# PEHRC Meeting

**Friday, November 16, 2018**  
Renaissance Arlington Capital View Hotel - Arlington, VA

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 a.m.</td>
<td><strong>BREAKFAST BUFFET</strong></td>
<td>Exhibitor Foyer</td>
</tr>
</tbody>
</table>
| 8:00 a.m. – 9:00 a.m. | **OPENING PLENARY**  
“Lessons from a Grateful Patient”  
Rolf Benirschke  
Former NFL Kicker, Founder Grateful Patient Project, CEO of Legacy Health Strategies | Salon 4         |
| 9:00 a.m. – 9:15 a.m. | **MORNING BREAK**                                                      |                |
| 9:15 a.m. – 9:30 a.m. | **Welcome and Introductions**  
(Steve Waldren, MD and Hon Pak, MD) | Salon 1        |
| 9:30 a.m. – 10:15 a.m. | **Legislative & Regulatory Update**  
Lauren Lattany, Assistant Director, Policy  
American Osteopathic Association | Salon 1        |
| 10:15 a.m. – 11:00 a.m. | **Implementing Digital Guidelines in a Digital Ecosystem**  
Frank Opelka, MD, Medical Director, Quality and Health Policy  
American College of Surgeons | Salon 1        |
| 11:00 a.m. – 11:15 a.m. | **BREAK**                                                              |                |
| 11:15 a.m. – 11:45 a.m. | **Joint Session: PEHRC and CMSS Clinical Practice Guidelines Directors** | Studio E       |
| 11:45 a.m. – 1:00 p.m. | **Working Lunch**                                                      | Salon 1        |
| 1:00 p.m. – 1:20 p.m. | **ONC Update and Q&A**  
Tom Mason, MD, Chief Medical Officer  
Office of the National Coordinator for Health Information Technology | Salon 1        |
| 1:20 p.m. – 2:00 p.m. | **National Decision Support Company**  
Mike Tilkin, CIO  
American College of Radiology | Salon 1        |
| 2:00 p.m. – 3:00 p.m. | **Next Steps for PEHRC**                                               | Salon 1        |
| 3:00 p.m. – 4:00 p.m. | **CLOSING PLENARY**  
“Not Your Grandfather’s VA: Envisioning a New Model for Healthcare”  
Carolyn Clancy, MD, Deputy Undersecretary for Health for Discovery,  
Education & Affiliate Networks  
Veterans Health Administration | Salon 4         |
| 4:00 p.m.  | **MEETING ADJOURNMENT**                                                |                |

**11/15/2018**
Republicans have enlarged their Senate majority but lost the House for the first time since the 2010 midterms

Control of Congress and the White House by party
2009-2019; COMPOSITION ON JANUARY 20 OF EACH YEAR

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>House</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D+77</td>
<td>D+78</td>
<td>R+49</td>
<td>R+50</td>
<td>R+33</td>
<td>R+33</td>
<td>R+59</td>
<td>R+59</td>
<td>R+47</td>
<td>R+45</td>
<td>D+30*</td>
<td></td>
</tr>
<tr>
<td><strong>Senate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D+16</td>
<td>D+20</td>
<td>D+6</td>
<td>D+6</td>
<td>D+10</td>
<td>D+10</td>
<td>R+8</td>
<td>R+8</td>
<td>R+4</td>
<td>R+2</td>
<td>R+4*</td>
<td></td>
</tr>
<tr>
<td><strong>White House</strong></td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Obama</td>
<td>Trump</td>
<td>Trump</td>
<td>Trump</td>
</tr>
</tbody>
</table>

*House & Senate margins as of 10 a.m, 11/13/18
**Independents Sanders and King, who caucus with the Democrats, have been included in the Democratic tally

[Table showing control of Congress and the White House by party from 2009 to 2019]
Composition of the 116th Congress: House

Partisan makeup of the House compared to the previous Congress

- Seats flipped R to D (Total: 36)
- Seats flipped D to R (Total: 3)
- Not yet called (color outline is incumbent’s party)

<table>
<thead>
<tr>
<th></th>
<th>115th</th>
<th>116th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republican</td>
<td>235</td>
<td>198</td>
</tr>
<tr>
<td>Democrat</td>
<td>193</td>
<td>228</td>
</tr>
<tr>
<td>Not yet called</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>

