

HIT Policy Committee
FINAL
Summary of the March 14, 2013 Virtual Meeting

ATTENDANCE

The following members were present:

- Joe Francis for Madhulika Agarwal
- Christine Bechtel
- Christopher Boone
- David Bates
- Arthur Davidson
- Connie White Delaney
- Paul Egerman
- Judith Faulkner
- Gayle Harrell
- Charles Kennedy
- David Lansky
- Deven McGraw
- Farzad Mostashari
- Marc Probst
- Joshua Sharfstein
- Paul Tang

The following members were absent:

- Neil Calman
- Richard Chapman
- Patrick Conway
- Thomas Greig
- Frank Nemec
- Latanya Sweeney
- Robert Tagalicod
- Scott White

KEY TOPICS

Call to Order

MacKenzie Robertson, Office of the National Coordinator (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) meeting. She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with an opportunity for public comment and that a transcript will be posted on the ONC website. She called the roll and instructed members to identify themselves for the transcript before speaking.

Review of Agenda

Paul Tang, Vice Chairperson, noted the items on the previously distributed agenda. He said that the meeting had been changed from in-person to virtual because of constraints imposed by the sequestration. He announced that Deven McGraw had been reappointed for another term on the committee. He asked for

approval of the summary of the February meeting, which had been distributed with the meeting materials. It was moved and seconded to approve the summary with no amendments and the motion was approved unanimously.

Action item #1: The summary of the February 2013 HITPC meeting was approved.

Update from CMS

Robert Anthony moved through his updated slides. Registration continued at its usual pace. Over 370,000 providers are registered. Medicaid meaningful use payments increased as some providers moved from AIU to meaningful use. Eighty-five percent of eligible EHs are registered and more than 73 percent of eligible EHs have been paid. About two-thirds of eligible EPs are registered. Approximately 35 percent of Medicare EPs are meaningful users and approximately 40 percent of Medicare and Medicaid EPs have made a financial commitment to an EHR. Fifty-eight percent of Medicare EPs receiving incentives are specialists. Moving to attestation data, he said that 190,260 EPs have attested, 190,047 successfully. (In responding to a member's question, Anthony acknowledged a probable error on the slide pertaining to resubmissions.) Regarding hospitals, 2,738 have attested, all successfully. CMS staff compared the first 90 days performance in 2011 with 2012. Commenting on the slide that compared the performance on the core and menu items, he said that EP performance was generally high without a "huge difference" in the two years. Joe Francis asked about information on quality measures (QM). Anthony replied that issues with calculation of the measures and their accuracy are considerable. He indicated that he did not know what his CMS colleagues planned to do with those data. Only a small number of providers are transmitting QM reports electronically. Referring to the 2011-2012 numbers, he said that performance is consistently high whether the EP was an early or a later adopter. Also, EH performance was generally high except for reporting lab results to public health authorities and syndromic surveillance, both of which were very low.

Anthony moved on to show a comparison of returning providers from 2011 to 2012, pointing out improvement by EPs in a few objectives but mostly consistently high performance. The same results were found for EHs. A member pointed out that on reportable labs to public health authorities, performance declined from 17.6 percent in 2011 to 13.8 percent in 2012, a difference that's most likely not due to random factors. As overall performance on public health measures is low, these numbers deserve attention. Gayle Harrell talked about the dearth of public health resources for surveillance. Anthony indicated that CMS analysts are examining exclusion and deferral data. He referred members to the website for additional information and reports.

Q&A

Tang declared that the CMS report shows that the overall high performance is being maintained. The numbers show that providers do not stop at the thresholds; when they start something, they continue. All of this information provides evidence in support of the assumptions made for Stage 3.

Christine Bechtel asked for an explanation of the difference between EHs receiving payment and being meaningful users (73 percent). Anthony explained that a few hospitals received AIU payments only.

Harrell inquired about the non-registered EHs. Anthony replied that staff is beginning to look at non-registered providers and non-returners in year two. Rural hospitals face significant hurdles. Harrell said that she wanted more analysis of and assistance to these providers. She also wanted a breakdown of non-participating EPs by state. Anthony assured her that CMS has those data, which he will include in his presentation next month. In addition, he suggested that ONC staff report on the results of the challenge grants to increase the participation of Medicaid EPs. Judy Murphy, ONC, said that an update would be a great idea.

Remarks

Farzad Mostashari, National Coordinator, was not present. This agenda item was tabled awaiting his arrival. (See below.)

