

December 2009 NeHC Board of Directors Meeting

Please standby for real time captioned text.

Good morning and welcome to everyone and holiday greetings to all of you. I want to welcome you to our meeting. We appreciate those of in person and online. The presentation slides are available on the registration table for those of you in person--Before I began I'd like to thank you our very capable South--Alex Baker-[Audio/Speaker not clear] for their work. As always we welcome your suggestions and comments. We ask everyone participating online to submit your questions. We will also have a public comment period where I will take the phone lines off of mute. Please make sure you are logged into the webinar. We are looking forward to--I will now call this session. We ask all of our directors and federal liaisons' to identify any conflicts of interest. Who will present our panelists and then we will have a Q&A period.

Thank you, John. We will have the opportunity to cheer or moderate the panel and for those of you in the audience--The Palace for today close session include Jack--Phil Assistant--And Jerry who is a practicing lawyer and partner for Information Technology and HIPAA practices. I wanted thank you those, especially those that traveled long distances--By way of introduction, I wanted to put up a Way to begin discussion by putting up definitions that I pulled from the main variety of sources and just want to put this up. Integrity is the way we make sure that data is consistent - - transforming storing or sending. To go through the history, lineage, characteristics--Data is exchanged. --The way we ascertain the data source. These are a little bit overlapping. It guarantees the information--it ensures that the authenticity desirable back Wesley is accuracy, the closeness to the truth value of meetings are calculated values. That includes an a concept is measured by different methods and the level of agreement. Today we will focus on these three areas as pillars of for Exchange. I have the pleasure two weeks ago of half my physician bring me back for a routine blood test--Sent to the laboratory and processed under another name. By physician called me back to repeat the test and only because the other person--it was processed in someone else's named. This is not uncommon and most of us Maxim point in our lives will be subject to the issue of the inaccuracies. On another note in terms of my personal experience--I just wanted to make a few comments--We have dealt with some of these issues--to exchange information on how we predicate our - - there is integrity. To do that we spent a fair amount of time--we spent an enormous effort-[Audio/Speaker not clear] not a small task. It is a big issue. It is not easily it managed. There are issues with how you deal with [indiscernible]--The last name might be represented twice. It is quite an effort. The information we were able to give back help improve the quality--propagating areas across the rest of the exchange--now our next phase of additional support for the statewide effort. Withas an introduction, I would like to now invite Jack to start off our discussion and go through the four. We will have a full discussion at the end. Jack, please.

Thank you.

Thank you to the National health collaborative to speak with you this morning that. Starting with the beginning, accuracy of information gathered--With the patient. When you talk about the three pillars, really the foundation of these is how the information is gathered from the first encounter. If you do not have access at point--You will not have the ability to make good

decisions and have a [indiscernible] health Information Exchange--Let me talk about our organization and tell you experiences we have had-- Particularly involving electronic medical records--we are an organization out of Washington that provides shared services--hospitals and clinics and so forth that do help information technology and Exchange--Health Information Technology and Exchange. A large portion of our health Information technology is in the area of electronic medical records speak we have been doing this for about 14 or 15 years--on the EMR side--we also provide centralized application models and have not made higher rate of EMR adoption in the community. What we have learned through this is there is a fundamental balancing act when you are talking about EMR operations. You want to provide standardization to support interoperable tea and quality of the information you are gathering. On the other hand you have the efficiency of operation and how easy it is for the provider to enter information and have clinical controls. I have a quote on here from a physician. He said we try to standardize data entry but in doing so we end up frustrating and slowing down the physician so we have to [indiscernible] our standards. [indiscernible] gets upset when they find their data is not accurate.

A particular example where we have been learned about the perils and pitfalls of the EMR utilization is a project we have been working on over this past year around--We are actually importing data-- to a patient health account.

[Music playing in the background].

The Personal health record project was started about a year ago and is a new project--[Audio interference] [Music playing in the background].

Currently we are limiting--For reasons I will go into in a minute. --[Audio interference] [Music playing in the background]. One of the things we have learned is how the EMRs argues and the health information exchange, in general. [indiscernible] Sharon of them are in our network--[Audio interference] [Music playing in the background] have that data set is captured--A basic example, after we brought the system alive we've found there were some HL7 systems that were not getting across--[Audio interference] when it went for the HL7 interface engine, it interpreted that--Just a very simple thing but took a fair amount of investigation to see why some messages were coming through and won on track others were not speak for you would think that medication technologies would be fairly standardized. Went to the easiest case scenario. We also found things like how the data is displayed to the patient is affected by the way that data is entered. Google has it all displayed as transmitted into the Google account and some physician have found that alarming because they were not sure they wanted the patient to see exactly what they typed in. Apparently some of the physicians type things like this person by the a drug abusers. We found complexities which From what turned untracked started out as a very simple process--if we go beyond that to diagnoses and procedures, it will get even more complex. So, based on our experiences we have not made you recommendations that I will walk through quickly. It is important that the EMR support how [indiscernible] is delivered in different practice settings. Everyone is aware of for the need of workload changes and the EMR is brought into play, but the processes have to be flexible and allow different users and different practices to use the system differently. There is not lot involved with the human-computer interaction and the human side is, definitely, the complexity in is equations. We are aware that any end user has the ability to mass of the best designed application and is important that the end user-how the end user will interact with it, the screen and navigation and so forth will make it easier. The order

it is for the end user, more likely they are to skip over or MS type or skip complete information. With that in mind, the EMR design can affect equality and is something we are seeing over and over again. If they are entering abbreviations, do they all use the same abbreviations? Probably not. The number of [indiscernible] thinking you will get a nurse or physician assistant to go through 20 clicks to go through something, they probably will not. You have to make it as easy as possible so they are not missing steps. If it takes too long to get from one screen to another, they will skip steps. They are under time pressures and are trying to go through as much as possible and EMR should be facilitating that, not getting in the way. Thinking about to the [indiscernible] I showed, standardization is needed. It will be sharing data. There are some examples of the importance they were having to do around identification--So, that standardization, as we all know, has to happen but has to happen also in the background and thinking about Amazon as some of the other current models for customize interfaces' that still need to be standardized in--They are customizing all kinds of things based on your history. We need to be building that kind of intelligence with our electronic medical record systems. If we tried to force compliance there will find them way to work around them and that will affect the data quality that will affect the entire chain of for Critical Care. So, I know we will be going onto the next.

