may have been collected through chart review or claims data in the past they will be modified to be available through electronic health records. So we now have, in a sense, this larger pool of 491 proposals from the field plus the 113 that have already been in play. As you see there, 79 of those are actually duplicates, 79 of the 113 also appeared in the submissions from the public, so there is some consensus to some degree around those.

Then the draft superset in red on this slide is meant to suggest that our job now and ONC's job is to say what is the next cut out of the 491-plus. What is the next cut that we want to get to of a smallish set, 30, 50, 20, some number of measures, which becomes the pool for serious work over the next year or so? That's starting at 491-plus. We have to somehow get to a tractable 20, 30, 40, some number in that range. That's our discussion today that we'll try to walk you through.

Here is just a summary of the distribution of the 113 retooled measures that are now going to be in play. Again, I'd just remind you; we'll come back to this at the end of our comments this morning; the model for stage one has been that specialists can choose some measures from a menu for their specialty, as well as a core set, which we struggled some to define. That may or may not be the right way to proceed for stages two and three. For the moment we'll assume that that structure remains in place, but it is probably worth another conversation by our group here about whether that's the right way to proceed or what does that menu look like as we begin to populate it with some additional opportunities from this new set. But here is the current availability of measures that will be coming through the retooling process.

Okay. I thought what I might do is just take each of these five areas one-by-one and we'll just take a few minutes on each and get your input if that's okay? Because I think conceptually, there's a lot of material

here and probably trying to pause over each one and digest it is worthwhile. What I'll do is just summarize what we got back in the category of Patient and Family Engagement and I think what we want to sense from you is whether this feels like we're going to capture the key things if we succeed in developing measures as described on these simple slides over this next year. Will that be appropriate and capture the key domains that you're interesting in on a policy level?

Under Patient and Family Engagement, the review process to date has flagged three categories of the most promising measures we may be able to use in stage two and certainly in stage three. First of all, is patient experience of care as measured by something like the CAP Survey or a part of the CAP Survey? We'll come back to that in a minute, but as you know, the existing patient experience surveys that are commonly used have many questions and many item sets and many measures within them. We'll have to contemplate whether that's the full instrument, such as the CAPS instrument, is the right tool to use in the context of meaningful use. We also have to understand that meaningful use, of course, includes both, hospitals and individual physicians. CAPS is not a tool designed for individual physician measurement, so there are some questions to be considered as we look at these different instruments.

There is, in addition, a special supplement, a module of CAPS being refined right now on HIT, the patient's HIT experience with their provider. That is something that surfaced in the review as something we may want to capture for our purposes going forward. So the patient experience of care is one area we think we can bring forward measures for stage two.

Secondary are measurements of functional status and health risk. We've uncovered a lot of great work going on around the country in this area and somewhat similar to the patient experience domain, there are many instruments, many items, many measures. There will be a real task in selecting which ones are most germane for our purposes, but the tools seem to be out there with a lot of consensus from the measurement community.

Thirdly, patient activation and self-management skills: There are, again, a number of instruments well refined and accepted. Our job would be to select within them the components we think are feasible and appropriate for our purposes. So those are three areas we think we can capture for stage two and again, certainly for stage three. There are some important methodology challenges in this space. One is, as I said, we have some large, validated instruments. Whether we pick and choose components from those or apply them to different settings of care, is that still going to be methodologically valid? That's some work that would have to be done in the next year to answer that question and come up with sound answers that we could deploy through meaningful use.

Secondly, the data platform: There are many issues here. I won't try to get into all of them, but there is certainly concern that if you capture patient experience data or patient functioning data in the clinical setting it may not be as unbiased as you'd like when the patient is away from the care provider. There are issues of sampling. Do you sample a whole population of patients or a sample in this? How do you define the sample? Is it only patients who are somehow e-enabled or do you try to capture all patients? Where do you capture this data? Is it on an independent survey system, an e-mail survey platform, which all providers tap into or is it through, somehow, the enterprise itself or the EHR itself? How do you configure the relationship between the EHR, which is the subject of our program, and this potential separate data collection service to get patient data?

As I mentioned, then there's a question of whether you take samples of patients and if so, how do you define that sample and what are the requirements for that sample versus trying to capture a whole population of patients? These are non-trivial questions and part of the work of the year ahead, if we stay on this course, would be to engage some advice and consulting to answer and get the best advice we can on how to handle these questions.

So that's my initial Let's see if Tom or Josh, who have been staffing this, have any other comments on this battery. Let me just pause there and see if there are suggestions, comments, reactions to this part of our findings from the public.

Christine Bechtel – National Partnership for Women & Families – VP

I think this looks good. I'm particularly excited about the promising measures that we've seen in each of the three categories listed at the top. I just think it's worth noting two quick things. One is that shared decision making is a particularly important area and a promising area, but I think it's a gap area that is listed that you will cover a little bit later in the slide. But it's such a key measure of patient and family engagement that I want to find that as something that's important to continue to pursue.

Then secondly is the area of outcomes measures. I think outcomes measures are falling into some of the other categories, but we know that in order to get to improved outcomes in particular conditions where it requires some patient involvement and activity it's going to require patient and family engagement in that sense. I think that needs to include some of the patient reported data around symptoms and tracking weight, height—not height, because hopefully that's not changing on a daily basis, but you get the point. So I think that's another area that I would continue to flag that we think through how to leverage some telemedicine and data exchange capabilities to begin to support that data flow, particularly focusing on stage three. What do we need to do in stage two to support that?

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

Can I just link that back to the question we'll have about specialty profiles? One could imagine that there are symptom or outcome specific assessments associated with each specialty or many specialties or with services within those specialties. As we think about the potential menu of specialty quality measures it is feasible to imagine, for at least some of them, some of the domains you're describing, Christine, appearing on that menu set? the card thing.

(Participants speaking at once)

Josh Seidman – ONC

... just to your point about the shared decision making measures, we probably should have labeled this most promising measures for stage two. What? I'm sorry?

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

Just say who you are.

Josh Seidman – ONC

I'm Josh Seidman from ONC. Certainly there were some measures of decision quality that are very promising, but they're not, in a sense, going to be ready for stage two, so they are certainly things that we would be working on for stage three.

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

Thank you, Josh. Let me go to Adam and then we'll go around.

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

Just a little clarification around the data platform for patient reported measures. Was it brought up or is it being discussed to have this in alignment with NIH's PROMIS Program, the PROMIS and ... FDA's attempt to capture patient reported outcomes in clinical trials?

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

Yes. In fact, those were among the submissions we received and the PROMIS Program in particular has a lot of attention from our workgroup as a methodology or an approach, because it is able to tailor to certain sub-domains. That is when a patient is identified with a particular need or functional limitation the questions can become more specific to that particular issue because we're doing this on the Web. So there is a lot of interest in that approach.

Gayle?

Gayle Harrell – Florida – Former State Legislator

I just wanted to again emphasize how important I think these specialty measures are and encourage you to go down that line and make sure that we do encourage really the broadening of the population of physicians out there, who are going to get involved by including the specialty measures for them. I'm delighted that you're putting this in. I'm looking at the 113 retooled measures. Are these measures that are coming directly from the specialists, who have been presenting those to your group or are you going to be designing around these?

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

Let me explain what I think I know about those and maybe the staff can help me. Originally they were, early on, a year and a half or two years ago, NQF identified from their large inventory of measures that have already been vetted and approved, many of which came from the specialty societies, those which they thought would be suitable for our purposes in meaningful use. They then agreed that they could be retooled from their current specifications to be EHR based, so the source was often the specialty societies for those, but in the previous iteration through the NQF process, but Tom can—

Tom Sang – ONC

Many of those 113 measures are coming from PCPI, AMA, NCQA and many of them come from professional societies themselves.

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

Thank you, Tom. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This may go without saying, but I felt I needed to say it. Since we're looking at new platforms to be collecting this information that providers, who are being assessed by these survey tools actually get some feedback in relatively real-time about how they're doing. So that they don't get an annual report that says, "Oh, you've had a really bad year," but they actually have time during the year to get on top of things and make them better.

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

Other comments about this domain? Any other guidance you want to provide to the staff?

Jim Borland – SSA – Special Advisor for Health IT, Office of the Commissioner

David, if I may? I'm curious about the second bullet. When you talk about functional status are you talking in more general terms, mild, moderate, severe or are you actually looking at specific code sets, like ICF?

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

The proposals we received, actually, some of them were condition specific for asthma, for example, in terms of functioning with asthma. Some of them were generic health status assessments, like the SF-36, SF-12, the PROMIS ... and so on. So I think whether this is done as a cross sectional measure of overall health and functioning or if it's drilled down to condition specific is part of the question we'll have going forward. We've seen both in the submission.

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

... I think what's promising about that, to Gayle's point, is that a lot of Patient and Family Engagement measures can apply across different specialties to the extent that they aren't condition specific. That's one of the things that I like about these kinds of measures.

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

Thank you. All right. Any other comment? Okay.

Next up is the Clinical Appropriateness and Efficiency. The most promising measures that we discussed in our first half were lipid control, but linked to the Framingham Risk Score. That is being able to sort of

titrate the measures against risk classes within an area, so people who may be at a higher need or higher risk for heart disease may get a different type of measure than others. So this idea of segmenting or stratifying the measurement is really kind of a breakthrough from some of the broad level population measures we've had before, making sure that we're using, in this case, lipid statins or other approaches suitable to a particular target population.

The second category here is measures assessing the appropriate use of diagnostic imaging procedures. We've got a lot of measures around imaging and appropriateness of imaging. You see several dimensions of those measures that have been suggested, including not having redundant tests, avoiding excessive cumulative exposure through these tests and whether they're being ordered appropriately, the right test for the right clinical presentation. We have quite a few of those suggested. Then finally, a third category of appropriateness is appropriate medication use, including over use and under use, again, a number of measures there.

Some of the methodology problems or challenges that we will have, certainly an interest in linking claims of administrative data in some of these areas to find out what medication was actually, for example, dispensed or looking at claims data to look at previous imaging studies that might have been ordered against the current imaging order being evaluated. Can we do that kind of linkage realistically? Then secondly, the idea of allocating some of the measures to certain risk groups based on prior data from a risk score, like the Framingham score, would be another challenge that we haven't previously undertaken.

Let me pause on that one and see if people have questions about the adequacy of this list or whether it's capturing the domain that you all have had interest in. Yes, Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think you're raising some interesting questions in terms of these measures that are looking to combine data, beginning to look at some longitudinal issues, because those are clearly important if we want people to make use of the data, make use of the history. Some of this is not just an outcomes problem. It's also a decision process, work flow problem, so if we're looking to see our tests appropriately ordered based on previous claims the person placing the order needs to know that there was a previous order and ideally have access to results. Because without access to results the fact they know there was an order doesn't really help them a lot in making a current decision. So there's a fair amount of under tow to these in terms of the data platform is not just an outcomes reporting platform. It's actually a care delivery platform.

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

Right. That's a great point and it's one that I think actually Dr. Blumenthal made in one of our calls is these measures are intended and have the potential to pull through process redesign if we are holding people, in fact, accountable for not ordering redundant or unnecessary tests. Then they would need to figure out the internal engineering and decision support tools to reduce the chance they will be doing that. So whether we, as a policy body, need to anticipate the solutions to that need or simply measure whether they're succeeding in avoiding the undesirable behavior is a question we have to wrestle with. I think in terms of the Meaningful Use Committee there is a give and take between the functional requirements. I mean if we use some of the outcomes here—

David Blumenthal – Department of HHS – National Coordinator for Health IT

Just a comment and it's something you have heard me comment about in my own experience with radiology order entry as a clinical decision support. I often tell stories about avoidance about myself avoiding duplicate tests because I had a software package, which is now commercially available, which basically screened all of the previous x-rays in a record, high cost images in a record and said if there was something within three months that was a duplicative test alerted me to that. So that was an enormously powerful decision support tool.

Now, I didn't have access to all of the tests that that patient might have had in the greater Boston area or in the United States as a whole or in the world, but I could at least find out if I or one of my immediate colleagues had ordered that test and that's a start. So we have to be careful not to hold ourselves to some ideal standard, which says until there is perfect information exchange, so that everyone knows

everything, we can't begin to think about duplication and inefficiency. Believe me, clinicians don't remember what they have done for their own patients six months earlier or three months earlier. If they're going through paper they easily miss or don't bother to look, so just having an EHR in a single practice that kind of says, "Don't forget, Dr. Jones, you did this three months ago," will at a minimum get them to look for what they did and make sure that what they're adding in is non-duplicative.

For an oncologist this is an especially powerful tool, because oncologists are enormous users of high cost imaging with high radiation exposure routinely ordering CT scans on an every three-month basis or more often and just for them to know what the cumulative radiation exposure is from the tests they're ordering would be a very ... safety addition to records.

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

Charles?

Charles Kennedy – WellPoint – VP for Health IT

Well, as a health plan representative I just wanted to endorse the measures assessing the appropriate use of diagnostic imaging and readmissions and the like. Imagine that, huh? But I'd also like to offer a caution, which is you have the issue down here about incorporation of claims data. Your HIT sensitive measure indicates that there should be evidence that EMRs can incorporate this and when we try to incorporate claim data into EMRs we found almost no vendors who can support that. So on the one hand, great measure; on the other hand, I'm not sure how the methodological issues get resolved.

M

Great point. I would say it sort of hints at a larger challenge we're all going to have, which is third party data integration, whatever you want to call it, ... patient data. We've had some advice that while it's important to capture data from the patient for all of the reasons we've said, it may not be wise for that data to go back into the EHR because of exposure of patient concerns or preferences, except perhaps as aggregate data and even then there would be issues of re-identification. So we're going to have that problem in general. Is there some registry or intermediate layer or HIE where this data gets integrated for the purposes of quality measurement.

M

That's right. I think we'll also find a fair number of technical challenges making those disparate data sets come together. I mean when we've tried to do that we found the same clinical event is represented about four times on average in the data stream when you start combining clinical and claim data, so pretty big challenges in sorting through all of that and getting a clean representation of this is what happened to the patient.

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

Thank you

W

We have had significant experience with measures, quality measures and we're using the electronic health record for several years, actually over a decade. I have to say that from a clinician's perspective having the ... logic or some decision support as a part of the electronic health record has been immensely useful and helpful in determining, as you pointed out, clinicians don't remember what they did six months ago and there's no point. The record actually helps us to get there as to what really needs to be done, not just looking back, but also forward. I think it is a great asset to have. That's how we've been able to track on our diabetics with their A1Cs on who needs it, who needs to have an eye exam, who's had it done, what next steps.

Then more importantly, this has got to be thought of as part of transactional quality from a clinician's perspective. It should not be an add on, but part of the care that we deliver where it is captured and then measured. So I think if those principles are sort of kept in mind I think there's going to be a greater chance of success.

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

Thank you. All right. Any last comments about this domain? I'll say with the caveats all suggested that hopefully you're feeling comfortable with the direction we're going in in each of these and if not, please signal that so we can give the staff that feedback.

The third area is Care Coordination. Here you see the most promising measures that surfaced are adherence to a comprehensive care plan, measures of patient and family experience of care coordination across a care transition in particular, so this is an example of a measure, which may be captured through the methodology we discussed earlier on the Patient and Family Engagement domain.

Thirdly, advanced care planning, measures of advanced care plan as a product of shared decision making. That last caveat may again suggest that part of this involves asking the patient if they were involved and so it's not only the presence of an advanced care plan, but whether the patient felt they were fully engaged in shaping that plan. Then last on this list, composite measure assessing receipt of both care-team members and the patient or caregiver of a comprehensive clinical summary after a transition. So did both the professionals and the patient receive the clinical care summary after a handoff across settings of care?

The methodology issues implied by this roster include that we don't have the interoperability broadly available to allow us to assess care coordination. So just simply finding out did the patient make it to their next stop and what was the quality of that transition is non-trivial right now. We do send EHRs in their own silo, so to speak. Secondly, how do we verify that care coordination has occurred? We don't have a closing the loop function really enabled today.

Thirdly, how do we standardize a longitudinal record or action plan? So even though we may contemplate the importance of such a plan we don't have a standard for it or a way of documenting or assessing whether it's in place. Then what are the specific elements of it is part of the same standard. So there is some pretty deep methodology work to be done here to identify what exactly do we mean by a care plan. What are its specifications? How is it accessed? How is data linked across multiple settings or multiple EHRs to confirm that the loop of a patient transition has been closed? Then how do we assess that transition? This may be in some ways a more challenging area than others because of the interdependence of the components of our system.

Now let me ask you for feedback on this on, whether you think this captures the right domains or other suggestions you have for us. Adam?

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

I guess in looking at standardizing plans and defining specific elements, I guess my concern; I have little concerns with that. There is going to be multiple plans and I don't necessarily know that that would be a bad thing. I do worry a little bit about saying this is what X plan should look like.