Privacy and Security Tiger Team Update

Deven McGraw, Chairperson, reported that the team is currently in the process of drafting recommendations on query-response. By way of background, she said that HIPAA and other laws regulate when most health care providers are permitted to disclose identifiable protected health information (PHI), including in response to a query or request. The rules permit, but do not require, providers to release PHI in a range of circumstances. The team's goal is to reduce potential real or perceived barriers to release – such as through clarification regarding provider liability for responding to a query – to enable them to respond to external queries consistent with their professional ethical obligations and the law. She announced that she expects to present recommendations on this topic at the April HITPC meeting. The Tiger Team is deliberating on three scenarios or use cases:

Scenario 1: Targeted query for direct treatment, controlled by HIPAA

Scenario 2: Targeted query for direct treatment, controlled by stronger privacy laws

Scenario 3: Non-targeted queries

To date, the Tiger Team is continuing to talk about scenario 1, in which both the requesting provider and the patient are known to the data holder, who needs some reasonable assurance of the requester's identity and the existence of a direct treatment relationship with the patient. The holder must: make a decision about whether to release data consistent with law; send data on the right patient; and send the data securely. The requester: needs to present identity credentials; must provide assurance of a treatment relationship; and must send identifying information in a secure manner to enable the data holder to locate the record. She went on to report on questions that the team answered:

What supports “reasonable” reliance, by the data holder, that the requester is who it says it is?

A DIRECT certificate, network membership that the data holder trusts, or a pre-existing relationship

What supports “reasonable” reliance, by the data holder, that the requester has (or will have) a direct treatment relationship with the patient, and is authorized to obtain data? Data

holder's knowledge of the requester, network attestation, patient consent, or a known existing relationship

Does it matter if the data holder makes the decision to disclose as opposed to the response being automated (set by data holder or automatic by participation, as in a network)? Yes. The data holder should adopt policies to govern when an automated response is appropriate.

To what extent does automation trigger a need for meaningful choice by patients? Data holders can automate their decisions (i.e. through an algorithm) if they have the ability to make decisions on when to disclose PHI. Meaningful choice recommendations apply when data holder no longer has the capacity to decide on record disclosure.

What patient identifying information should be presented as part of the query? Ideally, no more (but also no less) than what is needed to accurately match, per previous recommendations on matching accuracy

How should data holders respond to a query? Data holders should respond to queries in a timely manner by either providing some or all of the requested content or a standardized response indicating the content requested is not available or cannot be exchanged. (DURSA)

Should there be a requirement to account for and log query and/or disclosures, and to share the log with a patient upon request? Yes. The data holder should log both the query from an outside organization and the response, regardless of its content. This information should be available to the patient upon request.

Should the requester also log the query? The Tiger Team is debating. The team has yet to apply these same questions to scenarios two and three.

Paul Egerman, Co-Chairperson, said that health care organizations are doing all of these exchanges now but not necessarily in an automated way or through an intermediary.

Discussion

Tang inquired about meaningful choice when the holder does not have a choice. If a vendor network requires a contractual relationship without meaningful choice, what happens? McGraw opined that such a situation would likely invoke meaningful choice. She acknowledged that the Tiger Team had not discussed this situation. If a holder makes a decision about automation, that is choice. Whatever constitutes a decision indicates choice. Egerman agreed, saying that organizations have policies about responses, and if those policies are automated, a choice is made.

Judith Faulkner referred to a recent hearing during which panelists agreed that patients should have choice.

Francis reported that he had submitted comments and recommendations on behalf of the VA, saying that electronic automation presents new challenges that were apparently not considered by the team. Those challenges include data segmentation. McGraw informed him that the comments will be relevant for the discussion on scenario 2, at which time segmentation and state laws will be considered.

Remarks

Farzad Mostashari, National Coordinator, joined the call and remarked on the remarkable way in which the market has responded to the demand for interoperability and exchange. Concepts such as consumer engagement and population management are on the way to solutions. EHs are showing commitment and sharing solutions for the next stage. Challenges come with progress. There is more to be learned about what is working and not working. There will be more time for Stage 3 preparation, though the decision about the timing of the final rule has yet to be made.

Charles Kennedy commented that he had attended the same conference that Mostashari referred to and noticed that many vendors are implementing things that health plans ordinarily do. New competitors are engaging in new areas of activity. Harrell reported that she was impressed with the emphasis on analytics. Mostashari referred to the announcement of an initiative and suggested that Paul Egerman be assigned to investigate and report back on what is new and being proposed in the industry. Egerman agreed and Charles Kennedy volunteered to assist him. Mostashari continued to talk about the business case for exchange and interoperability. ONC and CMS have issued a RFI on the use of payment levers to encourage sharing of information for treatment. There is a 45-day comment period. He urged the committee to comment. Tang assigned the comments to the Certification and Adoption Workgroup. Robertson interrupted to say that the assignment was to go to the Information Exchange Workgroup. Tang agreed.