218 votes needed to pass
Composition of the 116th Congress: Senate

Partisan makeup of the Senate compared to the previous Congress

- Seats flipped R to D (Total: 2)
- Seats flipped D to R (Total: 3)
- Not yet called (color outline is incumbent’s party)

<table>
<thead>
<tr>
<th>Party</th>
<th>115th</th>
<th>116th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republican</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Democrat</td>
<td>49</td>
<td>47</td>
</tr>
<tr>
<td>Not yet called</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

*Independents Sanders and King, who caucus with the Democrats, have been included in the Democratic tally.
Democrats lost at least three close elections, but flipped Nevada and Arizona; Mississippi heads to a runoff

Change of seats in the US Senate after the 2018 midterms

- Democratic gain (2)
- Democratic hold (22)
- Republican gain (3)
- Republican hold (6)
- Election not yet called (2)

*Sen. King (I-ME) caucuses with the Democrats
**In MN, both Democratic candidates won
***In MS, Wicker (R) won reelection and Hyde-Smith (R) is going to a runoff
The Republican Party maintains its majority in the Senate

Composition of the 116th Senate map

- 2 Democrats (19)
- 2 Republicans (20)
- 1 Democrat + 1 Republican (9)
- Election not yet called (2)

*Sen. King (I-ME) and Sen. Sanders (I-VT) caucus with the Democrats
**In MN, both Democratic candidates won
***In MS, Wicker (R) won reelection and Hyde-Smith (R) is going to a runoff
### Potential House committee chairs based on seniority (1/2)

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Ranking Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Zoe Lofgren (D-NY)</td>
<td>Rodney Davis (R-IL)</td>
</tr>
<tr>
<td>Agriculture</td>
<td>Collin Peterson (D-MN)</td>
<td>Mike Conaway (R-TX)</td>
</tr>
<tr>
<td>Appropriations</td>
<td>Nita Lowey (D-NY)</td>
<td>Robert Aderholt (R-AL)</td>
</tr>
<tr>
<td>Armed Services</td>
<td>Adam Smith (D-WA)</td>
<td>Mac Thornberry (R-TX)</td>
</tr>
<tr>
<td>Budget</td>
<td>John Yarmuth (D-KY)</td>
<td>Steve Womack (R-AR)</td>
</tr>
<tr>
<td>Education and the Workforce</td>
<td>Bobby Scott (D-VA)</td>
<td>Virginia Foxx (R-NC)</td>
</tr>
<tr>
<td>Energy and Commerce</td>
<td>Frank Pallone (D-NJ)</td>
<td>Greg Walden (R-OR)</td>
</tr>
<tr>
<td>Ethics</td>
<td>Ted Deutch (D-FL)</td>
<td>Susan Brooks (R-IN)</td>
</tr>
<tr>
<td>Financial Services</td>
<td>Maxine Waters (D-CA)</td>
<td>Peter King (R-NY)</td>
</tr>
<tr>
<td>Foreign Affairs</td>
<td>Eliot Engel (D-NY)</td>
<td>Chris Smith (R-NJ)</td>
</tr>
</tbody>
</table>
## Potential House committee chairs based on seniority (2/2)

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Ranking Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeland Security</td>
<td>Bennie Thompson (D-MS)</td>
<td>Mike Rogers (R-AL)</td>
</tr>
<tr>
<td>Intelligence</td>
<td>Adam Schiff (D-CA)</td>
<td>Devin Nunes (R-CA)</td>
</tr>
<tr>
<td>Judiciary</td>
<td>Jerry Nadler (D-NY)</td>
<td>Steve Chabot (R-OH)/Doug Collins (R-GA)</td>
</tr>
<tr>
<td>Natural Resources</td>
<td>Raul Grijalva (D-AZ)</td>
<td>Rob Bishop (R-UT)</td>
</tr>
<tr>
<td>Oversight &amp; Government Reform</td>
<td>Elijah Cumming (D-MD)</td>
<td>Jim Jordan (R-OH)</td>
</tr>
<tr>
<td>Rules</td>
<td>Jim McGovern (D-MA)</td>
<td>Tom Cole (R-OK)</td>
</tr>
<tr>
<td>Science, Space &amp; Technology</td>
<td>Eddie Bernice Johnson (D-TX)</td>
<td>Frank Lucas (OK-3)</td>
</tr>
<tr>
<td>Small Business</td>
<td>Nydia Velázquez (D-NY)</td>
<td>Steve Chabot (R-OH)/Steve King (R-IA)</td>
</tr>
<tr>
<td>Transportation &amp; Infrastructure</td>
<td>Peter DeFazio (D-OR)</td>
<td>Sam Graves (R-MO)</td>
</tr>
<tr>
<td>Veterans’ Affairs</td>
<td>Mark Takano (D-CA)</td>
<td>Phil Roe (R-TN)</td>
</tr>
<tr>
<td>Ways &amp; Means</td>
<td>Richard Neal (D-MA)</td>
<td>Kevin Brady (R-TX)</td>
</tr>
</tbody>
</table>
Future Debates in Congress