Any clarifying questions from the Group? We will move on.

Your EMR penetration is what?

About 66%.

We will move on to Hope Anderson.

Thank you. I want to focus on instilling confidence in the users and consumers of this. I am looking that different groups that look at this process differently. Consumers are one group and care providers are another group and organizations are another group--Accuracy, consistency, integrity. Then, business associates and vendors play a major role in year. From a consumer perspective, of course, they are interested in the quality of care. Family care--they are beginning to get it that their companies are affected by the time as and quality of care. They want accountability. Their privacy and security is that the forefront and now that the [indiscernible] is beginning to take into consideration consumer preferences and be unable to express those preferences and handle an exchange their information is crucial. If you are not made provider, they are really dubious of information they get from sources other than from their own organization. The [indiscernible] we are talking about is extremely important. There is a certain expectation that the information you get from other sources is or is not complete. I know we give them confidence in the completeness of that. Be flooded with information is not, necessarily, helpful. Giving it to them in and organized, concise fashion that they can digest and quickly is awfully important. Who is accountable for this information? If I am using information to make clinical decisions, how do I know I am doing the right thing? Old simile, each provider is getting information from other sources and is responsible for making that final decision, final interaction, verify that information with the client. If you are an organization, then you have business considerations for this exchange of information and what are the rules for opprobrious? This whole new world of the health information exchange is giving me as a manager, provider, organization, you need concerns. What about the exposure that we have for send the information to other places or receiving information and

acting on it in and inappropriate manner? What about a breach that is caused by [indiscernible]. The breach might have happened back another organization. How does that affect me? This is not made more complex environment that we have to manage and have to transition from the Legacy systems. Am I be going to be going full board into this area of the health information technology or be cautious and step into this lovely? If you are not made business associate, you are going to look that it somewhat differently in that-what is my liability as a business associate? Am I going to be caught up [indiscernible]? Am I going to have to get my legal people involved more than I have before? What is my exposure? If we do have a breach, there is 60 days from the [indiscernible] Report. Maybe I can go to 59 days--There our a lot of issues to be resolved and I think some good use and we have been working with some of our vendor-advisory council members that are members of the EHRA, make electronic health Records association that are going to be developing and monitoring and identification System and looking that this issue and see as a vendor community, what we need to be doing to make sure that the community is safe.

From a policy standpoint a lot is emerging--The new ARRA additions to HIPAA, we need increasing enforcement to give confidence to everyone that the system is working and enforceable, that we are getting new technology requirements through the [indiscernible] that wishes to join this exchange and being able to validate that they are not going to be a we clank in the chain. Along with those requirements, which will be memorialized will be all of these requirements for coming on board as a participant in the NHIN and now that we have the DERSA coming to light and other related documents around policies and procedures and operations with communities participating, we think it will be helpful in instilling this degree of confidence. The DERSA, itself, has developed over a period of two years, related to the governance of the NHIN and has recently been signed by a number of leading entities in the country and it in force and ready to go. The document, itself, is the policy/foundation for building trust and confidence in the system. There will be the a joiner agreement for an association that wishes to participate. It sets the foundation for expectations and responsibilities and behavior within the NHIN network of frameworks and presupposes that each of these entities has a trust framework within his own community and is acting as a proxy for organizations that are using the health information technology as an entry point to communicate with others.

Some of the key components we have already talked about. I want to focus on the permitted purposes. You will notice that within this list, treatment, payment, operations, public health activities, the quality reporting that will be required for meaningful use, and other disclosures that are based on authorizations from individuals, but not explicitly researched. Research was too difficult in as point in Time to encompass. If you have the authorizations, fine, go ahead. With respect to liability, organizations are responsible for their actions and we try to keep it very simple from that aspect. Applicable law is lot within the state that you operate and the federal law. Your federal agency is federal law. I have tried to keep it very simple. It seems simple, but if you read the agreement, it might not appear to be as simple. There has been a coordinating committee established, technical board, to work on issues like breach notification, resolving disputes and working with memberships. If there is a participant in the NHIN that violates the agreement, any of the agreements, it becomes a risk to others. They might suspend their ability to communicate using NHIN. That is a pretty serious matter and necessary to instill confidence and in the system. That is all I have for now and would be happy to respond to a question or two.

Thank you. Are there any questions from the Group?

We will move on to Phil from the NCQA to talk about their efforts regarding integrity and authenticity.

I will take a slightly different way because I do measurement and think about measurement and will come to this list from a clinical-generating the information and more on how we rely on data generated out of clinical care processes to do performance measures. So, what I want to do is rely on insights that we have gained through data collection supporting a number of data collection efforts that NCQA does through EHRs and others. What we do is to collect data and the performance and quality measurement and have been doing this since about 1990 and tried to enable and ensure transparency and accountability through measurements. We have about nine 2/3 of the health plans in the United States are accredited, about 75%-- submit date set to us and we also collect data from physicians and physician groups through our recognition programs. I will talk in the next couple of slides on how we validate and audit those programs that might give us insight into how we want to do this through electronic health records. I will skip the slide in the interest of time. So, talk about our diabetes recognition program, we have a number of measures, about 10 that are endorsed that assess critical aspects of caring for people with diabetes. These measures are used for pay for Performance--Other health Plan programs. It can be submitted either through paper and chart abstraction or through submission, directly out of electronic health records and because it is used in paper performance programs, the bar is fairly high for making sure that we have accurate and valid information. We are receiving submissions for the diabetes recognition program from the main number of EHR programs--And others. What we use is a XML schema that we have developed to facilitate this submission and is also being used to pass this information along to CMS to support [indiscernible] reporting as do a number of similar registries and one of the things that we have learned is, despite the electronic system's edit checks, the automated checks, it still requires not make significant amount of user support. How do we interpret? How do we do this and then further allegation upon submission. Just having the obstruction in place does not always mean we are getting accurate data set.