Health Information Exchange Hearing Report Out

Claudia Williams, ONC, talked about the January 29th hearing. She encouraged them to look at Micky Tripathi's presentation slides. The testimonies indicated that significant exchange is occurring and is increasing. Exchange has shifted from a noun to a verb. Payment reform is driving business needs for

exchange. Business drivers should select the technology. Data must be integrated into the providers' workflow. Much work remains to be done; in particular, cross-vendor exchange must be supported since a considerable amount of exchange occurs out of network. Exchange across all stages and types of care and treatment should be increased. LTPAC and mental health providers want to be part of exchange. Meaningful use has created a tipping point for patient engagement. Patients want data liquidity. Vendors are implementing the Blue Button functionality.

Williams went on to talk about ONC activities around information exchange. She repeated the information about the CMS-ONC RFI on interoperability and exchange that Mostashari had described earlier. Other efforts consist of guidelines to support HISP to HISP exchange for Stage 2, Blue Button development, and LTPAC provider engagement.

Q&A

Francis announced that the VA supports standards for interoperability. With the implementation of the ACA, the payer perspective will become more important. He recommended looking at savings under different structures.

Referring to incentives for information exchange, Egerman exclaimed that patients may also have an impact as they demand exchange. Transparency to patients is needed. Harrell said that ONC should play a role in informing patients of information exchange and in encouraging trust in the system. McGraw told Harrell to look at the ONC videos for consumers, which she called great resources. Joshua Sharfstein reported that Maryland's state readmission incentives have spurred an increase in information exchange.

ONC Update

Jodi Daniel talked about the expansion of FACA workgroups. In addition to the two new consumer workgroups and the new Accountable Care Workgroup, for which 200 applications were received, a FDA Safety and Innovation Act (FDASIA) Workgroup will be organized. Its charge is to provide expert input on issues and concepts identified by FDA, ONC and FCC to inform a report on a risk-based regulatory framework pertaining to HIT.

The National HIE Governance Forum will convene key stakeholders to address cross cutting governance issues, such as trust, use of data and best practices. Applications to participate are due March 15th (<http://www.nationalehealth.org/hiegovernance-forum>). ONC will put out a framework on governance. A grant announcement on governance was recently issued.

She reported that the February 21st Achieving eHealth Equity Summit, co-sponsored by ONC, resulted in ideas such as: partnering with other sectors; that CBOs need to "better document their successes"; and building demand for e-equity. Participants are planning a webcast to find out what is working. Summit proceeding will be published in April.

ONC is collaborating with ONDCP, CDC and SAMHSA to stage pilots on linking PDMPs to health IT. Six sites were selected to test the integration of existing technologies with PDMPs. Integration is at the point of care to make the data more accessible to physicians. Ninety-eight percent of pilot participants reported that the information is more accessible. They reported that the information had a positive impact on care. And at the Indiana site, changes in prescription behavior were observed. More information, including resources, can be found at the ONC website.

Two new data briefs on hospital adoption of HIT were recently published. This is an ongoing project, and adoption reports will be presented at all forthcoming HITPC meetings. Data are from the AHA annual survey IT supplement, which, most recently, had a 63 percent response rate. From 2008 to 2012, the greatest increase in adoption was in CPOE. Daniel repeated the announcement on the Advancing

Interoperability and Health Information Exchange RFI made by Williams and Mostashari. The comments period ends April 21st.

Bechtel asked for help in understanding the similarities, discrepancies and differences in the findings of the hospital data briefs and Anthony's data.

Harrell announced that she wants EHRs to have PDMP data. The PDMP is not being used in Florida. Daniel recalled that comments on that topic were received via the Stage 3 RFC. ONC has contracted for work on standards. She indicated that she will ask the contractors to report at the April meeting.

Doug Fridsma showed his S&I portfolio slide. The Direct project, lab results interface and transitions of care projects have been adopted for Stage 3. Staff is convening forums to get feedback from the community on implementation and to feed that information back into SDOs for standards development. The other projects are proceeding in various stages. ESMD is supported by CMS for fraud prevention. Longitudinal coordination of care is being driven by the community. Standards for care plans are being considered. Lab orders interface is making progress toward a compendium. Health eDecisions is supported by CMS, and staff is working with HL7 to ballot standards. The Blue Button used existing building blocks to solve a problem. An implementation guide that satisfies view, download and transmit requirements was piloted. Structured data capture is concerned with linking data collected for various purposes and supplementing them with EHR data. The idea is to create a way to capture metadata and to allow EHRs to interact with the metadata.

He went on to show that the HITSC workplan is connected to the portfolio projects. He characterized the workplan as a living document and said that he expects the HITPC to weigh in on priorities. Near-term projects consist of standards to support transport, image exchange, current gaps in lab orders, formularies, cancellation of transactions, and genomic data. Examples of projects for the second quarter and beyond are: support for transition of care and CDA; standards for support of quality measures; CDS; data segmentation; and standards for documentation, to name a few of the many listed.