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

Yes. I understand. I think that's a very good point. I think probably what we're getting at here is having the structure standardized enough to assess whether it's been conformed with, not that the content would be the same. I'll look at my colleagues and see if they have more clarification on that. Josh ...?

Josh Seidman – ONC

We also have been having similar discussions in the Meaningful Use Workgroup and, Paul, you may want to comment as well. But clearly there is this balancing between trying to ensure that the comprehensive care plans and the other kinds of care plans that are being discussed are meaningful for all parties involved, but also trying to leave enough flexibility to allow for innovation and not to be overly prescriptive.

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

Marc?

Marc Probst – Intermountain Healthcare – CIO

First of all, thank you for doing this. This is a very good discussion and the work that's been done is obvious. I mean it's really good. On a care transition is that well defined somewhere? Because I'm a little concerned there's a fairly broad definition of a care transition.

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

Right. My memory of the hundreds of submissions we had, there were a number of different definitions or characterizations and maybe not even definitions of care transition. I think that's an important challenge we would have to take up or narrow the scope of just a couple of transitions that are common and potentially risky. Any further ... on that?

Tom Sang – ONC

The definition of transition itself wasn't really defined by the commenters, but I think they're really pointing towards a lot of the work that's been done by Eric Cowman and parallels some of the work that CMS is thinking about in terms of the readmissions work and the care transitions work there.

Marc Probst – Intermountain Healthcare – CIO

Yes. I just think we're going to have to get clear on what that actual definition is.

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

Yes.

Tom Sang – ONC

Yes.

David Blumenthal – Department of HHS – National Coordinator for Health IT

It strikes me that part of the work of meaningful use will always be in the next stage to understanding where we want to get to on the next step on the escalator, so there may be 50 kinds of transitions. It doesn't mean we have to apply this measure to all 50.

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

Other comments about this care coordination? Judy?

Judy Faulkner – Epic Systems – Founder

Just a little thought about what's going ... so far, which is seeing this as a totally different thing to accomplish if you're a large healthcare organization than if you are a series of small organizations that have to work among and between each other to make this happen. It's not too hard to imagine it working reasonably well in a large, coordinated healthcare organization. It becomes challenging to figure out how in the world to make it work when you have, as in some areas of the country, a lot of healthcare provided by a lot of very small groups, who somehow have to coordinate together. So that gets us into interoperability and I wonder if there was any thought given to how that would happen. Is interoperability just going to be something they have to think through themselves and work through or is interoperability going to be something that is going to be facilitated somehow so maybe definitions are set up? I don't know. How do you get to that next step?

David Blumenthal – Department of HHS – National Coordinator for Health IT

Well, one of the reasons I started this meeting by talking about what I'm doing at noon is that we are working hard to get the simplest, most practical, sort of irreducible level of workable interoperability available as an option. The view here is if you could do it by paper or fax you should be able to do it electronically. It strikes me that in setting a target for these measures in meaningful use stage two we would have to take into account what is possible to do and to achieve using secure e-mail and a lot of what is possible to do using fax, mail or secure e-mail doesn't happen now. So there will be a constant dialogue in our work between demand and supply. No demand, the supply never works; no supply, the demand can't be realized. So we're going to have to have a constant ping-pong between those two requirements, making sure there's a pull, but also making sure there's a supply of technology.

Judy Faulkner – Epic Systems – Founder

I agree that if you can do it by fax you can send it back and forth, but that does assume then that you're not getting discreet data as you go back and forth, because the concept of bringing it over by fax, just bringing over the non-discreet data. So if we assume that as we make up our requirements then we'll be okay. If we assume discreet data is coming back and forth then the fax analogy doesn't work.

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

Farzad?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy

I think this—the discussion around the comprehensive care plan that Judy brought up raises governance issues also around who owns the care plan, who owns the patient's care and gets into in some instances there may be social service agencies responsible for a behavioral health care plan. Those are special circumstances, but it, I think similarly, takes us into more complex healthcare delivery and data ownership and plan ownership and payment issues. Whereas the analogy might be to the complex query and being able to assemble and pull information from all places and then to govern that; whereas the more direct corollary to the direct kind of transactions would be verifying that care coordination has occurred, that closing the referral loop; there was a referral sent, did you get a referral back. That is much more tractable, I think, in the near-term and it doesn't really involve considering ways of changing the delivery of healthcare to be more coordinated. It simply says given the system as we have today, you sent someone a referral. Did you get it back? You got a referral, did you send it back? I think some of those may be more tractable than others.

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

Judy, I think Micky will talk this afternoon about the Information Exchange Workgroup's discussion recently, which is to your point. How do we take whatever emerges from this process and then roll it back through the HIE and IE requirements so that we have a feedback cycle within our policy work of as we take whatever steps forward we take here, translating them back to the other workgroups and to the Standards Committee so that we can make incremental progress towards the structure data transfer you're talking about.

Paul and Gayle?

Paul Egerman – Software Entrepreneur

I was wanting to respond to what you just said, David, because the fundamental challenge as I listen to this is are we designing quality measures based upon the data that we have now. Or are we trying to define quality measures for what we want them to be and have that drive the rest of our process, even looking at what Larry talked about for the whole issue of quality metrics and ordering of images or radiology? When you look at what's involved in that whole process at some point you might say, "Well, in order to do the decision support correctly we need to gather additional data earlier in the process, because maybe there are some data elements that we don't have that would help us make these decisions." So to me this is terrific what I'm seeing here, but the part I'm unclear on is what are we designing for. Are we designing quality metrics about the way things are now or is it flipped around? Are we saying this is what we want for quality metrics and now we're going to design the rest of our EHRs and data structures around the quality metrics?

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

Okay. Gayle?

Gayle Harrell – Florida – Former State Legislator

I think we're really moving almost into stage three on this level. When you get to what I view here is certainly care coordination is the critical element of the whole process that we need to get to, but we are. When I look at how complicated this is and making sure you have that claims data integrated, you have the clinical measures and the coordination of care, we're almost moving into stage three, especially given that we don't have the interoperability yet to get this into stage two. Certainly setting the table for stage three is something that we want to do in stage two, but are we pushing this to such a point now what we're going to set this thing up for failure in stage two?

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

I think that's a really excellent point. I think we're very sober about that and the work to date has basically understood that much of this will be more realistic for stage three, but we want to start the developmental work now that will permit us by 2015 for some of these things to be realistic rather than do this strictly as staged. We don't want to not look at this now and wait for a few years. I'll come to the end of this presentation at the end with the schedule we have in mind, but I think we'd like to take this list and effectively triage it into what's very short-term, stage two ready and what really needs to start being worked on, some of the issues you described, towards stage three.

Gayle Harrell – Florida – Former State Legislator

I think it's critical that you ramp this up slowly enough so that you don't create that sense of failure in stage two, especially for the vendors, who are going to need to make some significant changes to make this happen and also for the providers out there that are going to be very concerned. They've made this initial investment to get to stage one and then they see stage two unattainable. You're going to have a real problem, so I want to caution where we go in this.

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

Okay. Tom?

Tom Sang – ONC

I think a lot of these comments are extremely critical and very important for us to consider. Just for context, I just want to let the group know that in terms of measured development testing, there is usually lead time of about 18 months to 2 years. So with that in mind I think we really need to start planning ahead on incrementally, yes, but I think we still need to really think about these things since we don't really have any care coordination measures, per se, at all within the universe of endorsed measures that are e-specified or retooled. Second of all, I think it's a really tight balancing act between balancing what we should aim for versus what we have right now and really pushing the envelope in terms of leveraging the data that's in the HIT to Paul's point.

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

Okay. Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I have a couple of things to say on this topic. One is I'll just reiterate something I've said before, which is the number-one thing that patients want. They want their doctors to talk to each other. It is that simple. So I think for stage two, to Gayle's point, we know how to do some things that will get us talking to each other. We know how to create a structured document. We're doing it under the Patient and Family Engagement criteria in meaningful use stage two. We know how to say these are the elements. We know how to move documents around, hopefully Direct will play a big role. But even if not, I think it's helpful to think about the kind of parsimony that can be created between a quality measure like this and the functional requirements of stage two, so if we think about what's in the functional objectives it's things like knowing who the care team is. You should be listing that here.

To Farzad's point, that care plan should be jointly owned by the patient and whoever they designate on their care team as the person that they would like to own that. So stage two functional criteria have some information exchange requirements around defining your primary referral network and exchanging with some number of them and hopefully that will get more robust. This is something that would have great parsimony with that aspect of referral loops, access to information. I mean there is so much already in the proposed stage two criteria that this particular piece could really support and leverage to create some of that parsimony that I think it's really worth thinking about how we do it simply and elegantly in stage two. It may not be perfect, but it is something and it is good and it is robust and it gets people talking to each other as ONC then invests in developing even more robust ways of doing that for stage three. I just want to encourage us absolutely not to lose sight of this for stage two.

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

Any other comments on this category? Thank you very much. We'll move on to Patient Safety.

A great number of submitted comments on this area and a great number of them were on medication safety in particular. Adverse drug events was one of our most commonly suggested areas of focus, as you'll see in a moment, also some methodology challenges were surfaced there. Similarly, monitoring of patients on chronic medications and whether that's being done properly. Healthcare associated complications of several kinds; infections, process measures, VTE outcomes was mentioned several times, so we have a couple of hospital oriented categories here, and falls assessment. Someone even suggested falls index or monitoring of falls. Those were all suggested under patient safety.

Some of the methodology issues that are associated with these recommendations: How to measure adverse drug events. Secondly, capturing relatively infrequent events, such as the ones listed there in the hospital context and how to use them as part of a quality measure given the low incidence. Measures of falls and adverse drug events that could be applied in a parallel way both in inpatient and outpatient settings and then whether these measures have to be risk adjusted for the differences in setting or population has been suggested.

With that let me ask for comments and suggestions about the patient safety area. Adam?

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

I don't know if you can even answer this or not or if it came up in the comments, but as we look at adverse drug events, will this be aligned with the FDA's Sentinel initiative as well as that continues to evolve?

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

David, you're nodding.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Well, we will ask the FDA for their input. Every rule that gets through our department and through the government is shared with all of the relevant agencies, so it would be important, of course, to get the FDA involved in thinking about this early. The same would be true for CDC about hospital associated infections and AHRQ to make sure that we are capturing their latest thinking about measures. So absolutely, this will be closely coordinated with other activities of the department, which are growing very fast under the Affordable Care Act because of the Center for Medicare and Medicaid innovations and also the Accountable Care and the provisions of the ACA that specifically addressed hospital or healthcare associated infections.

Neil Calman – Institute for Family Health – President & Cofounder

Can I jump in here?

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

Yes. Sure, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

I think that one of the things that sort of differentiates this sort of safety issue is that you're sort of measuring things that shouldn't happen. Whereas, on the other kinds of measures we're sort of looking at positive attributes of these systems and stuff. Here you sort of have an issue, which I think is similar to a lot of other kinds of reporting issues, where you're asking people to report on things that maybe shouldn't have happened. I think that creates that sort of sense that providers always have as to is it a good thing to report more or a good thing to report less.

I think one of the things that the tiger team discussed was, first let's really, especially on the ambulatory care side, there is a clear sense that adverse drug reactions are grossly under reported, which creates a deficiency of information in the country about adverse drug events. If we're going to do any kind of measurement what we ought to be doing is trying to encourage people to use it and so I think we need an equivalent of sort of the blue button. We need sort of a red button or something that basically makes it

very easy for providers to create through their electronic health records the major components of a report and figure out a way to get that information transmitted quickly. I think a good measure ought to be the number of adverse drug events that are reported, which kind of makes it difficult, because people are reporting things that maybe shouldn't have happened if they had done stuff right.

The other thing about the adverse drug events is that they can be tied very closely to whole networks of decision support about medications in the elderly, medications in pregnancy. So I think that we have to think about what we're trying to measure here, but also be cognizant of the fact that we're trying to get more reports of events so that they can change the way these things are happening across the country.

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

Thank you, Neil. That's very helpful. Charles?

Charles Kennedy – WellPoint – VP for Health IT

Well, just following up on those points, I mean one of the things health plans do typically get is when there is a hospitalization due to an ambulatory adverse drug event. We usually do get that on the claim for the hospitalization, so you actually can create a pretty decent measure around the number of ambulatory adverse drug events that were severe enough to create a hospitalization.

I think the methodological issue we tend to run into is when you then try and prove or assess whether health IT avoided any of those. You get into a lot of issues around was an alert fired. Was the alert acted upon? The EMR and e-prescribing vendors have a wide variety of how they manage the data for that particular process. So I think we'll run more into the methodological issues of measuring the influence of HIT than actually an ADE that creates a hospitalization.

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

Interesting. Thank you. Gayle?

Gayle Harrell – Florida – Former State Legislator

Two comments. First of all, I think in Florida we started a program years ago called The Gold Standard Program, that we actually did measure adverse drug reactions, interactions or potential interactions and wound up saving huge amounts of money in averted ones, so the methodology may not be consistent, but there is methodology out there to do that.

You then raise the liability issue and who owns the liability at the end of the day on some of these safety measures and how are these going to be reported. If these are all measured and reported are they confidential? Are you opening up a giant database in the sky for trial attorneys to go searching?

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

Thank you for that. Very good discussion. Any last words on Patient Safety? Good. Thank you.

The last category for our discussion here is Population and Public Health. The most promising measures submitted to us, looking at patients with undiagnosed hypertension by using a calculated algorithm to get at the under reported incidence of hypertension. Looking at longitudinal assessments of blood pressure and blood glucose; that is taking a time stamp early in a reporting period and again at a later time in the reporting period and look at improvements, hopefully, in management of those two indicators. Then looking at the ability to stratify a number of quality measures by different patient demographics, particularly to get at equity and disparities issues. So those are the ones that surfaced through our review.

The methodology issues that continue to affect us: The traditional outcomes measurement, person-by-person measurement and, for example, of blood pressure, persons looking at this as a population health management issue. Again, on the EP context of individual doctors we'll have issues around methodology of capturing the data, of how long the patient's been in their care, of how many recordings of, say, blood pressure there and which ones we use to do the measurement, so that will be a challenge and then how to generalize that in a population level. Then we don't have some standards for some of these measures

that were submitted to us that we can rely on, so there would need to be some work on data capture conventions for those.

With that distillation, let me see if there are comments about the public health and population level measures. Art?

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

Yes. Thank you, David. These are a good set of measures I think, but they are directed toward a population that's probably more for an internist or the adult population in a family practitioner's office, so there would be hope that some of these population and public health measures may be applicable to pediatric practices, things like immunization up-to-date rates. In an OB practice it might be the screening measures used during a pregnancy. There are probably ways for us to expand this. I understand we want to have a parsimonious approach, but that may be a little bit limited at this point to try to find population measures for other practitioners.

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

That's really an excellent point. We did have a number of submitted measures in pediatric care, for example, and I think looking at them through this lens would be something we should take another look at with your suggestion. It also raises the question of whether; it's kind of a peculiar blending; some of the specialty measures should be population health oriented.

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

I would agree. Some of these, we need to vet them first, but we would hope that regardless of your practice that you have some population orientation when you're thinking about the use of HIT for a quality metric.

M

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

Yes.

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

Other comments? Yes?

Connie Delaney – University of Minnesota School of Nursing – Dean

I think these are a good start. One example of a measure that I'm surprised is not on the list is something related to obesity, which would certainly cross the variety of populations and steer us in the direction of increasing prevention.

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

Actually, I'm very glad you raised that, because in the initial pass we did BMI was one of the measures we had highlighted. I'm not sure why it isn't on this cycle. Was there a reason, Tom, we dropped it or is it still in our pool?

Tom Sang – ONC

... discussion.

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

Yes. I appreciate it. Thank you, Connie. It's very helpful to get that back on our radar.

W – Department of Veterans Affairs

Another one along the same lines is a screening for depression.

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

Yes. That also was on the list. One of the issues there was there is some wide agreement the Minnesota measures, for example, Minnesota has a quality measure of PHQ-9 screening that was on our list to be considered. That's worth our bringing back into discussion. One of the issues, I think, is again the uniform adoption of something like that across the wide pool of meaningful user applicants, whether we can achieve that in this time frame, but with your encouragement we'll take another look at it.

Adam?

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

Not to add to a laundry list, but the other one with obesity that caught my eye was smoking status as well. Just raising that potentially as a topic, but I wanted to go back to the obesity issue. Is there anything that inhibits the pediatric or childhood population for that data to be collected as well? I mean can we collect under 18 to know where overweight and obese children are actually to do public health interventions?

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

I'll let Tom answer this group.

Tom Sang – ONC

I just want to remind everyone that actually the BMI and the smoking cessation measures are actually part of the stage one clinical quality set, so it's already an existing measure for eligible providers.