The health Plan [indiscernible] that we get from managed health plan organizations, this undergoes a multi-level validation approach. We provide detailed specifications and are very clear about algorithms, codes, how do you select people, the Jets'. We certify software vendors. If a health Plan uses an outside vendor to calculate, we go in and certify them to make sure that their systems accurately and completely calculate the performance measure so that we know we are getting good data. We also certify auditors and put them through an auditor's certification program so when they go out to the health plan, they assess how under and if they are using the right methods and approaches, again, to make sure the data is accurate and complete, since so many health plans, purchasers, regulators, are using the data, we want to make sure what they are getting is accurate and reliable. So, what we do through the validation, the audit program is to make sure that both these structures and processes are there to make sure the data submitted is complete and accurate.

So, what does this tell us for the future over the next couple of years gathering and using EHR-based data for measurements? Piece I that I have here is, essentially, and assumed data flow process that we are thinking, how would this possibly work, are these measures for me to use or for a HIE or [

indiscernible] program? The measures are developed and endorsed by [indiscernible] or others, endorsed the the [indiscernible] process. Standards have been developed so the measures-the measures can be imported into the EHRs more seamlessly. Then, the measure goes into the EHR and is linked up to a reporting system whether it is a meaningful user or something similar, and there is an applied [indiscernible] at the end that has the clinical data, clerical process data that feeds into the reporting system and the data is reported out for Performance measurements. We are assuming, and I think we are all hoping that the measurements that will be done in the future will be done through an automated performance measurement collection, not Manuel. The scale of having physicians and clinicians, everybody go into records and do this by paper or pulling it out of their EHRs and doing it manually is not going to work. We need to have this flow automatically. Are some of the NCQA ones we have had in our learning? We need to think about to standardize the measures. NCQA collaborated with the EHRA to have the electronic quality measure format which is a XML-based schema for representing a performance measure. It was founded and led by NQF through the enhancement and submission of that format as a HL7 Standard. It was reached under recently approved as a test standard. We are beginning to put measures into that format. The first thing we need to do is retool the measures and to the health Quality measurement. I think Floyd has talked about the difficulty measurement--And how the NQF is making the measures and breaking down the data elements in such that it needs to be standardized and in the end, standardizing the measures and getting them into a format that is EHR readable will have helped minimize the ambiguity that is in the text that we have. That is the step that we need to think about. The first up is standardizing the capabilities of the EHRs to support performance measurement. Can they capture the data that we are--CCHIT will certify the functionality and have put forward the preliminary ARRA certification standards that cross link existing functionalities and capabilities to what likely will be needed in order to support reporting or meaningful use. Is the functionality maintained, a problems, medication list, etc.. You are probably very familiar with that. The second thing that comes in in terms of standardizing capabilities is making sure that we have validated the measure calculation with the EHR or the entity where the data is being submitted to will calculate the measure so that the data comes out of the EHR. We do this as part of our software certification program we have standardized test X of a population and patients and run it through the system so we know what the answer out of the population should be to see what result comes out in the end and has not made way of validating, pulling down and using and calculating the results correctly. Finally, we are looking at how you standardize the reporting out, quality and the reporting architecture provides a good tool for this and allows the system to either submit the results, new radar/denominator or individual patient level--The third level is submitting detailed patient-Global data, what are the blood pressure readings so that the HIE can combine that with other external information or a registry can compute that, the measurement--Using that data combined with others. We are going to need standardize ways to pass this information so that we can make sure it can be validated as it is passed through.

Speaking of validating the data, the other two pieces I have talked about, I am much more comfortable that we have systems in place--What some of my colleagues talked about previously and what I will talk about now will and that is what makes me more nervous as the goods is obvious that is worth restating. The measures will only be as good as the data that underlies those measures and goes into the data calculation system. What we have seen in a lot of the research we have done with building measures into electronic health

records is the workflow going into the practice can affect whether or not we do Automated data Measurement, not in your head--if the problem list or medication list is not up to date, we cannot use that to populate should this patient be denominator? There will be requirements for a physician to do this, but we have seen where specialists or other non-primary providers to ask [indiscernible] information but are not updating the centralized problem or medication less and can affect the reliability of the data [indiscernible] historical information on a problem list. What we are all facing is, are we getting this data into a discrete field? Does the blood contract--The LDL value, is the lab report scanned and put into as an image or as a--Again, for clinical processes--patient management as a-- Finally, how do we know-how are we going to check this? Some of the things we are seeing about meaningful use--Yes, I did this. I am not sure what they will link the testing to. We need to think about how we go beyond that--we can do it by looking at the data completeness. When a clinician segments [indiscernible] are the rates reasonable? Should we pull a small sample of those? This is to not only validate the integrity of the data but understand on a system basis what are some of the root causes so that we can build in error prevention into the system, not necessarily a gotcha who are trying to do the right thing. We pull data on a sample of senators and see what is going on.