• Improving the ACA
• Prescription drug costs
• Data security
Physician Fee Schedule
HCPCS code G2012 – Brief communication technology-based service (e.g. virtual check-in).

HCPCS code G2010 – Remote evaluation of pre-recorded patient information.

CPT codes 99446, 99447, 99449, 99451, 99452 – Interprofessional internet consultation.

CPT codes 99453, 99454, and 99457 – Chronic care remote physiologic monitoring.
CY2019 PFS: HCPCS G2012

- Performed by a physician or other qualified health care professional who can report E/M services
- Must be established patient
- Allows:
  - Audio-only real-time telephone interactions
  - Two-way audio interactions enhanced with video or other kinds of data transmission
- Not originating from a related E/M service provided within previous 7 days  Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
- 5-10 minutes of medical discussion
- No frequency limitations
- Work RVU of 0.25, based on a direct crosswalk to CPT code 99441
CY2019 PFS: CPT 99453, 99454, and 99457

- Remote monitoring of physiologic parameter(s) (e.g. Weight, blood pressure, pulse, oximetry, respiratory flow rate)
- CPT 99453 – Initial; set-up and patient education on use of equipment
- CPT 99454 - initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- CPT 99457 - treatment management services (WRVU of 0.61)
- 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
- CMS will provide additional guidance regarding what types of technology are covered under these codes
CY2019 PFS: Acute Stroke Treatment

- Removes originating site restrictions
- Services may be furnished in any hospital, critical access hospital, or mobile stroke unit, or any other site determined appropriate by HHS
- Mobile stroke unit provides services to diagnose, evaluate, and/or treat acute stroke symptoms
• Medicare Telehealth Services list:
  • Diagnosis, treatment, or evaluation of acute strokes
  • Treatment of substance abuse or co-occurring mental health disorders
  • Clinical assessment for monthly end state renal disease (ESRD)
CY2019 PFS: Substance Abuse Treatment

• Removes geographic requirements for telehealth services furnished on or after 7/1/2019
• Individual’s home now a permissible originating site
• No originating site fee required in this case
• Practitioner responsible for diagnosis and determining whether telehealth treatment is clinically appropriate
• CMS will provide additional subregulatory guidance
CY2019 PFS: ESRD

- Removes geographic requirements
- Individual’s home now a permissible originating site
- ESRD patients receiving home dialysis may choose to receive monthly telehealth clinical assessments on or after 1/1/2019
- Must receive a non-telehealth face-to-face visit on a monthly basis during first three months of home dialysis and at least once every 3 consecutive months thereafter
Telehealth
Interoperability
Questions?
PEHRC 2018
Digital Health Information Guideline Activities

Frank G Opelka, MD FACS
Medical Director, Quality and Health Policy
American College of Surgeons
Guidelines
Digital Health Information Activities

• AHRQ & CDS Connect
• The Magic Project:
  – a multinational effort
• Center for Disease Control:
  – Update to guidelines
• Aim Specialty Health:
  – Vendor for Anthem’s Prior Auth work
Improve quality of care through clinical decision support

For Clinicians and Provider Organizations
Improve quality of care through clinical decision support and identify evidence-based standards of care.

For Health IT Vendors
Pilot CDS tools in a live, clinical workflow environment. Discover and use interoperable tools with your EHR system.

For Federal Health Research Organizations
Translate and codify information into an interoperable standard and provide tooling to promote a collaborative model of development.
Translation of practice guidelines into implementable clinical tools.