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

As a quality measure or as a—

Tom Sang – ONC

As clinical quality measures. There is one specifically targeted for pediatrics, as well as adults in the BMI issue as well, but not in the perspective of a population management lens.

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

Thank you. Other comments about this group? All right. Let me then close that with a couple of summary comments of where we are on our process. Thank you, all, for those comments.

So some of you have already mentioned some of these; these are some of the gap areas we've already mentioned; I'll just review them with you; that we think we didn't get as much ready to go measures in the pipeline as we'd like and maybe these are things we want to keep on the radar for stage three development. Measures of decision quality Josh mentioned earlier on. The definition of a comprehensive clinical summary and whether it's being managed; closing the referral loop; measures related to action plans for patients; so that whole battery of care coordination measures are not really where we'd like them to be. Capturing adverse drug events from a variety of sources we talked about; the equity measures and then readmission and adherence that require data over time.

Our next steps are to, based on our previous work and input you've given us today, to recommend a super set of measure concepts and measures that are worth additional work over the next couple of years. We're going to go back to our tiger teams—the five tiger teams met earlier in the late fall—and ask them to review what we just shared with you plus your input, plus anything else they want to bring to the discussion from the larger submission and let them drill down into their area in more detail based on this input. So then in the next couple of weeks they will have those meetings and based on this input and their own expertise, make recommendations to ONC for which areas are ready to go forward.

The workgroup then will get back together, probably in March, and start working on some of these fairly challenging, but cross cutting issues. How do we capture data from patients? How do we integrate multiple data sources and longitudinal data sources? How do we deal with the specialty reporting question of core menu and so on? So those are three topics I think the workgroup itself will turn its attention to once the measures pipeline is back in flow.

Then the rough timeline going forward is, based on this discussion and the Quality Workgroup discussion, we are going to recommend to ONC these priority measures and concepts and the tiger teams will do a little more refinement based on this discussion. Then we'll try to harmonize these measures into a more elegant and parsimonious set, as we can and the ones that best address the criteria we talked about earlier.

Then the hope is that during the balance of this year, through the fourth quarter a first set of stage two ready measures will be developed, tested and validated. We will then start the process, obviously, the slower process of getting ready for stage three measures with the target being late in 2013, having fully developed and vetted those measures for 2015 deployment. So that's our strategy.

Now just to wrap this all up it's probably a good time just to sort of see if people as a whole are comfortable with the report and with where we're going. Any other guidance you want to give to ONC as far as whether this is going to hit the target we set for the quality measures strategy?

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

I have a question, David. One of the words that been used during the workgroup meetings is aspirational versus more ready. What's your sense of what proportion roughly of these concepts are aspirational versus potentially ready for stage two, recognizing that what Farzad said about the 18-month development time and so on and so forth, what percent could actually be developed, tested and validated by the end of this year?

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

I think in several cases we can take an incremental step in stage two, which will build to a better, more robust approach in stage three. So I wouldn't want to categorize them that broadly. They're all aspirational given where we are today, but I think all of them have made it to this point in the discussion because credible people have told us they're feasible and are being done. So I'm hopeful that we can get all of them by stage three to fruition. If I were having to answer your question I would say 60% or 70% we can make good progress in stage two and then some number will take longer to really make significant progress.

Yes, Gayle and then Judy?

Gayle Harrell – Florida – Former State Legislator

Yes. Paul, I want to just piggyback on what you have said. I said that previously. I have great concern as to what is aspirational and what is realistic. I also have a great deal of concern when we come to what happens to these measures. We've measured. We're reporting in stage one. Providers were attesting that they had done this. They had met the criteria. Stage two, it's my understanding that we're actually going to have providers report to, presumably, CMS as the payer of the incentive funds. Is CMS going to be ready to accept this reporting? This takes two to tango. You've got to have the ability to report and then the acceptor of the report. Are we going to be at a point where CMS can accept those reports, evaluate them, determine that the provider has met the measures that we've established and then provide the payment? There are a lot of questions as to how we get to where we're going.

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

Judy?

Judy Faulkner – Epic Systems – Founder

I was just going to suggest that you consider adding another criteria to the very first slide I think it was that you showed or one of the first of your goals and that is reasonably attainable; that kind of piggybacks on what both Gayle and Paul are saying. Reasonably attainable, as I listen to this one of my concerns or thoughts is that it's not just the individual. It's the aggregate. If you have a lot of things that clearly almost anything can be done that we're not questioning, it's in the aggregate; the analogy isn't really throwing the baby out with the bathwater, because it's not getting rid of stuff. It's what we're putting on and if in fact the end is that we make the aggregate too much then we'll lose the benefit of having folks get to where

we want them to go. That was number one, to consider the aggregate and especially consider the concept of reasonably attainable.

The second thing is that in the end not only should we be focusing on things like blood pressure, smoking, etc., but I think we should be focusing, as we do this, on prevention because it will have the greatest effect down the line. Especially prevention of childhood problems that will later on help all of the citizens in our country be more healthy years from now. So I did want to just put in the comment the stuff about childhood obesity, childhood immunizations will have some of the greatest effects in future years.

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

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I just want to make a quick comment about stage three and what Farzad is looking at, the timeline for measure development and getting things into the pipeline. I'm recalling that ONC has said all along that stage three meaningful use should be actually about improving outcomes and so I see outcomes measures, a couple of them, listed here, not as many as I would want, but I get that that's primarily because these are listed for stage two. So I just want to say that we need to make sure that we're preparing for stage three by focusing on outcomes. I think you have to narrow the field of outcomes. One way to do that would be hopefully to look at the national quality strategy, assuming and hoping that that comes out within a period of time that would allow ONC to make the right investments for outcomes in those priority areas.

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

Good. Paul Egerman, Larry and then Art?

Paul Egerman – Software Entrepreneur

First, this is outstanding work. This is really very exciting and it sort of takes us to a whole new level. This is great work. Some of this work was briefly commented on during the implementation hearings and what was said is very interesting. There were like two concepts. One was a concern was expressed that ONC is looking at its own work. It's sort of like in isolation without realizing the other things that providers have to do for other federal and state and regional and accreditation. There is a whole series of things they have to do and in particular there is already a whole series of quality reports that many provider organizations have to produce. So part of what I heard; if I could paraphrase it correctly; was not another quality report, please. We're doing 32 of them. Now there's going to be a 33rd one. Why is this one different?

So my suggestion there is, on one hand, saying this is very, very exciting. On the other hand is we need to clearly articulate why it is ONC is doing something that's different. What is the value that we are adding to the entire process? If we can't articulate that or whenever it's possible can we use some of the existing quality metrics so that the providers, who are already doing the work, don't have to do the work twice to produce two metrics that are very similar?

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

It's a shame Dr. Blumenthal isn't here. In HITECH, it does require ONC and CMS to try to harmonize these measures. I don't know what the current state of that is and I don't know whether staff want to comment at all.

Paul Egerman – Software Entrepreneur

Maybe they are being harmonized in just the feedback that I got, so maybe we don't know that.

Tom Sang – ONC

There is a tremendous amount of work in terms of coordinating. There is a lot of interagency, committee activities going on actually trying to do exactly what you just said, Paul, trying to coordinate the measure development moving forward prospectively in terms of trying to get multiple agencies to use the same or similar measures for multiple purposes. But there is a provision in the Affordable Care Act that actually

requires the secretary to develop a strategy on harmonizing PQRI and meaningful use. So right now, as it stands, CMS and ONC are working on developing that strategy. Does that answer your question?

Paul Egerman – Software Entrepreneur

It answers my question. I think that somehow a lot of people have the same question, so that's very important information.

Tom Sang – ONC

All right. The other thing is that ONC is working with CMS and other agencies, as well as NQF in developing a standard. Paul is very, very familiar with that standard, which is the QDS model, the Quality Data Set model, which is kind of like an information vocabulary set so that moving forward everyone will be speaking the same language in terms of developing the specifications for these new measures, these electronic measures, the numerators and denominators.

Paul Egerman – Software Entrepreneur

That's great work. Thank you.

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

So it is a definite intent and there is deliberate work going on. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We seem to have a groundswell of all thinking the same things about let's leverage existing measures, so from Christine to Paul to me, so let me reinforce that message that we need to coordinate things here. Also, I think that the notion that there are national priorities, we should be specifically looking to align with other activities and to pick up on one of the other themes, where there are unique aspects in terms of HIT usage that we're trying to sort of add to the mix. I do think we need to take leadership, but that should be very focused and very parsimonious in what we add. They clearly should be things that the systems themselves can report rather than requiring additional quality reporting efforts and data collection efforts. I'm very hopeful that what we've heard from ONC is that they are working actively to pull this together because that would be really great.

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

Let me take the opportunity to give David Lansky an opportunity to comment on this groundswell, because I'm sure the Quality Measurement Workgroup talked about what exists now and had intention about can we reuse what exists now or is there not only an aspirational. But a very productive way of moving in a different direction that we couldn't move before using only administrative and claims data. It goes back to something that Paul Egerman said as well, so that tension of what exists versus what we need to create, did the group have a thought on that? It looks like they've decided that there are some new concepts that we need to move toward.

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

Well, I think the public submission process was a great opportunity for all of the people in the country, who know what's out there, to submit it to us for consideration and we are working within that universe, so we're not doing any new measure development at all. We're identifying people, who have brought some ideas to us and trying to coach them into producing something that meets the criteria that Larry and others just described. So we're trying to find a middle ground. The challenge obviously is that the legacy of measurement development didn't address some of the domains that we all now really want to focus on, including Congressional language saying to focus on some of these things. So we have to go into new areas. We have to build on work that's already been developed in the private sector and the VA and elsewhere that we can leverage. I think we're all identifying a balancing act that we have to just continue to work on.

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

Art and then ...?

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

A clarifying point here: I thought that we were working toward, from the Meaningful Use Workgroup, the current comment period to try to release or work toward a rule that would be ready to at least begin the process through government to be happening sometime in the summer. I just see this Q4 up here. Have we backed up the timing for the rule or did I miss a memo?

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

Our original—and then Josh can fill in the gap—the Meaningful Use Workgroup’s original time frame was to come up with our final recommendations to the Policy Committee that it would hopefully approve by the summer of this year so that could be input towards the NPRM process that ONC and CMS go through. Maybe this is the question, so hopefully there will be some recommendations by that time that we can insert into our matrix that may or may not be finalized in terms of the actual testing and validation of the final QM. Is that the way—

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

Yes. I tend to think the timeline obviously is very aggressive, but I think what we’re doing here today and the next step, as the staff refines it, would be an input into the June discussion. It won’t be fully specified and final until this technical work gets done during the rest of the year, but I think we want to see if we can get to something that is conceptually aligned with the cycle that Art described, but Josh can clarify the timeline.

Josh Seidman – ONC

Right. As was referenced earlier, the Meaningful Use Request for Comment from this committee is out for public comment through February 25th. All of that public comment will be collected and the Meaningful Use Workgroup will be meeting again April 5th on a full-day meeting to really sort of go through all of that comment.

Also in April though there will be input that will come from the Quality Measures Workgroup around some of the issues that were listed on David’s Next Step slide, things around what should the framework for quality measures reporting be. We talked about all of the options around a lot more specialty measures. Should there be a core set? Should there be expectations around certain numbers of measures being reported, etc.?

There also will be inputs coming from other workgroups. Certainly, the PCAST Workgroup, the Privacy and Security Tiger Team will be coming with recommendations in April that will feed into that process so that in May this committee can have a full deliberation and hopefully finalize recommendations to HHS by June. Then we will go into the development of the NPRM. We are hoping that we know enough about the measure development process that we can have numerators and denominators of proposed measures by September so that when we put out the NPRM we can have pretty well defined measures that can be further validated in the first part of next year before the final rule comes out.

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

So hopefully we could have at least the super set of measure concepts to be recommended by the April 5th face-to-face group and then—

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

We’ll have that. Yes.

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

Okay. Good. Dr. ... ?

W

I wanted to make was that the domains that you have reflected here are just so wisely chosen. Bravo. Very nice. There are three areas where we know that significant amount of work has been undertaken in various other places. I know especially for the Department of Veteran’s Affairs, whether it is clinical appropriateness, patient safety and population health. The other two, the patient and family engagement

and care coordination, as was part of the discussion, really need to be defined. How do we bring all of the research that has been done into more practicable use I think just remains to be realized.

I'm glad the discussion happened about how we need to harmonize what currently exists with what is being thought of here. With that said, I have to say that getting the data, reliable data, consistently from providers, hospitals, multiple place on ... forward to a central place is going to be one of the major challenges. We know in VA we are facing that, but we've had a head start, even about over a decade ago with having electronic health records systems. We just need to be mindful.

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

Great. Any other final comments? If not, we are precisely on time. I want to thank David Lansky, one, for the terrific work that the workgroup and all of the tiger teams have done and for walking us through this. This is a tremendous amount of material and well thought out. Thank you.

With that we'll move on to Marc Probst and Larry Wolf and talking about the Implementation Hearing that they had, talking about what did you call it, reasonably feasible or something like that?

Gayle Harrell – Florida – Former State Legislator

Reasonably attainable.

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

Reasonably attainable.

Marc Probst – Intermountain Healthcare – CIO

I've already got a tag here. We figured we'd come up here so that if I say anything wrong Larry can jab me, which is pretty likely actually. We're going to give you a report out of a hearing we had in early January, January 10th and January 11th that several members of the Adoption and Certification Workgroup were part of. I think overall the fact that we got there and there wasn't a lynch mob either suggested things are going well and there's appreciation or we picked the panelists really well for that specific activity. Actually, overall I thought there was pretty good appreciation for the work that was being done by this committee, as well as the Standards Committee and that overall I felt a pretty positive attitude. Now, that doesn't mean everything was rosy and we'll hit on a few of the things that maybe weren't quite as rosy, but overall I thought it was a good panel. We got a lot of good information.

I guess the other thing I'll note, since I have the microphone, unbelievable, Paul, the amount of work that people are doing. I mean when these panelists came the material that they provide, the expertise that they bring to the table and the energy that they put in on behalf of what we're trying to accomplish here is amazing. It's really terrific.

Very quickly, we were asked to work with the Implementation Workgroup, which is a subset of the HIT Standards Committee that was pulled together and so it's kind of a hybrid group that was there. Judy Murphy and Liz Johnson, I think, did a very excellent job, a lot of work in pulling this particular set of panels together and they provided really good leadership for the process that we were in. You can see the members that were involved from our group.

Just some brief history: When we originally were pulled together as the workgroup for certification and adoption and then we changed our name to adoption and certification, meaning we pretty much accomplished everything we had to on certification, right, Paul? When we were pulled together, really, part of it was adoption and we really did, as a committee, feel like we wanted to do more in looking at adoption and overall what are the impacts of meaningful use and how were things going.

We weren't able to pull that hearing together prior to the end of last year, which we would have liked to have done. The Implementation Workgroup that was pulled together had a very similar charter. They were asked to do similar things, to look at adoption and how it was going, so it was fortuitous that we brought the two groups together. I think we were able to garner a lot of good information out of it. I think there's more to be learned. I think there's one thing, as I reflect back on a particular hearing that we had,

there was less aggregated data from groups that I would have like to have heard about, so I think there's more work to do on those particular spaces.

So we held the hearings back in January. Larry was very key in helping both, put the panels together and work through this particular hearing, so he'll drive us through a bunch of these slides and then I'll get back to you at the end.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, thank you, again, to everybody who made these hearings happen. I think the message of we have people's attention, we have their attention. The panelists were there. They were engaged and they were reporting on a really wide range of activities. I'm going to just walk very quickly through the breakouts here other than to say that we had people talking about the Regional Extension Centers, the certification program, health information exchange and then the experience of eligible providers and eligible hospitals. They were asked to look at challenges, barriers and successes and they talked pretty broadly about what they had and, as Marc said, they submitted really quite a wealth of material to us.

I'm going to flip through these other than to say that we actually had a really good representation of people from all over the country. Okay. Some of the things that they told us: That there is a lot of awareness out there about meaningful use.

Number two was sort of a surprise to us. That actually looks like it's going to wind up as a separate hearing. There was a statement made almost as an aside that physician malpractice insurance costs are going up. That was sort of a surprise because we had previously heard, not in hearings, but in just life, that some insurers were providing discounts for people using electronic medical records. So it was like, "What's this?" So we're working to assemble a panel and have some hearings probably in March, maybe, if we can pull it together by then, to drill into that further to see what's been the actual experience.

A lot of discussion about exactly what are the definitions, issues that were raised and acknowledged by CMS and ONC in terms of trying to turn around answers to frequently asked questions and that this is in some ways still an ongoing process. And the extent to which it is an ongoing process, of course, creates hurdles for people who are creating software or implementing things in care settings. As the definitions change, even in the details, it can create big, operational issues.