In conclusion, I think what we need to do today sure that valid data comes out of the EHRs are clear specification measurements systems and reporting. We need to make sure the data collection functionality has been rigorously reviewed across all of the dimensions I have stressed and, finally, we need to make sure that the workflows within the practices and the use of the EHR, itself, is supporting our ability to use the data within that system to do performance measurements. Of there any questions? --Are there any questions?

Great presentation, Phil. You made reference to the level of the health plan. Are those individuals trained--finding out what individual clinicians are using in the EHR in a way that is intended? --It is the issue of whether or not the clinician is taking the time to use the drop down menu or whether the go ahead and put it in the narrative fashion--

So, in general, they are not going out to individual practices. Some programs like the California pay per performance program they are going out to physician groups and validating the data and auditing the information. One of the things they are looking for is that the chain of evidence that what goes in and how it gets processed through the system. Right now, there are very few places where there is someone going out to do validation or technical assistance. We have some programs like New York's program [indiscernible] and--If I did not mention your program, it is not intentional, where there are people going out and helping rework the workflow in such to support these programs. --That is part of the technical assistance to capture the data.

It is and the male laborious process and I do not see it a way around it. SA will have to go to back initially periodically patch we will see the tension between the validating and trying to understand the root causes of errors and improving this System Quality.

We now move to our last. , Jerry.

Thank you. I want to make sure I am pointing in the right direction first of all, I want to thank the Meryt for Academy and organizing this Pavel. One of

the things that I enjoyed is the offline interaction with the paddle and appreciate the leadership. Our prep work was worth the price of admission for this. I appreciate that and what to acknowledge the support of your staff. It has been excellent. They did not make good as job as anybody could do. Originally, I was going to be first and set the tone and through the course of our discussion, it became very clear that I was the spoiler. I got moved to the add. I will try to make a you points. It goes very nicely from the remarks of the other panelists about, where are we now? Particularly this is in the context of NHIN and the integrity and accuracy of that information. So, the overall point I want to make today is the information that will be derived from any record that is transmitted to NHIN or local/regional HIE is focused on the recipient of that information to decide how valuable it will be. What you will see and I will if [indiscernible] DERSA that was introduced, you are not receiving any assurance of the accuracy or integrity of that information. The point is, what do we do in ordered to create a better framework for users of that information? That is the content that we were just taken through. We need to establish some sort of means to develop the standard of care for the practitioner around HIE and PHR. Wait until slide four.

[LAUGHING].

Let's turn to DERSA for a Minutes. I had the distinct honor of being the principal authors of the [indiscernible] data exchange agreement that took a lot of time to develop and I think have some important underpinning for the DERSA and other health information exchange agreements used around the country. From that experience, whenever a new agreement comes out that I have not been directly involved with I am always interested to see how another group addresses a problem that we have struggled with. The interesting part about data sharing agreements is no one wants to take responsibility for get anything or have any liability, but it all needs to be perfect. In the DERSA there is specific representation by sources of information that all you are getting is what was available at the time for Exchange. There are express disclaimers--that the information will be available tomorrow that was available today and you get bashed-kind of find like bind a used refrigerator. The participant acknowledges that they note is not complete and what is available that that time. Where does that put us? Well, I think as stated in the DERSA, it is the provider for making sure all necessary information--making those decisions and to addressing utilization management and quality management with respect to any patient. The DERSA tells us that [indiscernible] assumes any role in patient care by virtue of being in the chain of. This is not to criticize. Having been there in many instances, this is the best you will get. With that, where are we? I want to turn to PHRs. Janet made the point of, how are you going to make sure that the doctors are using them as light that? Now you are giving it to the patient and we all see our own physical and health conditions through our own filters. Sometimes when you get the message from the doctor and it goes into your PHR that they think you are a drug addict, you will probably not leave that in your record if you have any editing capabilities at all. There our a couple of different kinds of PHRs. Onism collection of records that come through third parties. You will get the things that's a typical example is the a PDF of lab reports, typical things. The [indiscernible] is the exclusive which is the aggregate, self managed-attract PHRs. As consumers that is what we would like, something more personal that allows us to collect things other than the official records of our health. It helps us understand what is going on. PHRs that allow you to do Web-based research and find out about your condition and say that information into your PHR, it would create something more useful for

you, personally, that has more commercial appeal. What happens is you can add it. You might lose direct source data. For example, a summary of a lab report, you might not have the lab report any more. It is difficult from a legal standpoint. If the practitioner relied on patient-supplied information inappropriately, it can [indiscernible] the patient later on. People much smarter than I have said that if our patients gave us health of the information we need to have lied to us all the time. It kind of falls to-what are you going to do with that? So, what do you think will happen with these records? Exclusive records are probably going to be more reliable and relied upon because it is another picture of the same lab report that I have somewhere here. I can look that that speed of this is your lab values and there we aren't. The exclusive record given to the healthcare provider is probably not going to be useful and a lot will probably disqualify that as a source of reliable information. As a practical matter our challenge is to let the public know when they are developing these PHRs, what is it going to be useful for? Also, to provide guidance to practitioners and what does the medical community think you are going to do with this information when provided to you? It has been suggested by some people that we should be looking at similar interoperability standards to make them more rigorous and that might take away the usefulness from the patient standpoint and create more usability from the care provider standpoint. That is something [indiscernible]. So, here is the \$25 million question. Who will be left holding the that? Any participant has a relatively small rest. There is representation there that they send you an accurate test-if they did not do that, and that turns out to have been the basis for someone getting hurt, then the participants will have the burden. It is not a particularly high burden but appropriately placed and in B DERSA. In the end, the healthcare decision maker, the provider on the front line is going to be held responsible for how they deal with this information. Those of you that understand how negligence works is you have the duty and in this case is the duty to provide appropriate care and you have to ask reasonably as a similar person of light qualifications would in the same circumstance. If you do not do that, then you are negligent and held responsible for the consequences of what you did. I think where we are-we are certainly at a point where there is hardly any good guidance out there for practitioners and what they should do. There our cases, not old cases, where courts have found it is not negligent for a physician not to have looked that the medical record before providing care. That is consistent with the standard of care that you examine the patient and get the information that the patient currently has and make a medical decision. The fact that you did not look back at a paper record or electronic record is not negligent. Over time, I question whether or not that standard will maintain itself. I think the public is going to expect that with the availability of information, the medical decision makers are utilizing that information to make the decision.