Q&A

Tang noted that many of the workplan activities were stimulated by discussions in the HITPC. He said that ONC is very involved in transforming the system, a once-in-a-generation opportunity. He thanked ONC staff and members of committee. He asked Fridsma for a timeline for workplan deliverables.

Faulkner proclaimed that the workplan points to standards for many areas in which the HITPC has not advised policy, in particular, usability and segmentation. Fridsma responded that the workplan includes staff-generated work. Usability needs to be discussed in the HITSC. The workplan is an iterative process with the HITPC and HITSC. Dialogue is required. It is not a one-way path. Faulkner declared that she was still confused. McGraw spoke about consent, saying that the Tiger Team acknowledged the laws on the books, had a hearing on segmentation, and found that more tools and standards were needed. She argued that the S&I work is based on policy discussions. Art Davidson referred to the PCAST deliberations. Egerman recalled that the recommendation on PCAST was to support pilots, not to proceed with standards on segmentation. Tang asked Fridsma to explain whether that work is exploratory. Fridsma replied that the work is being undertaken in conjunction with ONC efforts led by Joy Pritts. He talked about a learning health care system and the helpfulness of transparency. Tang asked for a sense of the committee: Do members need more dialogue on the topic? He recalled that no policy recommendation has been made on the extent of granularity. Egerman observed that Faulkner's objections were not exclusively on segmentation, saying that she was referring to the HITPC and HITSC relationship and interaction. Faulkner confirmed that Egerman's interpretation was correct. Daniel intervened, saying that both committees make recommendations to ONC. Sometimes ONC officials ask the HITSC directly for recommendations on a specific topic. Faulkner stated that she understood that there can be exceptions, but

usability is big issue that requires policy discussions. Egerman asked Daniel whether the HITPC was informed of these exceptions when ONC sought advice directly from the HITSC. He said that the HITPC should be informed in such cases. Tang observed that PCAST may be an exception because ONC is getting involvement from different sources. Egerman opined that the problem with PCAST was that it attempted a technical solution to policy questions. Tang repeated his question: Does the committee want to discuss segmentation with the HITSC and ONC? Faulkner declared that she wished to raise the questions to a higher level – the respective roles and relationship of the two committees. McGraw declared that members need a better understanding of the statutory language and the special protections for certain data in conjunction with the technology issues involved. She pointed out that recommendations on these issues have already been made to HHS. Daniel informed the group that ONC managers look strongly at committee recommendations, but they have other responsibilities from within the agency and the department. The HITPC has a huge effect on decisions, but other opinions and interests are also taken into account. The HITPC is not the only driver. Egerman asked her whether ONC has asked the HITSC to advise on segmentation and usability. Fridsma responded, saying that ONC is working with SAMHSA and others on how to support existing law and they want input from HITSC. Funding comes from SAMHSA. Advice from the HITSC is needed. ONC also works with the industry and NIST. Faulkner admitted her concern with government committees rather than vendors designing stuff. Daniel informed her that the HITSC is advising on usability. What the government will do with the advice is an open question. She indicated that she was not unwilling to discuss the HITSC-HITPC relationship with them. Tang said that usability is a big concern. The FACAs cannot prescribe design. He asked the members whether they were comfortable with Daniel's explanation. Bechtel noted that the law directs certain things. The concerns are less about what the law says and more about workflow and communications back and forth. The workplan includes a lot, and since it is relatively new, it is overwhelming. Faulkner argued for scheduling a discussion. Daniel agreed, saying that it can either be placed on the agenda for the next meeting or an administrative (non-public) meeting can be convened, whichever is more efficient. Tang asked Faulkner and Egerman whether they were concerned more about the process or the topics. Egerman expressed concern with both. Tang ruled for scheduling an administrative meeting on process. Depending on the outcome of that meeting, specific topics may be placed on the agenda of a FACA meeting. No objections to the administrative meeting were heard.

Action item #2: An administrative meeting will be scheduled to discuss the concerns of some members regarding the respective roles and responsibilities of the HITPC and HITSC to ONC.

Public Comment

Robertson announced a three-minute limit for comments and said that a committee response to comments is not required.

Josh Rising, Pew Charitable Trusts, read a statement on medical device safety and the FDA unique device identifier (UDI). He asked that the committees recommend as a Stage 3 core objective that the EHRs capture UDIs. He also wanted the electronic transmission of adverse event reports to be required in Stage 3 rather than in a future stage.

A member spoke in support of the request for the incorporation of the UDIs into EHRs as a meaningful use requirement.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the February 2013 HITPC meeting was approved.

Action item #2: An administrative meeting will be scheduled to discuss the concerns of some members regarding the respective roles and responsibilities of the HITPC and HITSC to ONC.

Meeting Materials

- Agenda
- Summary of February 2013 meeting
- Presentations and reports slides