The CDS Connect Project demonstrates a web-based repository service to enable the Clinical Decision Support (CDS) community to identify evidence-based standards of care, translate and codify information into an interoperable standard, and leverage tooling to promote a collaborative model of CDS development.
CDS Connect lifecycle

Artifact is improved for the CDS community to use
Identifies need for a new CDS tool (known as an artifact)

Implement in health IT system and collect feedback
Publish artifact in CDS Connect
Build the CDS artifact using CDS authoring

Source(s)
- Clinical practice guidelines
- Peer reviewed articles
- Local best practices
- CQM(s)
CDS Hooks AHRQ Project

Informatics experts consider many ways to integrate and represent guidelines and clinical decision support (CDS) into a clinical workflow.

- Integration in the vendor EHR
- Patient cloud APIs
- CDS Hooks
- Etc.

Overview

This specification describes a "hook"-based pattern for invoking decision support from within a clinician's EHR workflow. The API supports:

- Synchronous, workflow-triggered CDS calls returning information and suggestions
- Launching a user-facing SMART app when CDS requires additional interaction
CDS Hooks AHRQ Project

How it works

User activity inside the EHR triggers CDS hooks in real-time. For example:

- `patient-view` when opening a new patient record
- `medication-prescribe` on authoring a new prescription
- `order-review` on viewing pending orders for approval

When a triggering activity occurs, the EHR notifies each CDS service registered for the activity. These services must then provide near-real-time feedback about the triggering event. Each service gets basic details about the EHR context (via the `context` parameter of the hook) plus whatever service-specific data are required (via the `pre-fetch-template` parameter).
CDS Hooks AHRQ Project

1. EHR triggers a **CDS hook** and invokes a remote service.

2. **CDS Service** executes its own rules, leveraging FHIR data as needed.

3. Returns **CDS cards** (rendered and displayed by EHR).

**EHR Med Order**

Rx Toprol XL 50 mg daily

**information** card

$200 per month (patient pays $30)

**suggestion** card

Try HCTZ as first-line

Switch to HCTZ

**smart app link** card

Managing hypertension?

Launch JNC 8 Rx Pro

**EHR FHIR Server**
CDS Hooks AHRQ Project

CDS Cards

Each CDS service can return any number of **cards** in response to the hook. Cards convey some combination of text (**information card**), alternative suggestions (**suggestion card**), and links to apps or reference materials (**app link card**). A user sees these cards — one or more of each type — embedded in the EHR, and can interact with them as follows:

- **information card**: provides text for the user to read.
- **suggestion card**: provides a specific suggestion for which the EHR renders a button that the user can click to accept. Clicking automatically populates the suggested change into the EHR's UI.
- **app link card**: provides a link to an app (often a SMART app) where the user can supply details, step through a flowchart, or do anything else required to help reach an informed decision.
Magic Project

Living guidelines
MAGICs online authoring and publication platform created to solve key problems with clinical practice guidelines.
Magic Project

The Evidence Ecosystem
Digital and trustworthy personalised eHealth solutions to increase value and reduce waste in the current health care ecosystem.

Synthesize evidence
Analyze data, write and publish systematic reviews

Disseminate evidence to clinicians
Tools to analyze data, write and publish trustworthy guidelines

Produce evidence
Plan, conduct and publish primary research (trials and observational studies)

Disseminate evidence to patients
Decision Aids for the clinical encounter

Evaluate and improve practice
Recording practice & population-based data
EHR, Registries, Quality Indicators, Shared Decisions

Implement evidence
Personalized Decision Support Systems in the EHR linked to patient specific data
Magic Project

WikiRecs and BMJ RapidRecs

Providing clinicians and patients with trustworthy recommendations and evidence summaries for potentially practice changing evidence.

Day 45: Network submit updated Synthesize evidence
- Systematic reviews

Day 90: Updated recommendation
- Disseminate evidence to clinicians
- Trustworthy guidelines

NEW EVIDENCE
Primary studies

BMJ Rapid Recommendations
enhancing the Evidence Ecosystem

Evaluate and improve practice
- Recording practice & population-based data
- EMR, Registries, Quality indicators, Shared decisions

Day 90: Available for SDM
- Disseminate evidence to patients
- Decision aids for the clinical encounter

Day 90: Available at point of care
- Implement evidence
- Personalized decision support systems in the EMR
MAGIC app

Our authoring and publication platform for guidelines and evidence summaries

Author and Publish
- Collaborative environment
- Reference and content management
- Online access with version history