Also, what are we supposed to do here? We are trying, all of us in this room and those listening in, are signed on to this because we want EMRs to work and regional and local exchanges to work and improve the quality of care. So, I think the burden, and it is one we have to take on Square is, what guidance are we going to be giving physicians? What are we going to be teaching in medical schools with what you need to do with electronic health records? It is the elephant in the room. We have been talking about this but no one can get as to that point. From a technical standpoint we will create the functionality that will bring information to the bedside, to the physician's Office and lead it up in the air, what is the doctor is supposed to do with that information? In fairness to the medical community, if we are going to ask them to have their workflow completely disrupted by having to do drop down

boxes and all of this other stuff we are expecting them to do so the information is there and usable, we should give them a had up about what they are supposed to do. Groups like this and others that we all participate in can play a very strong leadership role in deciding what that answer will be and once that is known, I think the physician community can say, I can do that. I can play by those rules. --Case by case, I think we run the risk of [indiscernible] physicians from participating. We have these conversations all the time, the concerned about liability risk, it is real and we hear it all the time and is career altering. So, it is and a high price to pay for making a mistake about what you should have done. I think the industry owes it to the individuals that are ultimately left holding the bag to tell them what we think, or what the community thinks is and opprobrious standard of care. Be careful what you ask for--Thinks is an appropriate standard of care.

Thank you. We will move into some discussion around the presentations that the core. Had. For the purposes of our listening audience, letting them know who is speaking, if you would not mind announcing your name before speaking or asking a question--we also have on the phone Laurie Evans and Steve Finley. Martin Harris is on his way.

Good morning. I am Simon. I think you were right [indiscernible]. I have the a couple of questions and was reminded as you talked--Washington state review panel a couple of years ago where some of these issues came up around personal health records and how they should be applied and used. I am thinking back a couple of years ago when I was the commissioner--and seeing the women coming to testify who have a cards that she carried with all of the medical records on a chronically ill child that she had. That might be a program of a Personal health record, if you think about it--Personal health records what has happened and has happened for years for get people being the holder of their medical records that they scavenged from one physicians to another with these more complex conditions?

Thank you. I guess the answer is, it really depends on if there is some change. I have heard similar stories and is the doctor's nightmare when someone comes into the office with the whole cart. I have 11 minutes. The what need to read this or talk to you? I do not think it changes the question. It goes down to how much the physician--how much information the physician needs to make their decision and how reliable is the information they have once that decision is made. If your person had a whole bunch of physically and verifiable medical records, that is pretty valuable stuff, if you have the time to go through all of that. In the PHR, the risk is that information cannot be verified. It could be a formatting thing. Did create a New forms for your lab work and can you move your values over to get? I am a physician Nancy a printout of your PHR that Caesar personally entered the lab values, I will probably be suspicious about. If we are moving towards not having to run all of those tests, I do not know if that will move the ball in the right direction. I think that is a question over how does the PHR fit into all of this, ultimately?

Just a comment. This is Jack. You are absolutely right that the clinicians in our project made it clear that they would not rely on what came out of that record. Where they found it more useful is to promote conversation with the patient, partly for the it patient the use to gather the personal information from other sources. They bring that in a way to facilitate and trigger memory--

Kevin?

I think we would all agree that not every physician in our wonderful healthcare system has the resources of Dr. House and if you see Dr. House that has four attending physicians--Homes and doing investigations is not the reality to our healthcare system. With that in mind, today's panelists are fascinating both in positive ways and disturbing ways. I remember back in 1997, we established the a Group--Quality Improvement collaborative and took a bunch of our large users on the same database, same clinicians and dumped it altogether for the purposes - - this is now 12 years later. The exact items 12 years ago that were causing problems - - standardize documentation, what information you shared was not shared--I think that one thing that we have to recognize is that there are two charts. We have to keep in mind that they need to exist. The physician needs to have a certain amount of information. It is probably not appropriate for them to share with the physician in a meaningful way because it triggers certain [indiscernible] made by that physician. I think of it the same as the [indiscernible]. There are certain industries that look my credit balance and see what my payments are, if I am paying on time or late and that is sharing my financial information, but there are certain places that do not care if I Shop at startups--Other entities, obviously, do for marketing purposes. I think as we think about healthcare exchange of information, I would be interested in the panel's reaction on this. We can always come back and say that we do not need to [indiscernible] if we start this.

Stages knowing they are not all Dr. House, we have to decide what is the basic level of information that we share and show that we can share over the next few years and how do we solve the problem that was brought up today with respect to normalizing that data set in such a way that it can be manipulated and have credibility? I would like the panel's reaction to those things.

[LAUGHING].

Again, this is Jack. Based on our experience with the Personal health record, we'd like the physician to take that approach, which is what seems to be the high priority data elements and focus on those and get those right, starting with medication allergies. They said if we could not have anything else, this is what we would like to be able to share. As I pointed out we are finding complexities with that. The idea of not doing everything at once, but taking it a step at a time with the high priority data elements that will provide the--Is the way to go.