Using the system meaningfully versus meaningful use: The groups that were here really represented, if you will, two different audiences. We had early adopters, who had been using health IT for a long time. They were addressing issues of we had plans in place. Meaningful use happened and the world changed. It may have changed in details. It may have changed in a big way. Sequencing may have changed. We're going to do more physician order entry up front. We were planning to do that later, which then ripples. We've got great product, but we're not necessarily running the current version of something and now we're going to need to get on current version to have a certified software and that really wasn't part of our plan, so we need to deal with that.

A sort of questioning of what are we actually accomplishing, the generic understanding of meaningful use in the specifics that we were creating and a strong statement of wanting to truly have a replacement for what had been three to five-year strategic plans that people had. So that was coming out of the Policy Committee. It was coming out of ONC. In fact, it creates a true strategic plan that people can understand where they're going and how they're going to get there and start to align their resources and not just be going, "Okay. So I know the next two years and I'll scramble to get there. Then I'll know the next two years and I'll scramble to get there. Then I'll know the next two years and I'll scramble to get there." It's really not a very effective way to do anything. I know in the Meaningful Use Workgroup there has been discussion about trying to create a vision of stage three so that stage two can actually be taking us there, so certainly, encouragement for doing that.

Seven was sort of a hot topic. There was a concern that we were basically creating systems that could pass the test of certification criteria without necessarily the more important test of how do these integrate to workflow. Smoking cessation was one that got a lot of attention as we used to have ways to capture

smoking cessation. The questions weren't exactly the same as what was in the certification criteria, so to create the official answers, additional functionality was added on. It's a free standing piece and doesn't integrate with anything we've been doing. Let's be sensitive to that.

We've talked a lot this morning about quality measures. Time. We'll come back to time.

Certification: Overall, the process seemed to be going really well. The concern that was being reflected was vendors were sometimes submitting a whole application as a comprehensive EMR, but providers were only implementing part of that and had other, either vendor software or self-developed software to fill in the gaps. So how would they deal with the fact that the vendor didn't do modular certification, so they didn't have a checklist to pick the modules from?

Similarly, currency: People basically expressed the concern that in the past they could buy software and if they ran with it for three to five years they were in good shape and then they could look at an upgrade cycle. Now they're sort of in a forced upgrade cycle to get certified software. So both, the work and effort to stay on target and the need to now pay for and implement things much more quickly.

Some concern about vendor viability: Nothing specifically raised, just a general concern that an awful lot of people were certifying for stage one. Would they be able to make it to two and three? The RECs were really beginning to address the other population of people who don't already have systems and are now in a mode of learning about and acquiring systems. Mostly we heard that the RECs were running really, really fast to try and help people do the very first steps of system selection and assessing their needs.

I think it's back to you, Marc.

Marc Probst – Intermountain Healthcare – CIO

These were the ones that didn't fit in any of the categories above, but certainly, the layering on of various federal requirements, whether that was around security or privacy or whether that was around some of the functions that we're asking be done and certainly around reporting, quality reporting. That was definitely thematic through a lot of the conversations that we had and that there be good coordination between those organizations. It was nice to hear on quality reporting that we have a plan there.

A quote that was made is, "A bad standard is better than three standards." Certainly, there is no standard if there are three standards. There was really a fair amount of conversation about standards and getting those defined and picking one. I think there was some sincerity in a bad standard. Just pick one and we'll figure out how to use that and get to where we're going, but the fact that the standards keep changing and new standards keep being developed is pretty frustrating for those that were working through that.

Confusion about the rules of the road: Most of that was around certification I think. I have a point here. It wasn't so much that the certification rules were changing, but through the clarification of those rules they changed, as people understood it, at least in the perception it was a change when it was clarified. I think there's still clarity going through that process and so those are very frustrating to people. Then not a lot of discussion about workforce worries, but clearly, that's out there, kind of like this looming cliff and are we going to really be able to meet the workforce requirements associated with meaningful use.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Marc, let me jump in there for a second. One of the comments someone says, "Yes, I have no problems finding people to work on this stuff, even experienced people. They just cost twice this year what they did last year." So clearly, there is a huge increase in demand and not a corresponding increase in supply.

Marc Probst – Intermountain Healthcare – CIO

As a CIO that's not a bad place to be, at least for four more years. The top-ten requirements: We kind of adopted this from a list that was given to us by the Standards Committee. It isn't exactly that same list. We've modified it a little and first of all, when you get to the one about quality or don't let perfect be the

enemy of good, you'll notice it says the top 10 recommendations and there are 11, maybe quality assurance needed to be worked on here a little bit.

First, provide adequate time. Time absolutely was thematic in just about every group, whether we were talking about HIEs, RECs or achieving meaningful use. We'll talk about the bar in a minute. It wasn't so much the bar as the ability to comprehend what that bar meant and then giving it adequate time to meet that bar.

Keeping it simple: I think that's more of our conversation or our communication. Actually, it's more ONC and CMS' communication out, but keeping that simple, understandable, something that you can define and then you can go and achieve. That fits within don't let perfect be the enemy of good enough. We've talked about that before, but that came out several times in the discussion we had.

Keeping the implementation costs as low as possible: That was across the board. It wasn't just implementation costs, but it was the fact that we have to do multiple releases and each one of those releases have a significant amount of costs associated with them. Sometimes vendors change their systems and you need new hardware to support that or new operating systems to support that. All of that costs money and it absolutely increases the complexity.

Design for the little guy, not just for the big guy and whether that's quality reporting or whether that's the information systems in the meaningful use, keep the little guy in mind if nothing else. There are smaller groups that have to do very big things that they're not used to doing in the past.

Pick a standard and pick it soon. We talked about that. Address the workforce issues. Increase the focus on usability. Again, pretty thematic across all of the panelists on meaningful use. Talk about usability and not just getting functions out there that don't comprehend workflow or don't comprehend a good user interface. Improving the choreography we talked about. Creating a crosswalk between the meaningful use requirements and the certification requirements; that was a specific request and that's one that I know that came out of that panel and the Standards Committee is looking at.

Then finally, just to reiterate, provide adequate time. It's really a very big issue. What we do in meaningful use has tentacles into so many areas. It's not lost on the healthcare industry all of the things that are being asked of them. It's interesting; there were some organizations that came out and said the bar isn't high enough. My thought on that is we're setting the bar. You can go higher than that bar if you want, but we're setting the bar for many organizations that have to get over that and we have to keep that in mind. Not everyone started out at the same level and so some are going to have a much more difficult time getting to the bar that we set. We haven't limited that bar. We hope organizations go well above that. Those were our top 10/11 recommendations.

What we're going to do next is we'll continue to work with the Standards Committee relative to what we're learning from that and the next steps that we can take forward. How can we influence better the Meaningful Use Workgroup? Hopefully this is part of that process, but we'd certainly like to get more information and all of the hearing materials are obviously available to that workgroup.

There will be the hearing in late spring. Larry is really taking a big lead in that relative to the legal considerations of meaningful use in the electronic health record. So that would be our report.

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

Comments? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I have a lot of questions, so to spare us and save us some time, have you guys put together sort of a comprehensive report that summarizes the hearing? Because I think having—

Marc Probst – Intermountain Healthcare – CIO

... got it.

Christine Bechtel – National Partnership for Women & Families – VP

Well, right. But I mean so when you talk about focusing on outcomes and meaningful use I'm probably guessing that I'm going to define outcomes a little differently than the context of that hearing. I don't know what that means. I have questions about limiting the cost of implementation. What are the specific policies that we would pursue to do that? Because I don't understand how to get to limiting software releases from a policy perspective. I don't think the vendors would like that anyway, but rather than peg you with all of these questions, do we have something that's got more depth that the Meaningful Use Workgroup can look at? Then I'll just say I'm not sure if I missed the invitation to the hearing, but I think the Meaningful Use Workgroup ought to be part of those hearings so that we can hear how it's going on the ground.

Marc Probst – Intermountain Healthcare – CIO

Christine, I think those are fair questions on one side, but looking at things like a number of releases, I'm not going to specify the number of releases that are reasonable. Reasonable is one release.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Marc Probst – Intermountain Healthcare – CIO

Reasonable is giving vendors and those that have to implement these systems time to code. Judy has gone through a number of times kind of backwards from here is a requirement we get for meaningful use. These are the things that have to happen. I think the recommendation is to remember what Judy said as we're coming up with new functionality and new requirements around meaningful use, but I don't think we'll specify what a valid number of releases is going to be. So I think these are guiding principles as we look at meaningful use. They're not specific recommendations as to exactly what we should do as a committee.

On the time issue; and they're all pretty interrelated; the time is a big deal. That has to do whether it's having clear requirements for our quality measures or whether that's having clear requirements for when do you have to certify for stage two. Those are just being clarified and coming out now, so again, it's very difficult to come up with the specific requirements, but I think the general direction is what we were trying to outline.

Christine Bechtel – National Partnership for Women & Families – VP

So maybe to clarify or have two thoughts, one is a question whether ONC has staff or a contractor that could really dig through the hundreds of pages of testimony and get some more substance underneath these key points. Then related to that, if you were to take each of your recommendations and list the top two policy options—in other words, if we're providing more time we have statutory constraints. So we've got that to work with, but aside from that what are some of the more innovative ways that we could think about providing more time just so that we get more of the substance and the policy specifics that we could actually act on? I'm just worried that we're going to end up with this great slide that has 11 recommendations, but not really the specific meat of what are the particular policies that will advance though

Marc Probst – Intermountain Healthcare – CIO

Thank you.

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

Paul Egerman?

Paul Egerman – Software Entrepreneur

I was at the hearing. I just wanted to make an additional observation in addition to the great presentation Larry and Marc did. As Marc said, the entire tone of the hearing was very positive. I mean there was a tone of really good people on the provider side and also on ONC's side and CMS, good people trying very hard to get it right and in a few places a little frustrated with good people trying to get it right.

The other thing I wanted to comment on though is to sort of pick up on what Dr. Blumenthal said when he opened our meeting. This hearing showed significant progress in the whole area of certification. If you look to see where we were a little over a year ago, maybe a year and a half ago, we did a hearing, a day and a half of hearings on certification and it was like a day and a half of hearing everything that was wrong with certification. There was a lot of controversy about certification. There were conspiracy theories. There was a lot of strange stuff going on and now the certification piece, it's not like it's running perfectly, but it became sort of like just one panel in this entire process and there are some recommendations about it and that's a significant amount of progress. It's a result of, one of the impressions I have, a huge amount of work. Some of these people, Carol Bean, Steve Posnack; I don't know all of the ONC people; did a terrific amount of work to get us to the point where we're at.

So some of the issues that you raised, Christine, that's where the discussion needs to be in terms of meaningful use, as opposed to some of where we were before. So anyway, that was my comment. There is work to do, but there's really been terrific progress.

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

Thank you. David Lansky?

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

Yes. I think echoing Christine's suggestion, on the point you made, Larry, that the quality measures were a sore point, I think it would be really helpful to drill into that and say what are the specific challenges that stage one quality measures have raised so that we don't repeat them in stage two. This is obviously, as you heard this morning, the right time for us to get some good, specific feedback so if we could dredge the transcripts or go back to some of the witnesses and get more information that would really help us inform our process.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes. I think in general, David, that that point was what Paul brought up earlier, the overlapping and not necessarily conflicting, but that there were so many different quality measures coming from so many different areas. I think that was the primary sore point that was out there.

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

Harmonization and integration is a real challenge.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

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

Gayle?

Gayle Harrell – Florida – Former State Legislator

Thank you so very much. First of all, I want to say thank you for bringing this to us. This is everything I have been hearing out there on the street for the last two years. I seem to be the repository of everybody's specific comments on what we could do better. I don't know what hat I have on that gets that, but this is absolutely fantastic. I think this is exactly what the people on the street, the providers out there, who are doing this are sensing and feeling. I really like Christine's idea of drilling down into those specific comments. I'm a solution oriented person and I think we need to go back to those individuals, who made specific comments and ask them for their solution.

Let's do more than just define what's wrong. Let's get their specific solutions on how you do this. Certainly, usability is a major problem for people out in the workforce, especially when you're talking about the little guy on the street and the workforce flows. What happens in a practice, the usability is absolutely critical.

Also, I think workforce is a major issue. I have some individuals, who come to me, are in this process now of becoming certified in whatever in the workforce element. I can tell you there are some major issues out there in workforce preparation. Making sure that we are providing the funds and directing people down the right lines and making sure that they're getting the tools that they're going to need to go out there and be in the workforce and provide the services that all of the providers are going to need. So there are lots of things that we can do better, but I think we need to really be very specific in suggestions on the policy levers that we can promote and we can do, so drilling down is going to be essential.

Marc Probst – Intermountain Healthcare – CIO

As a bit of context around some of the suggestions that we got, for example, usability and how it ties to workflow, that was a place where sort of time to let things mature within an organization seemed to be one of the big themes. So historically people would implement something in a pilot setting; get feedback on how it's using; tweak it; change the process; change the software; back and forth, back and forth over a period of months. Many iterations and then roll something out inside their organization and then have a solution that worked in their organization. We're kind of trying to do that for the country and don't have the benefit of that kind of quick, close feedback loop to know what's really worked and what's not worked. So I think structurally that was sort of the problem that they were bringing to us; that their solution has been we take time to develop this. We try things out. We get feedback. We adjust and we go forward.

Gayle Harrell – Florida – Former State Legislator

May I comment further? I think the time element and this is something that we have talked about since our very first meeting on the rapid pace on which we have rolled things out and really allowing the markets to mature and the individuals out there. We are on such a rushed time frame that it's amazing we've gotten this far. However, I think that that needs to be addressed and you've done it twice there. I can agree with you totally on the very rapid pace on which everything is rolling out; that the time element is probably the key component.

Marc Probst – Intermountain Healthcare – CIO

And I would agree. I think that is a very key element; whether that's clarity and having time to understand what some of the rules and regulations are and even if you look at ONC and CMS, we've thrown a lot at them very, very quickly. I think they have reacted very well in trying to get the information out, but then we get clarification on what some of these things mean and it does create a trickle through effect that's been a challenge. But I want to reiterate and kind of what Paul said, this was not lynch mob by any stretch of the imagination. We think this is a positive thing for our country. We think this a positive thing for healthcare. If you were to do some things, understand you really are putting a stress on us and the time is probably the biggest stress, not the bar that you're setting and then it's being very, very clear in what you're asking us to do because when you modify it it impacts us big time.

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

Charles?

Charles Kennedy – WellPoint – VP for Health IT

Well, you know when we implemented systems we would always talk about quality, cost and time, pick any two. Cost seems relatively fixed. Time seems relatively fixed. So I worry that we're going to have some quality issues. I think in some of your recommendations there is an underlying theme of potential quality issues. Is the time factor is so bad that we should consider recommending an action as severe as going to Congress and saying, "You need to look at HITECH. You need to give us more flexibility on time."? Is there anything we can really do that's meaningful within the current legislative restriction?

Marc Probst – Intermountain Healthcare – CIO

Well, that's a tough question. I didn't see time as a huge lever that we had, so our lever was what are we imposing through meaningful use and asking people to do. So I don't know. I don't know the answer to that question. Do you know?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I guess I would give an equally vague answer, but say how can we creatively use the time we have. I'll go back to the notion of can we actually create something that begins to look like a strategic plan so people understand where we're going so when they are rushing to get somewhere it makes sense. They can start to make meaningful tradeoffs in their own organization, whether that's developing software or implementing things in the care setting and the same thing with working with quality measures. So I think this is not necessarily saying we need more time absolutely, although I think the more time the more folks get on board and at a more gracious pace perhaps. But it's one of those if you're a manager in an organization people are always complaining about something, so is this the something everybody is complaining about while they're going ahead and doing their job and doing their best to achieve meaningful use and to be successful.

So I would take it sort of under advisement that we're asking people to run really fast and therefore we should make the best of their running really fast and work really hard to get things aligned and that as we look at stage two and stage three that it actually looks like a reasonable progression. As we start to look at the feedback from PCAST and their suggestions that we don't create a mid-course correction that's a 90-degree turn, because that really would push people over an edge. But we think through, so if our goal is shifting how do we do that in a meaningful, sane way that is going to support people in that transition.

Marc Probst – Intermountain Healthcare – CIO

I think that we're conscious and caring about the scope of the things that are being asked. So coordination, whether that's quality measures, that I discussed briefly, all of the other competing initiatives in the IT space that are being asked of organizations and the most glaring to me personally is ICD-10. Some of these, although they're not competing necessarily in that this technology is going to harm this technology, they're competing for the very resources or the tools that the systems have to use to implement what's being asked by the federal government. Some of these are huge. I mean ICD-10 alone, the potential impact on AR days, as we look at 2013 could make this look like a small number on incentives for meaningful use. I know they're just building on one another, but I think by us being conscious of that, of us discussing that and having it on the table so that when we provide information to ONC that we're doing it in the context that we understand the scope of everything that's being asked. I think that will just be helpful.