Multilayered presentation
- User decides level of detail
- Most useful information on top
- Easy navigation and overview

Structured data
- Easy EHR integration
- Open API, integrate with any system
- Use your choice of terminologies

No install, ready to use
- Fully serviced platform
- All users get all updates
- You own your data

Decision aids
- Discussion tool for clinicians and patients
- Graphic presentation of evidence
- Automatically generated

Mobile applications
- Adapts to different screen sizes
- Offline and online
- Works for all devices

White label – 11 languages
- Organizations get own site
- Brand with your own logo and name
- Choose: En, Es, Fr, De, Ar, Dk, No, Fi, Se, NL, Pt

GRADE and process help
- Integrated handbooks and FAQs
- Guiding layout
- Step-by-step checklist

Try MAGICapp
View published guidelines
Study all features
Visit knowledge base
CDC Guidelines Project

Definitions:

1. Artifacts: tangible or derivative products from a development process, (mobile apps, rules on a CDSS, order set for CPOE)
2. Computer interpretable language: it is an agreed formalism to encode knowledge that computers can read
3. Computer interpretable recommendation: it is a representation of the narrative of the guideline using an specific computer interpretable language.
4. Use case: is a list of actions or event steps typically defining the interactions between a role (known in the Unified Modeling Language as an actor) and a system to achieve a goal
CDC Guidelines Project

Goal: Create a standardized process for adapting clinical guidelines for digital implementation

Guideline Development Process Breakdown (IOM and Kaizen)

1. Define clinical problem/Assess clinical need/Topic Selection
2. Establish Guideline Steering Committee/Explore International collaboration/External Partners
3. Guideline Project Management - Establish workgroups/guideline panel/SR team, obtain COL
4. Guideline Scoping
5. Identify, assess, and synthesize evidence
6. Formulate (Craft) the Recommendations
7. Write the Guideline Manuscript (Draft)
8. Clearance
9. Conduct External Review/Peer Review/Public Comment
10. Approve, Publish, and Disseminate Guideline Manuscript
11. Create Derivative Products (artifacts) for Implementation and Clinical Decision Support
12. Local Implementation
13. Evaluate Guideline
14. Update

Color Key:
- Development
- Informatics
- Evaluation
- Communications
- Implementation and Translation

STEP 7
Table on next page

Assess topic for informational needs and products
Agreement on Informatics standards and protocols, workgroup members, collaborations
Scope types of informational needs and products
Living SR Tables, Living Evidence-to-decision table
Formulate computer-interpretable language
Computer-interpretable language and format
Publication platforms – digital support
Evaluation of informatics
## CDC Guidelines Project

### Step 11: Derivative Products

<table>
<thead>
<tr>
<th>What to do (in sequence)</th>
<th>How to do (examples of strategies)</th>
<th>Responsible Entities</th>
<th>Success Indicators</th>
<th>Resources (Samples)</th>
</tr>
</thead>
</table>
| 1. Identify Use Cases (it needs to start since step 4) | a. It could cover the whole guideline or part of it.  
b. Identify reading level for users i.e.: professionals, patients, caregivers, family. | INFORM | | |
| 2. Workflow Analysis (this is related with the workflow where) | a. Further refine and expand use cases to determine all the roles involved and system touchpoints  
b. For each use case, create a flow diagram for each workflow that identifies the triggering mechanism, the applicability condition, and the actions to be performed  
c. Determine which aspects can be automated, versus which require interaction  
d. Determine feasibility of the data elements  
e. Review workflow for clinical implementability  
f. Perform UX review | | GLIA | |
<p>| | | COM | | |</p>
<table>
<thead>
<tr>
<th>EVAL</th>
<th>IMPLE</th>
<th></th>
</tr>
</thead>
</table>
| 3. Design Artifacts | a. Select the appropriate artifacts to describe the workflow  
   b. Identify existing profiles, value sets, libraries, groups, and rules  
   c. Determine new profiles, value sets, libraries, groups, and rules are required  
   d. Identify test cases required to demonstrate functionality  
   e.  |   |
| 4. Build Artifacts   | a. Build profiles, value sets, libraries, groups, and rules  
   b. Populate artifacts with knowledge from recommendations  | Recommendations |
| 5. Test Artifacts    | a. Build up appropriate test data  
   b. Build test scenarios  
   c. Verify each artifact performs as expected  |   |
   b. Include use case and workflow diagrams in the documentation  
   c. Document decision points for each recommendation, use case, and workflow  
   d. Document test cases  |   |
   b. Informatics Review  
   c. Implementation Review  
   d. Guideline Developer Review |   |
At AIM, it is our mission to promote appropriate, safe and affordable health care.
AIM is differentiated by its commitment to rigorous guideline development.
Programs are built with a focus on evidence, research, and expert collaboration