We are talking as if there is a provider [indiscernible] and personal health record in the hands of the consumer. This is an inner need of an intermediate step, the care coordinator, chronically ill with multiple providers and multiple--giving them access to a combined record, such as home monitoring devices for the patient and is able to provide information to the case manager that might not be a physician that is following up to see trend make sure that things happen. We have had great [indiscernible] was pulling paper chart obstruction's in North Carolina and managing [indiscernible] by the population. There might be this intermediate step that is thinking not just of the hospital record or record in the hands of the patient or person, but the case record.

There are not lot of different ways to respond to that. I think the first question, what is the basic level of information, I would suggest to start with data elements that are recommended coming out of the HIT policy and

Standard committee's around high value, high priority clinical data elements, the LDLs. There are other things we would like to get at so that we can understand board failure, but that is beyond what we would like to see. I think we want to look that those organizations that are already beginning to do this. [indiscernible] and others, I think they have not been proven yet, but the extension centers are intended to do this. It will be a little while before they get [indiscernible]. I think, again, there are people that are able to do this and have the clinical data for multiple uses beyond patient care. This is critical data that can be used for multiple purposes that have been able to make this work. We want to look to them.

For our listening audience, that was Phil speaking and prior to that, that was Hope Anderson.

No disagreement with any of those responses. They do not get all the way to what we are supposed to talk about today which is the accuracy and integrity. If we decide on the data set, the challenge is, can I rely on it? What I am arguing for is what [indiscernible] around that? I think his hard work to do that. Maybe we will never reach consensus. I think for the furtherance of why we are all here to gather, it is work that we need to do and build all of the reactions and responses from the panel.

Thank you, panelists. The next question?

Thank you. This is Mike from the National Association of Human health centers and thank you for the presentations. It is very helpful and enlightening. My questions are around-this is a moving target that we are trying to follow. It is a question and not couple of things that the presenters had. Jack, around you finding that problem within the hash mark that made the transmission not go through. [indiscernible] came up with the own algorithm for the index. You identified, Jerry, DERSA and people are trying to make it better for their own organizations. My question is, of retracting any of these in terms of best practices and putting them out there? If everybody working on doing their own algorithm? Do you have one that is better than others? Are you sharing that? Are we sharing contracts that improve on the DERSA? Are we saying to not do this because it makes it go out? Dhabi collecting bats in anyplace or tracking it?

For that particular project, yes and we are publishing lessons we have learned with other EMRs. Are we doing that in a formal manner Manor and aggregating all of this? No. It is a state and regional level.

I will quickly respond. This is Art. TeamColorado we are part of the state Regional Administration project which Rhode Island is as well and HRQ is writing a formal evaluation about the 5-year project, which is included there.

The next question is from John.

Good morning. I am looking that this from the perspective of the practicing physicians. I applaud the intent to have this as accurately as possible--it is interesting the terms used throughout here, data and information are being used interchangeably-I view data more as single elements. Information might come from multiple places, laboratories over time once you know the history of that particular patient. There is an exponential increase in the [indiscernible] of that once you have the information. When you look that a personal health record as opposed read and the tunnel health record, for the

Personal health record is more about the individual data and with that patient over time and you are looking for tech how they are doing overtime. Even now, I am particularly impressed with Jerry, looking that the data, even if they are accurate, what is usually assessed in terms of being held accountable for the liability is not the accuracy of the data but how it was used in the care of the patient. That makes the EHR actions much more complicated. There are some interfaces that are coming together that will be pretty profound and difficult. Now, we are seeing more and more [indiscernible] mammography guidelines as an example of not only information but now knowledge being applied to medical practices and this relationship of what patients see and what they want to know but now the knowledge being applied to their care that has to now interphase with the medical community. Think of the volume of work going on right now. We are approaching a billion outpatient ambulatory Care a here. It is an astounding amount of information being generated. I understand from one point of view--of getting the right information data sets--Remainder of the practice. That is more related to populations and management of practice than the care for the individual patient--So, you cannot boil the ocean, but that the same time, you cannot stop from the boiling the ocean. One of the things that impressed me--a lot of it was not about--A lot of it was about how we actually take care of the patient and when we talked about workflow, we do not know a lot of what happens with the complex interactions are around the patient and are focused on [indiscernible] for their validity and incorporating that into how outpatient care really takes place. It can only get more complex. I hope this research will look more at health research and how we take care of patients. This has been a great exercise and the reason we want to have the stakeholder forums here. Thank you.

Linda?

Thank you, so much. First of all, thank you for an excellent panel this morning. I think in many ways you show the leading edge of the conversation and talking about health Information adoption and leading us into the rest coming from that. Excellent conversation. I appreciate approaching any [indiscernible] from a technical standpoint. We no technology is the easiest part of this. It is everything else that comes into this, the workflow and legal implications--One think I did not hear speak about was you, Jack. Have you, within your organization, have an organization--is there an a need moving towards the NHIN or is that not something you have on your glidepath.

Jack: We are looking for the Gateway. First [indiscernible] with federal agencies, we are in a Current project with the CDC--Surveillance data across many of our hospitals and goes to the state and public health agencies. We are doing it through the CDC but are looking that meeting towards the [indiscernible] Gateway--Will be using that mechanism. Whether we would be using more at the local commander of local or regional level is more down the road.

Thank you.

We are close to the end of our time for discussions. I have one question online from Kathy in the office of the national coordinator. This is not my question for Jerry. Assuming the EHR will affect the liability standard of care, both in regard to Hughes and Exchange, what are your thoughts on how to form what that standard of care should be? Do you have thoughts on private accreditation, government certification or government regulation, for example the DERSA regulation of the a EHR? Are there credible best practices?

What a loaded question. The answer is, yes. I am teasing.

[LAUGHING].