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

David, a last comment?

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

You know, Paul, through your leadership we developed some starting point on a strategic plan here years ago. I'm thinking back. The challenges: HITECH was passed now two years ago and so we're looking from the time frame from 2009 to 2015 is our window for this program, so it's a long time frame. I think we're still all struggling to, in real-time, redesign work to take the input from the real world and fold it back into our strategic thinking. It just makes me think as a policy group we should consider an update or something to the strategic plan that would give the country a second generation of guidance. But where we think we can get in this six-year planning window and not think of this strictly as, even though we all said Eric brought us tactical data from this process that Marc and Larry are running. There's also a strategic layer and we should find a way to capture that and revisit what we're saying to the country and how do we tie it together with the other reform tools and requirements that everybody is being faced with.

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

Thanks, again, to Marc and Larry. I'd interpret the overall positive feedback as I think people recognize that this is the right thing to do, for one, and that it probably is reasonably attainable. As Larry said, it's just hard when you have to move fast. But I think the time pressure is not just the HITECH legislation, it's what we have to do for healthcare in this era. I think we're pretty much on time, and if we could resume at 12:45, after lunch. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

We're ready to resume the HIT Policy Committee meeting. Dr. Tang?

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

Thank you. We're going to kick off the afternoon with an update from our Privacy and Security Tiger Team to talk to us about their hearing on patient matching. Deven?

Deven McGraw – Center for Democracy & Technology – Director

Actually, what we have teed up for you today are some specific recommendations from that hearing. You'll recall at our last Policy Committee meeting we gave you a snapshot of the general themes that emerged from the hearing and then we promptly turned thereafter to coming up with some recommendations. So we actually do have action items for the committee today. So, can I have the first slide?

There's the members of the tiger team, for those of you who do not remember who we are. As usual, but we can never say it enough, we thank you so much for the amount of time that they spend with me and Paul working on these issues. I think all of us appreciate how difficult they are and it's a lot of work and I couldn't thank them more for hanging in there.

Just to refresh our recollection about, and this is a little bit of a repeat of what we talked to you about at the last Policy Committee meeting, but it sets the stage for the recommendations. We know that accurately matching individuals or patients to their health information has a number of benefits, and the ones listed here are probably, this is not an exclusive list by any means, but these were some of the themes that came out of the hearing that we had on the 9th. But accurately matching patients with their health information has a number of challenges. Perfection is really not the goal here. What we're seeking is improvement. This is not just a technology problem, so while we have some recommendations that are relevant to the technology and we have others that get to the human factor aspects of this, poor data quality is an inhibitor to accurately matching.

We don't have a lot of research on what the best practices are, again, both with respect to algorithms as well as workflow changes that can be implemented that can improve this. There is not a one-size-fits-all solution. The level of accuracy to be achieved and whether you err on the side of false positives or false negatives is highly dependent on the purpose for which you're exchanging the data. The challenges increased as the data gets further removed from the source, so as we increase our efforts on information exchange this is going to become potentially an even more acute problem. Of course identifiers, including a universal identifier, could be helpful but are not a panacea. This is a multi-pronged strategy to really attack this. So in addition to hearing about these benefits and challenges at our hearing, we did get some pretty specific suggestions as to recommendations, and we have five different areas for you to consider.

I'm going to turn it over to Paul to start us with the first.

Paul Egerman – Software Entrepreneur

The first recommendation is actually a technical recommendation, although to reiterate what Deven said, it's a mistake to look at this as a technical problem. This is a human problem, a workflow problem. Also, you need to realize sometimes patients give inaccurate information about their own registration data or the family members, whoever transported the patient. So there's a lot of sources as to where you can have some issues. But in this first recommendation, when we held a hearing on this topic there was agreement from the providers that some level of standardization on commonly used registration data elements would be beneficial, commonly used registration elements being things like name, date of birth, address, and gender. While we're saying it would be beneficial, we're not saying that necessarily people are required to use those data elements for matching. We just think that this would help in many circumstances.

So our recommendation is for the Standards Committee to identify standard formats for these data fields. Now, in some sense that's not much of a recommendation because these data formats already exist; they exist in the HL7 transaction definitions, they exist a lot of places. The problem is that a lot of organizations don't do what they're supposed to do. So the other thing that we said is that EHRs should be tested and certified for interoperability regarding these standard data fields, actually from data entry

through data transfer. So we're saying the Standards Committee should identify the standards that everybody should be using, which I think everybody knows, and they need to be certified and tested.

The other two things, I would say an interesting one is that as part of the standards effort there needs to be identification of what should happen when the field is unknown. To give you an interesting example that we heard in the hearing was patients that show up at emergency departments at one hospital but they didn't have time to get the address. They would put in the street address of the emergency department in that field, which would work fine within that hospital, because I guess the hospital knew what their practices were. But if you did any information exchange it would give you an address on that hospital and that could cause you to possibly think I don't have the right patient. So the issue there is simply to define what the correct thing to do is when you don't have the information, when it's unknown.

The final bullet here is USPS, United States Postal Service, has a validation normalization program, and the information from the hearing was that this would be actually very beneficial if that was adopted as a standard within EHR. We didn't want to tell the Standards Committee what standards to adopt, so we simply asked them to consider that information from the hearing. So these are the technical recommendations, which again, it would be completely inaccurate to say this somehow solves the problem, but it sort of mitigates some of the issues. It would be a positive step forward.

Deven McGraw – Center for Democracy & Technology – Director

Our second set of recommendations, and I realize as I'm sitting here, before we move on, that I neglected to point out to you that we have these recommendations set forth on slides. But we also have them in text form, like textual format, which makes it that much easier to turn it into a transmittal letter should you all adopt them. But even if they're modified somewhat we've got a text and it provides a little bit of framing in addition to the specific recommendations that are on the slides.

So recommendation two here relates to more of these human factors and the fact that, as Paul mentioned, the technology is not the sole answer here. We've heard a lot from the witnesses about the need to foster a culture of improvement within healthcare organizations, as well as with respect to HIEs with respect to improving matching accuracy as well as evaluating internally the efficacy of the matching techniques used. So whether that's evaluating the performance of specific algorithms or evaluating whether particular workflow strategies associated with getting the data entered correctly into the right fields are working.

The next two recommendations really get at fostering that culture of improvement, and essentially there are two prongs to it, one being that healthcare organizations and entities should really be evaluating the efficacy of their matching strategies and achieving accuracy really on an ongoing basis. We think that this internal improvement and effort ought to be both on the healthcare provider and institution side, but HIEs as well and then ideally, using the evaluations that are done in order to internally improve matching accuracy.

Now, as you'll see in a couple more recommendations, we still have a lot of work to do to improve the evidence base about what works and to start generating best practices, and we have some recommendations with respect to that, but we think, as an initial starting point, this ought to be a priority for organizations to focus on. As I say that I'm thinking about the recommendation that we just got about the multiple things that healthcare institutions and providers are juggling as they move into this meaningful use period and having to also move to ICD-10 and numerous other things. I don't want to feel like we're piling on, but we think that this is an important issue, both from a patient safety standpoint as well as privacy.

Paul Egerman – Software Entrepreneur

The next recommendation relates to accountability and it starts with a discussion about matching accuracy. Matching accuracy is a very interesting issue. One of the topics we spent a lot of time talking about was whether or not we should be recommending a minimum accuracy threshold. This was a discussion that we talked about. Maybe one way to handle this was to say there should be a certain minimum level of accuracy that everybody has to do, and there are some aspects of that that are very

appealing, however, we did run into two obstacles. One is, there did not appear to be a simple to use, well recognized metric to measure accuracy, so that by itself is a serious problem in terms of trying to define this on a national basis. But the other concern we had was we weren't sure that we could get a one size fits all measurement on accuracy because there are different challenges, depending on the populations that are being served, and even different challenges based on the type of practice in terms of what may be appropriate or may not be needed for that group.

To try to give an example, if you think about a solo cardiologist, especially one that works in a suburban area, may know all of their patients very well. Try to compare that with an inner city emergency department, safety net institutions, institutions that may have transient populations, institutions where the population may speak multiple languages, those latter organizations have significant challenges in terms of matching and linking their patients. To say that you have one matching standard across the country didn't seem like that would work. So we still wrestle with what we should do about this in terms of accountability for accuracy. The way we came to understand the issue is to say, well, you look at linking patient accuracy and the accuracy of some of these data elements, so maybe it's part of a bigger issue about all data accuracy, which is also an interesting issue. But the way then to handle it would be to handle it as part of a governance issue approach for information exchange.

So that's the way we came down on this issue, and so we said that matching accuracy really should be enforced through NHIN or HIE governance of the participating organizations. The more we talked about that, we became more and more comfortable with it, especially if the idea is the HIEs will have some knowledge of their participating organizations and the populations they serve, so they can establish what is appropriate regional expectations. But if there are participants who aren't doing what they need to be doing, they can take whatever remedial actions are appropriate, either instructing them to do something different or possibly something more severe in terms of their continued participation. So our entire concept, at least for now, until an additional study is done on accountability, is to handle it as a governance issue and so that's what it is written up in the recommendations.

Deven McGraw – Center for Democracy & Technology – Director

The next set of recommendations are the ones that I alluded to earlier about starting to create a better evidence base about what works in matching accuracy. We're recommending that the national coordinator establish either a program or programs to develop and disseminate what are the best practices in improving data capture and matching accuracy. Just as an example of what the programs should do: gathering and disseminating evidence about what works. If we have organizations internally beginning to examine this and establishing self-improvement programs that should help generate some additional data that can be shared, ideally nationwide, to help improve this issue overall. Establishing transparency programs with respect to the efficacy of different matching algorithms; pilot and testing the accuracy of matching strategies; where there are funds available, of course this is always the proviso, but funding the development of some innovative matching strategies. So it's not just about what we have today, but as technology improves and we can use it more effectively to help us improve in that area, it's something worth further thinking and development. Then of course developing and promulgating best practices for propagating corrections to the record among exchangers.

We're going to take on the issue of corrections as a subsequent topic. We didn't have enough time to put a robust set of recommendations forward about correcting data, whether that's an error that is perceived by a patient or whether that's an error that is discovered by a provider and sort of what the obligations are to correct that going forward. We'll take that up in another set of recommendations. So more is coming, but we certainly think that it's worth saying now that in terms of creating best practice programs that ought to be part of the agenda.

Paul Egerman – Software Entrepreneur

Before we go on to the next recommendation, just a couple of comments on this slide. It's interesting ... after the hearing how many great ideas are on this topic. There is a lot of interest in doing some of the very good work, but this is also in terms of best practices, where you can do work on matching accuracy metrics, if that's something that ONC chooses to do. The last recommendation relates to the role of the individual patient. Basically, this is a straightforward concept, is that if the patients have access to their

own information they can point out errors and perhaps correct them themselves, so that's an important thing to do. The tiger team did not want, however, to recommend like patient portals or anything for just the registration data, especially recognizing that this is an issue that the Meaningful Use Workgroup is working on. So we simply said that we support the Meaningful Use Workgroup's and the Policy Committee's efforts to increase the access of individuals to their healthcare records. But it's simply another reason why additional patient access is a very good thing. Then we went on to talk about audit trails through HIEs and basically situations where HIEs may be required by business associate agreements to grant patients access and what those agreements should include.

So these are our five recommendations, and what we're asking for is whatever questions there are and hopefully for your approval of these recommendations.

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

Thank you very much. David?

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

This is very important work. Thanks for doing it. I have two questions. One is sort of this accountability question. I know Deven remembers when we did some work on this in the past, this idea of incidental disclosures came up and the potential for risk or harm by incorrect patient matching and then exposing data about the wrong patient to a physician or someone else inadvertently. I think there was a reasonable provision against the incidental occurrence of that. But given the variability you've described that might exist in the ability of organizations to achieve a high level of accuracy and the potential that local HIEs or state HIEs could be setting thresholds based on accommodating reasonable variations. But perhaps based on poor performance, the lowest common denominator impression, how do you think about the risk management and the liability issues that would be faced by providers in a sloppier environment than in a more rigorous environment? What's our responsibility to set a threshold that protects against those harms?

I had a second question, but I'll start with that one.

Deven McGraw – Center for Democracy & Technology – Director

I think there was a desire among a lot of members of the tiger team to be evolving towards thresholds, but the problem was we didn't have good, strong evidence, based on at least what we had seen in the hearing, about where we would set those. So there's just been so little research in this field that it felt premature to do that, and hence why the set of recommendations on HIEs really sort of ask them to step up and work with their participating organizations to set those. Then we do have the bullet at the end here is that sort of accountability feedback loop that we would like the HIEs to establish should also include what happens when there's an incorrect match that is returned and what are the policies about what you do with that data. You couple that with the legal scenario that we have today, that we didn't have actually when previous work was done, such as with the Markle Common Framework, for example, where they looked at this, it's a breach now to send the wrong data.

We actually have national policy about what happens in that circumstance, that a provider who receives information that they realize is wrong needs to return it or destroy it. Lest it actually be a breach that perhaps that individual would have to be notified, and that's national policy for HIPAA covered entities, meaning that the business associates would have some responsibility for accommodating that as well. So it's not fully sketched out, but we did put some recommendations forward that movement to matching accuracy also means what do you do when that doesn't happen and having clear policies about that, and then as a baseline we have law on it now.

Paul Egerman – Software Entrepreneur

It's an interesting situation that you raise, David. It turns out in our workgroup, there's one member of the workgroup who had this happen in their medical records, somebody else's data was there. At least in that example all that happened was there was a laboratory test that the person never had, the result was in their record and they found out about it because it was a reminder that they needed to get it repeated. So you can't repeat something you didn't have before. In that situation, though, the identity of the wrong

individual was not disclosed, in other words, it was extra information, there was nothing there that necessarily identified who the other person was. In one sense that's a breach, but in another sense it was a data error.

Yet, the other comment I'd give you, though, is the concern you expressed is the concern that a lot of people express, but the way a lot of healthcare organizations are oriented, they're so concerned about avoiding that situation that they tend towards the other side and they create a false negative. In other words they create duplicate records, and that's its own patient safety policy, because if you have duplicate records, you think about decision support, you're not necessarily operating with a full set of data on the patient, or you may be operating with duplicated data in duplicated places. The duplicate record rates that we reported were high, they were in the ballpark of 10% of all records in large organizations were considered to be unnecessary duplicates.

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

I guess I just wanted to voice my desire that one of our jobs is to create a safe environment where people feel confident that they can use this. If providers, with their natural risk aversion, don't feel like this issue is one where the threshold is reasonable enough to afford, the protection will be in jeopardy. I hope we can be pretty aggressive on that piece of it.

The second point I wanted to make, this is more of just a question to you, did you talk at all in the group about the patient as the linker? I know some of the commercial services like HealthVault essentially let the patient draw down data from multiple sources and then they are in fact the one creating the virtual or real link. Is there a scenario by which the patient is the more authoritative source of patient matching?

Paul Egerman – Software Entrepreneur

We did in the hearing go through that. In fact, we had Sean Nolan from Microsoft describe how it all works with HealthVault, and I know that they're not the only organization that has that model. That's a model that right now is used to link between patient portals and untethered PHR systems and it's a very interesting model. To the extent we talked about we were exposed to it and we also talked about situations where the patient plays a role, where the provider says to them something like "Were you ever seen on this date?" and that's a natural process for that to occur. But most of the information exchange scenarios that we were looking at were consistent with what was in stage one of meaningful use, but we're also thinking ahead to stage two. But it was where data, like CCDs are pushed from one organization to another, which does not involve direct patient linking the way that you just described.

Deven McGraw – Center for Democracy & Technology – Director

There was very strong agreement among the tiger team members, and among the people who gave testimony at the hearing, that individuals and patients could play a really strong role in seeing errors and in reporting them and getting them corrected, whether that's through a portal, whether that's through a PHR. But we did actually get one testifier who said that they did not think patients were necessarily the most authoritative source on the quality or accuracy of the data. So I think the direction we had it in is the right one, which is as we increase patients' access to the information in their medical records. This will be a natural outgrowth of that and we need to have processes in place for what happens and how patients report corrections, and corrections is really the next issue on the agenda.

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

Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Congratulations for taking on some really challenging work that's fundamental to what we're trying to do here with information exchange, and even breaking down silos within an organization. You kept talking about accuracy, and I wonder if you actually had any particular insights into how to measure accuracy. I sort of feel it's a little bit like adverse drug reactions. The really bad ones we know about. The not so bad ones get lost in the mix. I don't know what a good baseline is or even how to measure accuracy. Did that come up?

Paul Egerman – Software Entrepreneur

Indeed that did come up, Larry. That's the reason why we did not come up with the recommendation that you had to measure accuracy and do a minimum standard, because we didn't know how you would go about doing that.