**Review of evidence-based literature:** 60+ independent subject matter experts review national specialty society guidelines and the latest clinical literature

**Active research agenda** in appropriate care and patient safety

**Academic affiliations** with leading institutions and experts to support guidelines
Peer-to-peer conversations are collaborative and conducted by experienced clinicians

**Resources**

- 180+ Physician reviewers
- 20+ Specialties represented
- 1,500+ Peer-to-peer consultations daily

**Performance**

- 300,000+ Registered provider users
- 96%+ Provider satisfaction
  (with clinical guidelines, ease of use in provider portal/tools, responsiveness of staff, and quality of peer-to-peer engagement)
With our newest product, AIM Inform, we continue our commitment to enhance the provider experience.

- Allows providers to complete prior authorization for advanced imaging and other services within the EMR
- Also complies with the CMS Appropriate Use Criteria (AUC) program
- Eliminates the need for offices to log into two systems for prior authorization and CMS AUC participation
Next Steps for Specialty Medicine?

- Set and select guidelines for conversion into CDS tools
- Seek to partner with Govt Agencies & Commercial Payers or their vendors to promote an open, scalable environment
- Own & maintain the clinical knowledge as your IP
- License the IP (freely or for a fee)
- Specialty Medicine to create open data standards for use in CDS tools
- Support an open architecture (avoid proprietary platforms) in order to create rapid dissemination
Open Standards Based CDS Developed & Owned by Medical Specialty Associations with Equity as Partners for Specialty Medicine
Thank you – questions?
21st Century Cures Act
SEC. 4001. (a) ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

• (1) (a) Reduction in Burdens Goal.--The Secretary of Health and Human Services (referred to in this section as the `Secretary'), in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health information technology developers, health care quality organizations, health care accreditation organizations, public health entities, States, and other appropriate entities, shall:

1) establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records;

2) develop a strategy for meeting the goal established; and

3) develop recommendations for meeting the goal established.
SEC. 4001. (a) ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.

- (1)(b)(3) Recommendations.--The recommendations developed under paragraph shall address--
  - actions that improve the clinical documentation experience;
  - actions that improve patient care;
  - actions to be taken by the Secretary and by other entities; and
  - other areas, as the Secretary determines appropriate, to reduce the reporting burden required of health care providers.
Clinician Burden Workgroups

• **Executive Sponsor**
  » John Fleming, MD, Deputy Assistant Secretary for Health IT Reform

• **Executive Leads**
  » Andrew Gettinger, MD & Kate Goodrich, MD

• **Documentation and Administrative Requirements**
  » Workgroup Lead: Thomas Mason, MD

• **EHR Reporting**
  » Workgroup Lead: Jon White, MD

• **Health IT and User-Centered Design**
  » Workgroup Lead: Andrew Gettinger, MD

• **Non-Federal Payers and Other Government Requirements**
  » Workgroup Lead: Kelly Cronin

• **Lead Report Drafter:** Robert Anthony
“9) SUPPORT FOR INTEROPERABLE NETWORKS EXCHANGE.—

“(A) IN GENERAL.—The National Coordinator shall, in collaboration with the National Institute of Standards and Technology and other relevant agencies within the Department of Health and Human Services, for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally. Such convention may occur at a frequency determined appropriate by the Secretary.

“(B) ESTABLISHING A TRUSTED EXCHANGE FRAMEWORK.—

“(i) IN GENERAL.—Not later than 6 months after the date of enactment of the 21st Century Cures Act, the National Coordinator shall convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks. The common agreement may include—
Health IT Playbook

In September 2016, ONC published the Health IT Playbook featuring an evolving collection of specific, user-friendly tools, resources, and guides that can help providers implement and use health IT in a way that best serves their practices.

www.HealthIT.gov/playbook
Let’s Continue Building upon Progress Together

Thomas.mason@hhs.gov

Thank you!