The way the standard of care evolves is what individuals think is the right thing to do in similar circumstances. I do not think you can regulate that and, frankly, I do not trust a regulatory agency to come up with the right answer. I think it has to fall on those that are being called upon to abide by the standard of care and say, this is what reasonable, under the circumstances. I do think there will be regional differences with everything that goes into this. bill that expectations about what you should do with respect to electronic information that you practice, physicians need to tell us what they think is the right answer and also challenged us, as the technical community to give them what they want. For example, it in the context of the DERSA that I described, if I were a physician, I would say that does not give me as much as I need and what someone else besides me to have [indiscernible] with respect to accuracy and completeness. That is also in the next. If there is a functionality standardization--than government regulations, it would be keeping the provider more than half that way-- Linda, do you have a follow up?

We also need to remember, especially in a large hospital environment-- Incorporated into the record and there are held back information professionals--Incorporated and manage the release of information that such conditions in terms of how they use that information. The Professional Association is certainly an authoritative source [indiscernible] a lot of our clinical environments. I think there is not lot of best practices that translate and professionals aren't there to give transition, as well.

[CAPTIONERS TRANSITIONING].

Laura Adams: As a believer, you can never be too rich or have too much software, I was thinking about a possible business opportunity when you were describing about going into practice to do audits. Is anyone thinking about software to detect things like when data fields are coming in not filled the way they should be or the changes in practices. More along the lines of how hard it will be to sustain if you go in, do an audit, there's a drift back to old practices, anyone developing software to do the audits or [indiscernible] someone coming into the office?

I am not going to answer that question, first; I think you might be putting two things together and I don't know if they are intentional or not in terms of the validation of the data and the ' how do we make sure that a change sticks'? I think that's actually the -- like you said, who said the software part is the easy part. It's the how do we make sure that process flows, work be flow -- flows that support the -- are made and stick, is the hard part. I know that some of the regional collaboratives, I have seen people that are not only going out and teaching it once, but going out and making sure that these practices don't decay. For the question -- I don't know of anybody actively doing what you suggest. That doesn't mean they are not out there. I know we are thinking about are there ways we can adapt the tools we have in terms of standardized population or patient test decks, and similar methods we have to validate the systems. One of the other questions we will need to struggle with is, the odd audits we do are burdensome, and how do we port that down from the hundreds of health plans to thousands and hundreds of thousands of clinician practices that will be reporting this, using these systems, doing so

in a way that is -- makes us trust the data, but is not so crushingly burdensome that everybody goes back to paper because it's just not worth it.

So that's, I think, another part of the trade-off that we are struggling with, we will all need to struggle with.

Okay, one last question from Janet.

Actually, I wanted to continue commenting --

Janet Corrigan from the Board. Laura asked a very good question we can try to figure you out how to develop some sort of auditing mechanism in an ongoing way, but there are probably two other ways to encourage proper use of the EHR. One would be through the use of clinical decision support, other tools, to make it valuable to the clinician to use it properly. Those tools are triggered, they see care gets better, a good decision to make the better care.

I wonder too, these types of performance data will be reported and in the future used more extensively in payment mechanisms. We probably need to give thought in the selection of measures for public reporting and payment to measures that encourage the proper use of those drop-down menus. If you have a measure of diabetics, the measure calls for periodic assessment of the diabetic visit, particular time period. You might want to have a trigger that measures, encourages the provider, in order to get credit, they would have to pull down the drop-down, indicate they updated the diagnosis, problem list, and provided appropriate care.

Maybe there are ways to select the measures in the structure, measures that encourage that use of record, presumably after you used it, when you really get in synch with using menus over some period of times it wouldn't require as much reinforcement to use it properly.

This is Phil [indiscernible], I want to follow-up on that. Great point, Janet. In a previous life I was supporting process improvement, and I figured out how to get to the database, putting together control charts on [indiscernible], one of the ED physicians said if I knew you would be using it for that I would be using the system differently. So I think that you are absolutely right. Making sure that the data is there and useable, and they know why. The other thing to balance is we want validation so we know the data is right. This will ultimately be a huge quality improvement effort, more about how do we steer the use of these systems towards best practices, rather than dinging those who don't use those best practices.

Thank you, Phil. Once again, I would like to thank the panelists for coming for an excellent thought-provoking discussion and I appreciate your spending the time to educate us.

[Applause]

I also want to thank, as well, the staff, for helping to organize this session. Thank you.

Let me add my thanks to our presenters today. We are now going to move to the nomination committee report. You are welcome to stay, but it won't have anything to do with what you just talked about.

Now, we do look forward to staying in touch with you, because these conversations will be ongoing for sure.

[indiscernible] will present the report today, Janet Corrigan, a Board member who chaired the nominations committee, members have been Art Hitchenson and -- Lily [indiscernible], RN, working with a NEHC from the beginning, and [indiscernible] alliance for health. Janet?

Thank you very much, John. Just to refresh your memory, the nominating committee was established in October, and was given two tasks. First, to bring forward a slate of nominees to fill vacancies on the Board, second, slate of proposed board of officers for 2010.

I want to thank my colleagues, Kevin Hitchenson, Art Davidson, Sherry Reynolds, for the time, effort they put into the process and will be as we go forward.

We first turned attention toward the selection of new board members. Here there are currently four vacancies on the Board. The by laws indicate there should be a minimum of 13 directors, and a maximum of 19 directors. I want to inform the board the nominating committee is giving some thought to, to proposing a modest increase in the number of Board members to probably 15 or so. We are taking a very close look at the depth and breadth of expertise needed, given the direction NeHC is going in the future are and give appropriate thought to the size of the board. I also want to take a second to ask current Board members if they would please carefully examine their level of commitment to NeHC. 2010 will be a critical time for this organization and one where we really need Board members who are fully committed and able to make the necessary time commitment to the organization.

If you have any concerns or reservations about that, we would appreciate knowing immediately, because that in turn will determine the number of seats that need to be filled.