Deven McGraw – Center for Democracy & Technology – Director

Yes, and we even toyed around with a public reporting strategy of matching accuracy and then had to throw that out because what's the measure, what are you reporting on? That's one of the reasons why we think it's so important, both for creating the culture of improvement needing to happen, but also for there to be some attention at the national level to getting some best practices both developed and disseminated and then ideally some transparency aspects of that too from a measurement standpoint.

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

Marc?

Marc Probst – Intermountain Healthcare – CIO

Really, very, very helpful. Recommendation two you mention that it might feel like a little more piling on. I don't think so at all. I think it's so fundamental to what we do in information systems, and having that accuracy is incredibly important so I don't feel that way at all. On the last recommendation, the only thing that would be helpful at some point, and I know these are really high level, is the audit capability is defining that. We've had the conversation, but it can get so difficult to do that you can't even manage it. But done right I'd agree with that recommendation.

Deven McGraw – Center for Democracy & Technology – Director

Yes, that's another one that some more detail around that, what does that look like in terms of providing that to the patient, what are the systems capable of automatically generating, is all in a future topic.

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

Judy?

Judy Faulkner – Epic Systems – Founder

Two things. First, a comment about the patient as link. I think a number of organizations do that, we do that too, patients as link. But you still have to check to make sure that it's correct. You still can get errors even though the patient is clear to link. Secondly, I just wanted to ask Paul and David, I've heard people from California say that if you see civil records that might be the matching records and you are to choose among them. Or if the wrong record is given, you have to report it to the state as review of patient information that you were not authorized to see, and therefore have the potential of being penalized for it. Do you know if that's accurate? Because I've heard at least one organization there say that that's how they're treating it.

Paul Egerman – Software Entrepreneur

I don't know.

Judy Faulkner – Epic Systems – Founder

There's a penalty on false positives that may really make—

M

Wrong name, is that what you're—

M

No, you just see the name.

Judy Faulkner – Epic Systems – Founder

... see three names that are Jim Smith, each which seem to match but not quite and you're supposed to pick among them, I've heard people say that that means that you have—

M

We certainly could concept that, and actually that was my question for you, which is, did you talk about the privacy issues around attempting to match and either deliberately or not having a broad scope to other things, so you find out information that was a violation of an individual's privacy. So you could do a search for Obama thinking, there could be lots of Obamas, but those kinds of things, did you talk about that issue? Because it didn't sound like that was what you meant by threshold?

Deven McGraw – Center for Democracy & Technology – Director

No, it's not at all. This isn't highlighted in the slides, but it is in the text, which is to say when we made the technical recommendation about the demographic data fields being consistently expressed. The one thing we did not say was a requirement to use all or certain data fields in the matching process, because essentially based on the testimony we got at the hearing what needed to develop a reasonably accurate match, again, is going to vary based on the purpose for which you're looking at the data. If you have standard fields that you use—name, address, and date of birth were the most common ones that were cited—and that doesn't get you to just one person, it gets you five, you're going to have to share some additional data in order to try to get at which match is the right one. But you want to do that selectively in an iterative process versus having all of it available in all sets of circumstances.

So that's essentially what we said, not setting the data fields that would be required, but saying accuracy is the goal that we want to achieve. When the data fields are used they should be consistently expressed, including when the data isn't available what does the data field say in a consistent way, and then acknowledging that there's some iterative human process associated with this that's always going to be present in terms of getting that match right.

I think the other place to have some more of a conversation on the details of this is when we talk about patient locator services, like a record locator service, or whether this comes up in the context of the PCAST Report with the data element access service. That sort of envisions the idea that there's some minimum demographic data that's available so that you can find the right links to where the patient's information is located. That might give us another sort of bite at the apple on this issue on how much data gets exposed.

Judy, in terms of your question, that wouldn't be a problem in the federal breach notification law, by my reading of it, because there are exceptions associated with sharing the wrong personal information with clinicians that as long as they behave responsibly with respect to it and return it and don't do anything further with it, then there's an exception.

Judy Faulkner – Epic Systems – Founder

I was curious as to whether people thought it was the correct interpretation of California law or whether it was an over interpretation.

Deven McGraw – Center for Democracy & Technology – Director

I don't know. I actually used to know California law on this pretty well because it was the first state breach law to be enacted in the nation, and now there are 47 of them.

Paul Egerman – Software Entrepreneur

I actually also wanted to make a comment on your scenario. The picture I have is an individual is searching and so they put in part of a first name and part of a last name and they get a display. During the hearing we learned of people who say, well, that's so 1990s to do that, that there are better ways of doing that now and that you should put in the person's full name, put in the date of birth, you should put in as much information as you have and then the system will do a match. It's the sort of thing that when we talk about best practices that would be the thing that we would encourage ONC to look at, to see is there a best practice as to how to do exactly the process that you described.

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

Interestingly, entering partial names is a process that we use to avoid creating duplicate records.

Paul Egerman – Software Entrepreneur

That's right. I know. It's part of the search criteria.

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

I wonder if I can ask that question a little bit differently. Do you think there's a policy issue or that we need to be more specific about how broad the search can be in a sense? Our new governor is Jerry Brown, and you can imagine people going around looking for Browns and being able to find where this person may have been seen. So should there be a limit on how many can be exposed? How many names can be a possibility? So when it's more than that you have to supply more information rather than receive and view more information?

Paul Egerman – Software Entrepreneur

Well, a couple of things. First of all, you mentioned the governor of California, most large healthcare organizations have specific policies for prominent individuals and will do something to segregate or separate their data and will also very carefully monitor all access. So it's less of a concern usually for a prominent individual. In the news, unfortunately, the terrible incident in Arizona where the Congresswoman was shot, there were workers at her hospital that were either disciplined or dismissed, I forget which, because they were trying to access the records. People do watch these things very, very carefully when there are prominent people involved, so I wanted to make that statement first.

The second statement I want to make is the issue about accessing during a search. That was not a topic that we addressed through this process. We were pretty much very focused on this issue of patient matching, patient linking, really from a standpoint of information exchange, in other words, exchange from one organization to another, and also looking at it from the standpoint of stage one of meaningful use. But we did also look at it from an understanding of what happens within an organization, because obviously that has an influence on the process. So you raise a good question, but that's not what these recommendations are intended to address and we should probably address it at some point.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I think it's related more toward who has the right and under what circumstances to do a query. Internally, organizations have to handle this with respect to assignment of roles and granting of privileges to the record of different levels of staff, but externally if you think about who gets to use the query in the HIE and under what circumstances are they permitted to do that. Then audit trails are typically used in order to provide a way to monitor whether those policies are being adequately enforced and hence why that's the way that they found out about the inappropriate peek into records, but this is obviously not a problem that's exclusive to famous people, although those are the ones that get reported in the press. I like to say that in a lot of places in this country the healthcare provider is the largest employer, which means you've got a lot of internal snooping because people are curious, and they're not necessarily famous, but they're famous in their towns or somebody's very interested in seeing why they're there.

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

James?

Jim Borland – SSA – Special Advisor for Health IT, Office of the Commissioner

First of all, Deven and Paul and to the workgroup, congratulations at looking beyond the technology and looking at the human factors. Mixing up peoples' medical records is something that we deal with all the time and it's as often as not done in the medical records department, where we receive medical evidence that is mixed. It presents its own set of challenges, especially at the federal level, with regard to privacy act protections and things like that.

I did want to share a little bit, and this is kind of a different take on the threshold issue, what our experience has been with our Health Information Exchange pilots that we have underway. Rather than return false positives, we've set a threshold for a match that will not return any information if that threshold is not met. It certainly protects patient privacy, but also it prevents us, in our case in disability claims, from relying on information that is inaccurate in order to make a decision. I think that the Health Information Exchanges have a vested interest in ensuring that false positives are not provided. I won't go

as far as to say it will be self-policing, but a high incidence of false positives will create pressure on the HIEs from the providers. So I think that there is some free market aspect to how accuracy is going to be dealt with in information exchange.

Neil Calman – Institute for Family Health – President & Cofounder

Can I put my hand up and get in the queue?

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

Sure, Neil. Paul's going to respond.

Paul Egerman – Software Entrepreneur

I just want to respond to Jim, first, Neil. What you said is very interesting, but it's also an example of how each organization sets their thresholds differently depending on what they're trying to accomplish. Although I personally suspect that, I don't know for sure, that going forward to do information exchange people are going to be so concerned about the false positives that we're going to end up with a lot of duplicate records. That will probably be our biggest patient linking problem is the situation you described, that they weren't sure that they had the right person so there's no match, and so they just put the data in, just it's a new person, and now you've got duplicate data and that has its own patient safety issues.

Neil is next.

Neil Calman – Institute for Family Health – President & Cofounder

I was going to say something similar that you just made the perfect example of why this is context specific. Because when I'm looking for a patient in the HIE and I put in three or four different fields, the more fields you put in the more chances are that one of those fields is just not going to match exactly. Somebody put in 141 instead of 144 as the address so it doesn't match and whatever, and then you missed the information. So in an administrative process that might not be such a terrible thing, you want to miss that information if you're not 100% sure. But in a clinical context using the first three letters of the first name and the first three letters of the last name and a year of birth or something that brings up 12 different possibilities might be exactly what I want. Because I want to make sure that I don't miss the information that I need critically at that moment in time. I think in our group the reason why this has been such a difficult issue is because it's so context specific.

The other part of the context specific nature of it is in a situation where, one of the examples brought up before, where a lab just gets transmitted automatically and matched, well, you might not want that to be matched unless there's a pretty good sense that it's exactly the person you want. But if I have an opportunity to make sure it's the right patient because the patient's sitting in front of me at the time, then I might have other mechanisms to say, is this you? Were you the one that went to the emergency room at such and such a place three days ago? And they say, no, that's not me. Well, that might not be your record then. Then you have a different process to verify the match. I think it's incredibly important that we've sat where we are with this, which is not try to call out some particular measures or things that we need to achieve, or methodology, but to understand that this needs to evolve and we need to understand how this plays out in different clinical contexts.

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

Thank you. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I was struck by a comment Deven made about technology being so yesterday. A couple of thoughts occurred to me related to that, so this is way diving into the details of where we might go on some of these matching algorithms, and that's things like photos. The ability of the computer to recognize image could mean that a photo of me could match other photos of me without a human actually seeing them and minimizing in some ways the breach potential because the system's doing the matching. Once you go down that road you sort of ask, well, what about all of those security questions people put out for themselves that they can embed in records. Sort of open up the net bigger than what we've classically used, which are demographics to match patients and maybe even selected clinical values that become a

signature for who I am that the computer starts to confirm, oh, these records line up, or Charles likes to cite that data shows up in the stream four times. So if this is really about me there should be redundancy in there and as we start to look broadly at how to address this problem that maybe we use newer technologies than the ones we had 20 years ago.

Deven McGraw – Center for Democracy & Technology – Director

Absolutely. That's one of the reasons why one of the sub-recommendations within the best practices program is exploring innovative new strategies, and that would include new technologies. I've spoken to the Smart Card Alliance previously and they have institutions that use smart card largely as a patient identity and authentication mechanism. But the cards also have bits of relevant clinical data in it, that it ends up serving a couple of purposes for these institutions, including being able to accurately match people with the data, it's got the chip in it. It's just an example. There are many. There are folks who are doing biometrics that are actively exploring how well that would work in terms of both identity and authentication in healthcare, as well as the matching issue, so there's some interesting stuff on the horizon and that ought to be part of the mix.

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

Any other questions? Judy?

Judy Faulkner – Epic Systems – Founder

Just a comment. Once that link is accurately made it should be maintained so that you don't have to actually do a matching a second time, but you know what the link is between the two organizations. You can solidify that match and not have to look again.

M

How do you do that?

Judy Faulkner – Epic Systems – Founder

Through technology underneath of saying—

M

... a number or something, a match number—

Judy Faulkner – Epic Systems – Founder

Some numbering system that links the two together and says, is this record on this system? Is that record on that system? Thereafter you get the right record. I think that really helps decrease erroneous things when you have to, I mean it's going to happen lots of times that you're matching you can decrease the problems of all the future times once you've matched correctly once.

Paul Egerman – Software Entrepreneur

Because you know the identification number and the other ... is one way.

Judy Faulkner – Epic Systems – Founder

I'm sorry, say that again.

Paul Egerman – Software Entrepreneur

In effect you know the identification number in the other person's system and vice versa, so you can link it to the other—

Judy Faulkner – Epic Systems – Founder

Right, so for whatever of the criteria you've looked at to match it the first time, if that is a successful match then you know the underlying ID number internally on each system that can be permanently linked and you don't have to go through a matching process again.

Deven McGraw – Center for Democracy & Technology – Director

Yes, the questions that are arising in my mind is what about when peoples' data changes

Judy Faulkner – Epic Systems – Founder

I'm sorry, what?

Deven McGraw – Center for Democracy & Technology – Director

When their data changes.

Judy Faulkner – Epic Systems – Founder

Oh, you're just linking the numbers, not linking the data.

Deven McGraw – Center for Democracy & Technology – Director

Since we're not endorsing a particular approach, I think that's one of the ones that would be put in the hopper for exploring how well it works and disseminating best practices about it.

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

Marc?

Marc Probst – Intermountain Healthcare – CIO

To follow on Judy's comment here, in Korea when we were trying to do this for the record locator service we indeed did have, at the record locator service, a unique number that linked the two identifiers at each of those other institutions. Similarly, to the earlier comments, there were some times when you think there's a match and you find out that there's not. Those things also were tracked to say never link these two, that we could say there's a highlight where you're given a link to these two billion Bobby because they're twins born on the same day, that you're going to get yourself into trouble, and these two will never link, and then the HIE stored that information as well.

Paul Egerman – Software Entrepreneur

Interesting comments. But to me they do reinforce the concept that ONC should be doing some best practices evaluation, because between those two comments those are great ideas, and I'm hearing there's actually starting to be a fair body of concepts about ways to do these things that are helpful for people to learn.

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

It also speaks to your recommendation about NHIN should enforce some of these best practices and certain thresholds. Okay, I think the workgroup is looking for an approval of the recommendations. Does anybody want to make a motion? Okay. Second? Okay. All in favor? All opposed? Any abstentions? There you go. Thank you, Deven and Paul.

Is Micky on the line?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm here.

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

Good. Thanks, Micky. Are you doing it? Okay, we'll give them 30 seconds to settle down, Micky, and then we'll begin.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

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

Micky's going to update us on the Information Exchange Workgroup. Go ahead.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Good afternoon, everyone. This is a very short update to give you a status report on the Information Exchange Workgroup activities on provider directories and on the agenda setting discussions that we're having to develop the road map for the workgroup over the next six to nine months.

Just to refresh everyone's memories, we have been working on the provider directory issues since about last August. We staged our recommendations into two broad categories; one which we call entity level provider directories; and the second, individual level provider directories. In December we presented and the HIT Policy Committee approved our recommendations related to the entity level provider directories. Some of those recommendations related to providing direction to the Standards Committee about creating a set of standards in alignment with ELPD directory recommendations. We presented to the Standards Committee on January 12th and our understanding is that the Standards Committee is now in the process of assigning work related to the standards to one of their workgroups, which I believe is going to be the Privacy and Security Workgroup, so that workgroup can get underway.

An important and great connection I think from a Policy Committee perspective is that Walter Suarez, who was the co-chair of the Provider Directory Taskforce on this workgroup, it also turns out is the co-chair of the Privacy and Security Workgroup on the Standards Committee. So that will be a valuable link, I think, across the committees to make sure that the spirit of what we wanted to have expressed in the standards is actually instantiated in the standards as they get developed.

This is the framework. Now I'm just going to talk about where we are on the individual level provider directories. We are using the same framework which we used for the entity level provider directories, which is to say we're walking through component by component looking at the different dimensions or different characteristics of what that individual level provider directory would look like, users and uses, functions, content, operating requirements, what have you. We're in the middle of that discussion right now. The Provider Directory Taskforce has come up with some preliminary recommendations which we've discussed at the workgroup level, and we'll have further discussion of that in the coming meetings. Then we'll turn a little bit to the policy issues and actions recommendations once we've settled down on a firm set of recommendations related to the characteristics of an individual level provider directory.

The timeline for February 7th is the taskforce itself actually will firm up its recommendations on these different characteristics and start to discuss the policy issues with an eye toward wrapping that up in the February 11th meeting. All with an eye toward end of the month to have the workgroup as a whole weigh in and make recommendations on the individual level provider directories, with the ultimate objective of being able to present the Policy Committee with a set of recommendations at the next meeting on March 2nd.