Now, in terms of the process we are going through, on December 3, there was a call for nominations posted online that is open until December 25. It's an online application. You can nominate yourself or a colleague. If you are nominating a colleague please check with the individual first and their level of interest and willingness to serve before if they are appointed.

Now, the week of December 28, the nominations committee will meet by Connie Freeman's call, and that time we will develop a slate of candidates. The staff will -- doing due diligence and during that time period notifying the full board of the provisional slate of candidates identified. The slate will then be posted online for public comment between the period of January 11 through 22. Very important to us that this be a transparent process and we maximize the amount of public input that can be provided.

Then, on January 27 at the membership meeting the NeHC members will elect the new board members, that will be an up or down vote on the slate. The new Board members would attend their first board meeting in early February. That's the current process we have in place for the new board members. Are there any questions at this point?

Any questions of the Board or Janet?

All right. Let's move on to discuss the officers, slight of individuals being put forward for officers. As you will recall, last month the nominations committee sent a letter to all Board members soliciting their interest in serve in 2010. We heard from quite a few of you, thank you very much. We wanted to provide ample opportunity for everybody to self-nominate or make recommendations to the committee. The committee then met to consider those expressions of interest, and spent considerable time thinking about the organization that NeHC is becoming as it moves into 2010 and the kind of expertise and quality needed.

The committee then recommended a slate and we have individual comments on the willingness to serve in officer capacity.

Why don't we go ahead and show the slate here. The individuals being recommended for Board chair, Laura Adams, the vice chair, Simon koan, and for the treasurer position, Tom fritz.

Now, I believe we had several Board members joining on the phone, Laurie evance, Steve Finley and Martin Harris. They are on the phone but they cannot speak.

I think I can speak. It's Laurie.

Okay, great.

I think at this point we are going to ask our slate of three candidates if they would please step out of the room to have a opportunity to discuss.

Right, and to be clear, we have a quorum, and will be asking the three candidates to step out of the room. This time I will entertain a recommendation to approve the slate of candidates.

So moved.

Second?

We have a recommendation to approve this slate of candidates, there any objections to this slate? I phrase this way because we operate by consensus rule.

No objections, I think it's a terrific slate. This is Laurie.

Thank you very much, Laurie. Seeing no objections here, the recommendation is approved by acclamation. Thank you. We now ask the candidates to come back in, please.

[Applause]

As the chair of the Board I am very pleased to congratulation candidates, Laura Adams, effective January 1, Simon Cone, [indiscernible] and I will close this part of the agenda with the nomination by thanking Janet and your chairmanship. The work is only half over, we will now be moving to add new members to our Board, which will be elected not by the Board, but members of the organization, and that will be in January. We will be posting on the website the process by which new members are nominated and elected to this Board. Thank you.

John, can I say one last word, but I want to thank all of our current officers for the hard work they have done over the hard work, and your incredible leadership.

Thank you very much.

[Applause] >

Doing a terrific job of teeing up the next part of agenda, to acknowledge and thank the members -- [laughing] as always, Janet is a forward-thinker. At this point I am very pleased to provide the certificates of appreciation to our officers and committee chairs, and I sincerely want to recognize Kevin Hutchinson, Steve -- the chair of the NeHC board, Tom, the treasurer, and Steve, the membership committee. They have done a remarkable job over the course of the year, helping to guide organization through their role as chair and members of the Executive Committee. So, Bryan, could we present those certificates?

Thank you all.

[Pause] >>
[no audio] >

[Applause] >

Thank you very much, Janet.

Simon. > >

[Applause]

Also want to recognize -- representatives on the phone, Steve Finley. >

From the Cleveland Clinic, Martin Harris, thank you.

We also had some members of the Board, for reasons -- had to resign. One of those is Linda Dillman, another is Lisa Simpson, another is [indiscernible] and the fourth is John Glasser, one of the original incorporators. John [indiscernible], also, as chair of the field research -- [indiscernible] thank you all very much.

All right. We are now moving into the public comment session of our agenda. I will like to let everyone know that during the executive session this afternoon we will be holding after lunch the Board will have several strategic discussions on the future activities of NeHC, and this will also include our membership program.

We will also hear from our finance and audit committee, the 2010 budget approved several new NeHC members, and talk about changes to our committee charters to reflect our mission going forward.

If you have joined us today and would like to make a comment. Participating electronically, would like to make a verbal comment you must be logged into the Webinar and using the Webinar-generated attendee ID when you logged in. Click the hand on the other side of the -- participant, or send a comment on line and we will read it aloud at the end of the comment period. Are there any

members here present who would like to come to the microphone, make a comment or ask a question?

While waiting for a moment, do we have questions from our audience?

[indiscernible]

Okay. Seeing no questions at the moment, please feel free to contact us in writing or by e-mail and we will respond to any questions you provide to us. Now, we thank you very much for your participation in today's Webinar, both in person and by the Webinar.

Next, [indiscernible] meeting will be held in Washington D.C. in early February. As soon as we have additional details we will provide to you via our listserv and website. Thank you all for a very productive discussion and particularly to the panelists, who did such an excellent job in talking about the critical issues of data integrity and to Art Davidson who organized the stakeholders forum, and the staff. We look forward to continuing to partner with you, and secure interoperable electronic health records. Seeing no objection the public section of this meeting is adjourned. For those joining immediately after we will be dialing into the beacon -- the office of the initial coordinator. Going into executive session at 1:00 we will only be able to host the first hour of the call, but you are welcome to stay in this room to participate for that first hour, if you would like.

Seeing no other comments or questions from the Board we will now conclude this public session. Thank you very much. > >

[event concluded]

Captioner: Please confirm that you have completed the portion of the meeting requiring captions; or if you require a captioner for the non-public meeting.

Thank you. > >

[event concluded] >