So that's where we are on the individual level provider directories. I guess something I would say in conclusion of that discussion is that the entity level provider directories were more complex than I think all of us appreciated as we started to discuss that and as we're finding the individual level provider directories are even that much more complex. We originally had hoped to have some recommendations for this meeting, but as we looked at it we realized that there were some more complex issues there that we wanted to go through and understand it a little bit better. The urgent need that is certainly out there, in particular from the ... level HIE grantees, is certainly felt. So we do feel a good sense of urgency to be able to get something out there so that they can move forward, not that all of them are waiting, but I think a number of them are waiting and hoping for some guidance to help direct their efforts. I did present to the community of practice, that is a provider directory community practice associated with those HIE programs, two days ago and gave them an update as well. There's a terrific amount of energy around that, so I think that there's going to be some good collaboration. But also there's a lot of hope and anticipation that we can get some good recommendations out there by the next Policy Committee meeting so that that can help guide their efforts on the ground.

The other thing I would say about the individual level provider directories is the way we're thinking about that right now, and we certainly need our process to unfold to see what the actual recommendations are. But the way we're thinking about it is that around the individual level provider directories there will be certainly some recommendations, but some recommendations that might be more in the form of best

practices. Because there is a recognition among all of us I think that the individual level provider directories are much more localized and decentralized. We want to be able to have in alignment in certain conformance so that whenever individual level provider directories are created, certainly those that are created with government funds are linkable and linked to the entity level, the national level entity level provider directory that we recommended. But on the other hand, we also recognize that there's a lot of individual variation in states and in regions related to what they're hoping to use the provider directories for and what their individual sustainability models might be. So we certainly want to leave a lot of room for that type of variation that exists out there in the market.

Turning next to the work ahead, one of the things that as we've been thinking about the workgroup—and David Lansky and I as co-chairs, thinking about what we've focused on since last August, which is the provider directory work—has been a real deep dive, full engagement type activity. Which has been terrific in the sense that it has engaged the entire workgroup. Indeed, one of the things that have limited the bandwidth of the workgroup as a whole is that when we asked for volunteers for the Provider Directory Taskforce, almost all the workgroup members volunteered to be on the taskforce. So just by the very fact of the way that sort of played out, that meant that we really needed to focus almost exclusively as a workgroup on the provider directory taskforce issues.

As it turns out, those were so complex that I think it needed the full attention of the workgroup. But going forward, we recognize that as we're starting to enter the world of stage two and getting our arms around all of the health information exchange issues that are out there in front of us. That we want to think about a different mode of operation going forward where we're able to take perhaps a lighter approach to a number of issues. For those issues in sort of a triage sense be able to identify for almost each issue what might be the core areas that are worth exploring, what might be some quick recommendations related to those. For those that seem like they need either more work or a deeper discussion of recommendations or some deeper recommendations, pausing for those and perhaps doing a greater deep dive. But we discussed this at the last workgroup meeting and there seems to be a pretty broad consensus among the workgroup that we want to be able to do that, and doing that through the lens of meaningful use stage two. So if you could flip to the next slide, please.

One of the things that we want to do—and this is just a slide we took from our last workgroup meeting so it may be a little out of context here, but—as we look at what the meaningful use stage two process is right now with the ... workgroup, I think as everyone knows, has public comments out there through February 25th. And looking at the plan of the workgroup one of the things that we discussed in the Information Exchange Workgroup—and it was great to have George Hripacsak there from the Meaningful Use Workgroup—just to sort out what we'll do as a workgroup. Start to engage on those recommendations, since those are frozen right now for the public comment period. Then we'll work with the Meaningful Use Workgroup to figure out how we're able to formalize our input into the various interoperability and health exchange aspects of the meaningful use recommendations and get those incorporated into the process. So that those, as they bubble up to the Policy Committee over the spring, have been vetted and we've done our workgroup work behind the scenes to make sure that what the Policy Committee is seeing are things that we've coordinated among ourselves and not having to try to sort that out at the Policy Committee itself.

So that's why we're lining ourselves up for, right now—if you can turn to the next slide, please—where through February and March we're going to focus on this stage two meaningful use recommendations that are out there for public comment. That will also be with an eye toward the S&I framework as that starts to get further developed. So I think, as everyone knows, there are three initiatives; one on CDA consolidation, one on lab interoperability, and one on transition of care. As those seem to move forward and get fleshed out a little bit, we'll take those into consideration as we look at the stage two Meaningful Use Workgroup framework, come up with our own view as a workgroup of the stage two recommendations and the S&I framework in that context, work with the Meaningful Use Workgroup sometime in March or early April. I think one of the things we want to work on is when the public comments come back so that we can all be able to take a good look at those and incorporate those in all of our thinking, and that would be the first tranche of activity for us in the coming couple of months.

Then we've laid out a high level schedule of how we would think we would address these individual topic areas through the summer and looking into September. But I will say that for what you see there in terms of the topic areas, those are very, very fluid right now and I think that we'll probably change some of those around I think almost inevitably once we go through our deeper discussion of stage two meaningful use recommendations.

I'm going to stop here. I think there are one or two more slides really just about the process that I just described for you. As I said, this really is just a status that they would love any guidance or any thoughts from the workgroup about things that we ought to be focusing on going forward. And David, let me ask you if you have anything else to add?

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

No, thanks, Micky.

M

I have a question. I think last time we met, stimulated by Paul Egerman's questions to, I think it was the NHIN governance, it was at the entity enterprise level provider directories, we were thinking that that could be part of the certification for being a participant, the coding, the conditions of interoperability and trust, that the provider directories would be wrapped into that. Am I remembering that correctly?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That was one of the recommendations that was approved, yes.

M

So would this not be similar to that in terms of going through that certification as being part of the NHIN versus it being a meaningful use objective?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I can give my quick response and welcome anyone else's from the workgroup who's there. We thought that both were important and that was in the recommendations from the Policy Committee. One was about having it be a part of meaningful use to the extent that that makes sense. The other was having it be a part of the COTI to the extent that that makes sense as well.

Deven McGraw – Center for Democracy & Technology – Director

I think one of the issues is that we still have a lot of uncertainty around what the COTIs will look like and what will fall into that bucket, and so you want a policy lead of some sort to enforce this and so you're throwing them both out there as potential. But I think as we move toward more clarity around what sort of follow on work to the governance recommendations takes place we'll be able to answer those questions a little better.

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

Any other comments or questions? This is an update, right, Micky?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes.

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

Okay. Thank you very much. Thanks, Micky, for being on the phone. We can move on to the PCAST Report from the PCAST Workgroup. Now, is Bill Stead going to be on as well or is it just you, Paul?

William Stead – Vanderbilt – Chief Strategy and Information Officer

I've joined. I'll stay on mute until you get to my slides to keep the airport noise out.

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

Thanks, Bill.

Paul Egerman – Software Entrepreneur

I'm here to talk to you about the PCAST Report Workgroup. What we're going to talk about is who we are in this workgroup and what we're going to be doing and when we're going to do it.

In terms of who we are, this is a list of the members. It's chaired by Dr. William Stead from Vanderbilt, who's on the phone, and me, and we have a group of I think it's 18 people that ONC helped to put together, and I'd say as usual for workgroups this is a talented group of individuals that have a great diversity of experience. Some do not have previous experience working with ONC, some are on the ONC Standards Committee, and there's a great diversity of experience that is going to be very helpful. People with privacy backgrounds and people with backgrounds in technology and the Internet are there also.

In terms of what PCAST is, this is actually a slide from a different presentation, on December 8, 2010, which seems like ages ago, this group called the President's Council of Advisors on Science and Technology, PCAST, released a report which is entitled "Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward." PCAST, the President's Council, is a Federal Advisory Committee, much like we are a Federal Advisory Committee, and so they give advice in their case to the President of the United States, and they give advice on a very broad range of topics that are important to the country. So it's terrific that they published this report about HIT in our work, so this is all very exciting. I understand the president has read the report and the report's about 100 pages long, and so I tell you, if you haven't read the report I want to encourage you to read it. One hundred pages may seem like a lot, but it's actually a very quick read, I guess it's good size margins and the fonts aren't too small, so I would encourage you to read the report. If you've read it I encourage you to actually read it again because there's a lot of very important material there.

Now on the same day the report was issued, ONC published a request for comment in the federal register and basically asked nine questions, mainly around the impact of the report on ONC activities, initial thoughts on the recommendations and how people wanted ONC to respond. The very fact that they did it the same day is a reflection of one of the things that you see in the report when you read the report, if you all read it you've seen it has statements in it like that ONC needs to act aggressively and accelerate progress and to take bold steps, all around interoperability. So there's a clear, at least to me I interpret that as a clear statement of a sense of urgency and priority around information exchange, and so I think ONC viewed it the same way and acted very promptly on the report. Public comments were due on January 19th and we got over 100 comments, which is terrific.

In addition to creating the public comments, ONC has created this workgroup, and this is our charge. What we're going to be doing is we're going to assist ONC in synthesizing and analyzing those public comments, we're going to be discussing the implications of the report and its specific recommendations to ONC on current ONC strategies, and talking about the feasibility impact of the report on ONC programs. We also will be looking at the ONC strategic framework and commenting whether or not any adjustments might be needed on the ONC strategic framework. What we are not doing is we're not making any judgments about the PCAST Report. We're not saying anything that we think is positive or negative about the report. We're simply looking at what are its recommendations and what are its impacts. So those are the things that the workgroup is doing or will be doing.

This is our schedule. If you look at the bottom of the schedule you'll see that on April 13th, so just a little over two months from now, we will present our final report to this group here in terms of whatever conclusions we come up with. We're on very much of an accelerated process. This schedule is, I think, created to be consistent with the other schedules so that it can feed into what the Meaningful Use Workgroup wants to do in May and can feed into any potential impact for stage two of meaningful use. So we'll present that on April 13th. I guess sort of like in a Groundhog Day type event we will present it again on April 20th to the Standards Committee, so we'll ... through the same report twice. Now in the middle of this whole process February 15th and 16th you see that there's a stakeholders' hearing. We'll be talking about that in a minute. The hearing on February 15th and 16th, all members of the Policy Committee and all members of the Standards Committee are invited to attend. The way we are approaching our work is we are spending all of the initial sessions simply trying to absorb the report and

understand its implications. Starting on February 16th we will be working on coming to some conclusions about the reports.

Dr. Stead, if you're on the phone, maybe you can take us through the next couple of slides to describe the report itself.

William Stead – Vanderbilt – Chief Strategy and Information Officer

The PCAST provides directional recommendations and then it provides specific technical approaches as examples. As Paul said, our job is to understand and explain these directional statements and then to provide alternatives about how they might be achieved for your consideration for recommendations to ONC. This slide is a working draft of three major directional statements. We drew them directly from the wording of the report, but they reflect largely Paul's and my understanding of emphasis. They've not yet been vetted with the working group. So we're really providing you them to let you know the nature of what we see is high level directional statements. The first one is self-explanatory, and Paul's already mentioned the idea of acceleration of progress toward robust exchange of health information.

The second one takes a little unpacking. The key point is to establish an exchange architecture, and I actually in reflection would have put the underlying there, not under the exchange language, because the architecture includes language, a supporting infrastructure, and strong provisions for privacy and security safeguards. The exchange architecture will enable physicians and patients to assemble a patient's data across organizational boundaries subject to persistent privacy statements. By physicians there that's really referring to anybody who has an authorized need to know subject to the privacy constraints for use appropriately for care, research, etc. The word "assemble" is very important, because it's really implying that you'd be able to assemble the data from its original sources and not just be working with summaries from a point in time.

The third bullet is that there should be an evolutionary transition along this direction that builds upon the existing systems and implementations that are in place and the existing architectures, such as the CDA. So it's important to understand that this is not about ripping and replacing, it's not about stopping what we're doing, it's a directional statement that we should try to set an alternative infrastructure side by side with what we have that would accelerate exchange and in that process, frankly, probably improve the value of the existing infrastructure.

The next slide tries to identify what we see as key characteristics or attributes of this architecture that they're proposing. The first is use of an extensible language. XML is an example, not a prescription. They're really saying that whatever is used needs to be able to accommodate very minimal change in first steps and it also needs to be able to accommodate progressive evolution of our understanding about medical concepts over time.

The second is the idea of a much more atomic approach to exchange using tagged data elements. The word "atomic" still needs to be defined and thought about and in the report they use the word the smallest aggregate that it makes sense to aggregate or exchange, so they're probably not talking about individual data elements, but that's still work that needs to be understood. The record locator and data element access service is an indexing service that is equipped to find where the information about a person is. They actually envision that you could have multiple of these, and these services don't actually hold any of the information. They just know how to find it, persistent, and that word's key, privacy safeguards that travel with the data so that any information provided by the patient about how it's to be used in the original system that captured it would actually still be there as it's moved through various levels of use by other systems. It emphasizes the idea of use of the personal health record in the exchange, both in the sense that the patient is able to use the exchange to aggregate information and to communicate information. It talks about decoupling syntax and semantics. In other words, the universal exchange language would be the syntax necessary to find transport encrypt and unencrypt the information, but not the information to interpret it. Semantics could be considered plug-ins and would start with all of the existing standards such as SNOMED, etc.

The final idea that seems important is decoupling of the security key infrastructure, the data indexing infrastructure, the applications it would aggregate, and then, as I mentioned before, the data that was stored where it was originally stored. This is an attempt to dramatically, through separation, decrease the risk of security breaches and also to reduce the need for overly complex governance. Back to Paul.

Paul Egerman – Software Entrepreneur

Thank you, Dr. Stead. As you go through this, for some people here that work on the policy side this may seem like a lot of technical jargon, and what I'd tell you is it's actually not that hard. If you want, we can work through Judy and give you a little tutorial that we did for the workgroup to make sure you understand what people mean when they talk about an extensible language or tagged data elements and even what the clinical document architecture is. The concepts are actually fairly simple and I think it's important that people feel comfortable with that as they go into the hearing. So if we want we can organize a call sometime, we'd probably have to do it before the 15th, maybe during the end of next week, to try to make sure people get a little bit of tutorial on those subjects. But the main comment here I want to tell you is that don't let the fact that you see something like three letters, XML, don't let that intimidate you. These are simple concepts.

The hearing on the 15th and the 16th, this is a fairly high level view of how the hearing's going to work, it will have panels one through six in it. They probably won't be in exactly this order. We're shuffling things around. We originally thought we were going to do this whole hearing in a very logical way, overview of the report, patients then providers, the basic constituencies, but because we had to do this on such a short time frame some of the people we tried to get to be present were only available at certain times. So we will go through all these stakeholders in a sequence that might appear to be random, but the purpose is to make sure that we get all of the information, and so that is what we will be doing.

Once we've done that on the 15th, the next day on the 16th we are planning to spend three hours in an open meeting with the workgroup and the Policy Committee and the Standards Committee to start to discuss what we learned. And how we're going to respond to our workgroup charge in terms of how we've absorbed that information and what we are to perceive the impact on of ONC's various programs, for example, what would be the possible impact on stage two meaningful use. So we will start to do that on the morning of Wednesday, the 16th, we'll run until about 12:30, and I think it's at 1:00 we'll start a Standards Committee meeting. So if you would like to stay and also attend a Standards Committee, I'm sure that you would be welcome to do that.

Anyway, that's our workgroup. We have a great deal of work to do in a very short period of time, and I hope you will join us on the 15th and the 16th. But do people have any questions or comments?

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

Thanks, Paul and Bill. Questions? Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Maybe I need to hold this until the acronym phone call, but PCAST talks about ONC CDA. Have you assessed whether that's the same as HL7 CDA?

W

It's a typo.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

No, no, no, because in the PCAST Report they refer to it as ONC as well.

W

....

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

What was the answer to the question? So the answer sounds like it's yes. Probably the answer is yes, okay. But it sounds like that's our assumption going in that CDA means HL7's clinical document architecture and not something ONC has in parallel. Okay, thanks.

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

Adam?

Adam Clark – FasterCures – Director, Scientific & Federal Affairs

Thank you, Paul, and the workgroup as well. When we went over at FasterCures the PCAST Report, we were actually very excited. We thought it was very promising. In particular with their letter to President Obama, they called out the importance of clinical research and clinical trials in particular as being able to integrate with this environment. They have an entire chapter dedicated to clinical research, and for many of our constituents in the disease advocacy groups who are focused on research for their disease it was uplifting to see. I was just wondering if when you were putting together these panels if that was a consideration, because without knowing much about XML it did seem like it was an enabler to bring together the research in the care environments that they really called out are disconnected at this point.

Paul Egerman – Software Entrepreneur

Yes, it's a great observation, Adam. If you look at the panels, panel number five says population health, well, that's where we're intending to look at some of these research issues. But you're right, that is a major theme that you see within the PCAST Report. It is very interesting. This should be a very interesting discussion because earlier today somebody talked about the FDA Sentinel program. One of the people that will be testifying in that panel is Richard Platt, who did some of the work on something called the "FDA Mini Sentinel" a fellowship paper on that very recently, and there's just a lot of very interesting issues. We're asking them to say give us some examples of research that this will facilitate, can you think of some examples where it won't facilitate it, and we actually want to look at how would this all work when we talk about population studies on extremely large populations. If you want to do a healthcare population on all of the people in the state of California, how will that be possible to do?

M

And if I could just follow, I think one of the things we've been trying to emphasize, because population health is a research issue, comparative effectiveness research is another, some things that the Sentinel is looking at, the biosurveillance, pharmaco vigilance. We also want to assure that clinical trials is incorporated in there, and the PCAST talks about the FDA having multiple drugs going against the same disease and not even being able to compare those in real time. So I just wanted to highlight that it is a focus for our group as well.

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

That's great. Thank you. Judy?

Judy Faulkner – Epic Systems – Founder

PCAST depends upon standardization of data elements and ... they're stored, they're stored consistently throughout all the different databases around the country that are going to be storing them and the data elements are defined the same across the country. Is that the underlying concept of PCAST?

Paul Egerman – Software Entrepreneur

Do you want to answer that one, Bill?

William Stead – Vanderbilt – Chief Strategy and Information Officer

I would say the answer to that would probably be no. They're hoping that this would be an exchange infrastructure that would let you represent or tag information within your systems with whatever semantic standard is appropriate, such as the ones that are already being worked through the ONC process, and that we would be able to find them, exchange them, and then access those standards to interpret them. This is not a top-down prescriptive model that would in fact regularize the meaning of all data across the country, unless I'm misunderstanding the report.

Judy Faulkner – Epic Systems – Founder

If in fact they allow each to do it their own way, then how are they going to bring it to together and analyze it? Just think of something like education, what grade did the person go through, and it has elementary school, middle school, junior high, high, and they're defined differently throughout the country and there's not a map. Because it makes a significant difference, what is 8th grade? Is it junior high or is it middle school or is it whatever? That's just a simplistic version of what can go on with much more complex data. How will they do that?

William Stead – Vanderbilt – Chief Strategy and Information Officer

We're still in the early stages of understanding it, so that my understanding is that you would have to use whatever concept matching algorithms and so forth that you would use now. Bear in mind, they're not taking away any of the firm's work. They're talking about coming up with a way to let things move more quickly while that work continues and is refined.

Judy Faulkner – Epic Systems – Founder

So if in fact what they have to do is mapping algorithms from one to another to another and the various vendors all develop their software very differently because the vendors don't get to look at each other and figure out what the coding schemes are that they're each using or how they each divide up the data. If the vendors on the whole who may make a suite system and you put them all together and you have maybe 80,000 data elements and it took us two years to define four, is that right, problems, allergies, does that mean it takes 20,000 years?

William Stead – Vanderbilt – Chief Strategy and Information Officer

As I understand it, they're not proposing to slow down the work that is currently underway to come up with reference semantic standards and representation, so that work continues. Those provide reference sources which I believe would be used by concept matching algorithms, not necessarily mapping. But these are things we have to work out as we, as a workgroup, we seek to understand the report and identify what the alternatives are for trying to move in the directions it recommends.

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

...?

W

Thank you. I'm looking forward to the vocabulary instruction, Judy, so please arrange that. I'm also very much looking forward to on Tuesday when we hear the different groups. When I read—and I'm not a technical person. I'm just your average every day state legislator, okay, who also happens to be interested in health IT. So what I have learned over the last two years being part of this committee and the direction we seem to have been going in really encouraging innovation, in allowing a lot of free things going on out there for every vendor to do what they do best, innovate. My sense of things, in just having read part and parcel of this is that this is a very different approach than we have been taking over the last two years. I have great concern in that we are expending a great deal of money right now and things are on the marketplace, things are going down a certain track, and in fact we have just let a \$19 million contract in Florida on HIE.

This seems to be going in a different direction. Is the work that PCAST has done, has that been at all coordinated, or have they discussed what is going on here? Are we then going to take a 90 degree shift or a 180 degree shift in the direction we're going, especially on Health Information Exchange, and where we're going on HIEs and where we're going in indirect? Perhaps I'm misreading or not understanding the report, and I very much look forward to a more in-depth understanding of that report, but we have a lot of things in progress, a lot of money being expended, where do we go from here?

Paul Egerman – Software Entrepreneur

Those are great questions, and in some sense that is a good chunk of the work that the workgroup is going to do, is at least to lay out the options of how to, as you call it, coordinate within the PCAST Report with what ONC is doing, existing ONC programs. The two comments I'd give you is to reemphasize what Bill Stead said. The third bullet that is clear in the PCAST Report, if you read the executive summary,

they are talking about an evolutionary transition and they're talking about doing things that build on the successes of what ONC has done.

In my opinion the report should not be interpreted as a criticism that ONC did something bad and now we've got to do a 90 degree turn or something. It seems to me that there's a fairly clear statement that it's supposed to be an evolutionary process. I would say that the report itself, the reason why I say people read it again, those of us who work within healthcare IT we have our own set of terminology and words that we use and a lot of this report was written from a different perspective. And so it takes a little bit of thinking to understand what they're getting at and why they're doing what they're doing. But what we just need to do is go through their recommendations very carefully, line it up with what it is we're currently doing, and understand what the impact is and what the choices are.

W

My point is—and perhaps I did not say it appropriately—is that yes, this is going to be evolutionary, but we're spending large amounts of money right now. We're setting in place an infrastructure, especially in the exchange area. Once you establish that and we're rolling that out right now and developing it, if we're going to take a course directional change, that needs to be rather rapid so that those of us who are expending these dollars down at the state level can direct those changes right now appropriately. If that is indeed the direction this committee is going to go and the ONC is going to go, who is the ultimate arbiter of the correct direction? Is it PCAST? Is it ONC?

Paul Egerman – Software Entrepreneur

Well, your question asks, there's like two choices. ONC is the one that is setting the policy that it's simply a matter of looking at the PCAST Report and understanding it and understanding its implications. You ask about HIEs or HIE organizations, we have a panel on that, and that is one of the things we'll be looking at is exactly the issue that you raised, what is being done so far, how does this change it, and that will indeed be one of the issues we'll be looking at.

Jodi Daniel – ONC – Director Office of Policy & Research

If I can just jump in. This is a report from an advisory committee. It is a presidential advisory committee, so it's one that obviously is important for us to pay attention to and to look at. We wanted to understand a lot of the very questions you're asking, which is why this PCAST Workgroup or Tiger Team is looking at this now, to understand the interaction of this report and ongoing activities. Hopefully the hearing will bring out some of the answers to some of the questions you're raising as far as how the report compares with existing activities, what things can we do, and layer on to what's going on, what things would be a directional shift. All of these things we hope will come out in the hearing, we're going to be hearing from lots of different types of organizations.

The timing issue that you raise is obviously an important one. There are some things in here that are different from some of the activities ONC has undertaken so far and that other folks have undertaken so far and so it's something to seriously consider. We're eagerly looking forward to hearing from the folks that testify as well as from the committee to report back. ONC sets our strategic direction on federal health IT activities, obviously we're part of the administration, and this is a report from an advisory committee to the president, so it's something that we're looking at as we're developing our direction for the next steps of our activities.

Paul Egerman – Software Entrepreneur

It's also important to understand that it's not like the PCAST group is on the planet Mars or something. We have a good relationship with them. I think in our second meeting we had, I think it was the vice chairman of PCAST, Bill Press, spent the entire time answering the kinds of questions that people are asking right now for our workgroup. During the hearing we will have two members of PCAST present, Christine Castle, who is a physician, and Craig Mundy, who will actually be dialing in from the other side of the world, but they will be present to answer questions. We set up an entire arrangement where there's back and forth discussion with the PCAST people on lots of different issues, and the relationship is totally and completely cooperative. They're very interested in the hearing because they want to hear what some of these issues are and so it's an exciting opportunity. People should not look at this like

there's a threat here or something. They should look at it as, in my opinion, is this is an interesting opportunity to really look at what we're doing, to think about a lot of issues, like the population health issue and understand the report.

W

A follow up, please. What is your time frame, or what is ONC's time frame perhaps in looking at these discussions and issues and coming back with recommendations that ONC is going to act on, especially in the HIE area? Because these contracts have been let and do we want to say to our vendors perhaps we need to hold off in doing any development of how we construct a statewide HIE in Florida until we have some indication from ONC where we're going.

Paul Egerman – Software Entrepreneur

Our workgroup's time frame is what I set out, that April 13th is when we're going to produce our final report. It will not have recommendations. It will simply lay out where we see the impact of what it says and it will also lay out if we see any alternatives that could mitigate that impact and still accomplish the same directions of the report. So that is our alternative, our time frame. In terms of answering your question whether or not people should do anything different in terms of contracts, my answer is there's nothing I would see in this report that would cause anybody to do anything different right now. I'm not suggesting that. I would say, however, for the HIE in Florida if I were you I would tell them to work harder. But that's all I would say.

W

At some time too, Paul, do you want to discuss the open source concepts that are in PCAST?

Paul Egerman – Software Entrepreneur

There aren't open source concepts in PCAST, and we will have both vendors and open source people talking about that. Again, I'm not here to advocate for the report or to say it's good or bad. I'm just saying this is what it is. Let's understand it. Let's try to understand what it's saying. Let's understand what its impact would be. Let's work with the PCAST people. And let's see what comes from that.

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

Any other comments from the committee? Okay, I think we're ready for public comments then, please.

Judy Sparrow – Office of the National Coordinator – Executive Director

... to invite public comment. We do have a comment in the room. Mr. Morrison?

Tom Morrison – NaviNet – Chief Strategy Officer

My name is Tom Morrison. I'm with a company called NaviNet. I'm also on the board of a clinical group or a collaborative and we've been doing some work with PCAST as well. I think one of the opportunities that is really represented in PCAST is that PCAST sort of is reflective of some new directions in technology where things work a little bit differently. I think there are some policy level implications for this group in PCAST because one of the assumptions that we've been making is that the data is what's exchanged and the receiving application in the EMR is how it's presented. The problem that Judy was raising, which as a vendor you can't create an application that can support 80,000 data elements. It just doesn't work. I think part of the thrust of PCAST is that in a Web-based world the presentation and the data all come together, so you're not actually expecting the receiving application to present the data. That opens up a lot of possibilities for the kind of exchange that Dr. Blumenthal mentioned earlier around NHIN direct, where you're just trying to get information from one place to another. That ability to exchange the information that's been defined by the source in terms of its presentation, they deal with all the issues because they know the data and they know how it needs to be presented. So I think one of the things that this group should look at is the implications of the ability of the source of the data to also be the entity that defines how that information is presented when it's been exchanged. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Mr. Morrison. Richard Singerman?

Richard Singerman – BioQuest – President

Hi, I'm Richard Singerman. I'm the co-founder of TrustNetMD, we have social media for augmenting hospital physician collaboration and innovation, and I also wear the hat, I had the opportunity to serve on the Institute of Medicine's Advisory Board for Learning Health System. And there are a couple of comments here. One, the comment was made earlier on the quality measures that the providers are still responsible at the end of the day for figuring out the process redesign to leverage HIT tools to reach the quality targets. That's a big mouthful. That goes back to an issue, I think, that Dr. Tang brought up almost a year ago about culture and change, and we heard from testimony, I believe, in the meaningful use group, from the VA on the inefficiencies that happened for the first six months to a year when they were starting to roll out their systems. So that's a huge cultural shift and process redesign shift and so as I hear the quality discussion it would be helpful maybe if there was some stratification or different paths for small providers, medium providers, and larger providers and hospitals on what were those process benchmarks, maybe three or four pathways to get to the quality goal? Because to say here's the quality goal, here's the HIT tools, you figure it out, is a pretty big mouthful. So that's area one.

Area two, in the upcoming session for PCAST I would also advocate that entrepreneurs, organizations with disruptive technologies, especially those that leverage new breakthroughs in telecom outside of healthcare, be invited too so that we bring in the non-traditional thinking. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Richard. On the phone we have Chantel Worzala from American Hospital Association.

Chantel Worzala – American Hospital Association – Sr. Associate Dir. of Policy

Good afternoon, and thank you all for having such an interesting meeting. A few quick comments for you, in the context of the lessons learned from the Implementation Workgroup, that number one and number ten, or is it eleven, recommendation, provide adequate time, isn't that something that you can address and CMS can address? There is no statutory requirement that stage two of meaningful use start for hospitals on October 1, 2012. It is up to CMS. That's a regulatory decision and you can recommend a later start to stage two.

Also, about the Implementation Workgroup, I want to clarify that the certification concerns center on what does it mean for a hospital to have a certified EHR. You cannot get a meaningful use incentive unless you attest under the False Claims Act that you have a certified EHR. Right now the rules and guidance are very complex and very unclear, in fact, how you can attest to that fact that you have a certified EHR. It's an extremely complex area, but two examples. ONC has told hospitals and physicians that they must possess EHR technology certified for all stage one meaningful use objectives including those they choose to defer. This did not happen until the 23rd of December. It does require additional work in negotiating with vendors to get additional technology. It does mean that you may possess technology that will soon be out of date and you may not choose to use. ONC has also said that a hospital must buy all modules included in a vendor's complete EHR in order to say that they have that certified EHR technology, even if they're going to be using other solutions to meet their meaningful use objectives. For example, most hospitals actually report to public health straight from their laboratory information system. They will still need to buy their vendor's product to do this at considerable cost, even if they do not choose to use it. This is what we mean, and what those who testify mean, by complicated and uncertain, unclear requirements for certification. It's not what the vendor needs to do. It's what the provider needs to have in order to attest against a false claims risk that they have a certified EHR.

I want to also talk a little bit about quality measurement and emphasize what you've already heard, which is the need to coordinate measures across federal quality reporting programs. We have many new programs under health reform that will in fact address many of the measures that you're considering directly. For example, there's a separate payment policy focused exclusively on readmission, including payment penalties, so there's no need to include readmission measures in meaningful use. It would be redundant and confusing if there are different readmission measures included in meaningful use. In addition, hospital acquired conditions are also part of a specific financial penalty provision in Medicare law and regulation. Again, we know it's important, folks are working on it, it's being addressed elsewhere, and it does not need to be a part of meaningful use.

We also strongly recommend against including the HCAHPS patient experience of care survey information in a patient's EHR. This data is already being collected and reported for Medicare quality reporting purposes but it's very important that the data collected from the patient be seen as anonymous for the patient. Obviously including that survey data in the patient's EHR does not maintain that confidentiality or anonymity and we want the data to be reported by the patient without them thinking that it will in any way impact the care that they receive because they are identified as potentially giving less than stellar feedback on their experience of care. So we really want that confidentiality to be maintained. That doesn't mean that we wouldn't necessarily want Web-based tools for collecting the data, but it should not be incorporated into the EHR.

We also want to emphasize that the stage two and three quality measures really need to be tested in the field so that we know they're thoroughly specified clinically valid and actually feasible to collect before they're put into place for the meaningful use program. We're already hearing reports and are extremely concerned that the stage one measure specifications for hospital clinical quality measures were not field tested and the accuracy of the vendor data collection algorithms is in fact not even tested. A vendor can be certified for clinical quality reporting without having shown that their algorithm is correct, that's specifically stated by NIST. It's only that they need to calculate something, not that they need to calculate something correctly. We've also had brought to our attention large errors in the specification for the stage one measures. Again, they were never field tested and we really do not want that mistake repeated. Moving forward, all quality measures for stage two and three must be fully tested and verified, including field testing. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Chantel. There are no other comments, so I'll turn it back to Dr. Tang.

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

Thank you. In my haste to get Paul Egerman off the hot seat I forgot to thank him and Bill Stead for the good work you're doing on the PCAST, and that's certainly a challenging exercise, so thank you. Any other final comments before we break? So we will see you next month. Thank you very much.

Public Comment Received During the Meeting

1. PCAST - I am glad to hear members express concerns about the PCAST report going in a different direction, because it is. Most especially with HIE. It states quite clearly that PCAST sees current HIE as doomed to failure.
2. Patient matching accuracy is not necessarily a question of HIE quality but often because of the community from which the data comes. Puerto Rico has a much more complicated set of issue surrounding individual names, for instance.
3. Having followed the meetings of the Tiger Team in which Patient Matching was discussed, it is surprising to find that recommendations are being made to the Policy Committee. The outcome of Tiger Team meetings on this subject were that the members were basically unable to reach consensus. The presentation of recommendations now seems more driven by the goal of meeting a timetable to decide something rather than because real results have been obtained. In particular, the topic of Matching Accuracy is argued against by the information delivered during this presentation itself - one size fits all will not work, lack of metric. Saying that it is a governance issue does not resolve this. Sharing data of "what works" nationally is contradicted by the previous statement that "one size fits all" is not true, so that "what works" will also not be a one size fits all solution.