Collaboration of the Health IT Policy and Standards Committees

Final Summary of the June 8, 2016, Joint Virtual Meeting

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator for Health Information Technology (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) and Health Information Technology Standards Committee (HITSC) joint meeting. She reminded the group that it was a Federal Advisory Committee Act (FACA) meeting being conducted with opportunity for public comment (limited to 3 minutes per person) and that a transcript will be posted on the ONC website. Consolazio called the roll and told members to identify themselves for the transcript before speaking.

Remarks and Review of Agenda

Jon White and Elise Anthony, ONC, greeted members and thanked everyone for participation in the recent annual meeting and other activities.

HITPC Co-chairperson Paul Tang mentioned the importance of each of the agenda items. He asked for a motion to accept the summary of the May 2016 meeting as circulated with the meeting materials. A motion was made by Gayle Harrell and seconded by John Derr. The motion was approved unanimously by voice vote.

> **Action item #1: The summary of the May 2016 joint meeting was approved unanimously by voice vote.**

ONC Data Update

Vaishali Patel, ONC, said that her presentation is based on the 2015 American Hospital Association IT Supplement Survey, which has a good response rate of approximately 55%. Findings are published on the Health IT dashboard and in *Data Briefs 35 and 36*. Patel displayed slides showing that 96% of hospitals report having adopted a certified EHR) and 84% report having adopted a basic EHR. The percentage of hospitals electronically sending, receiving, and finding key clinical information grew significantly between 2014 and 2015. However, only 26% can send, receive, find, and integrate, with integration being the least available option. Hospitals conducting all four domains of interoperability have twice the rate of information electronically available from outside providers as the national average. About half of hospitals report that their providers use patient health information received electronically from outside providers or sources.

Regarding barriers to Interoperability, the most common reason (53%) for not using patient health information received electronically from outside providers is information within the EHR being unavailable. Lack of exchange partners' capabilities to receive data remains the most frequently identified barrier to interoperability.

Patel concluded that progress related to interoperability (sending, receiving, and finding key clinical information) among hospitals significantly increased between 2014 and 2015, although the integration of information remained stable. A majority of hospitals are sending and receiving information to and from providers and sources outside their hospital system. About half are querying patient data from

outside sources. Nationwide, about half of hospitals have the necessary clinical information from outside their hospital system electronically available at the point of care; approximately 90% of hospitals that engage in all four domains of interoperability have outside information electronically available at the point of care. The most common reason for not using outside information electronically received relates to the information not being available at the right time and place. Common barriers to interoperability are exchange across different EHR platforms, the lack of provider directories, and difficulties with patient matching.

Q&A

Tang asked about the criteria for use and integration. Patel replied that use refers to use for clinical decision making, and integration is defined as incorporation of the data into the EHR. The items ask about information being available routinely. Hospital CIO) are the respondents, which is not the same as asking providers about their use. ONC is interested in identifying systems data to measure interoperability rather than relying on self-reports.

HITSC Co-chairperson Arien Malec asked about the exchange of summary of care records outside hospital systems. Patel indicated that the survey provides some data on that exchange; further analysis is forthcoming. Malec wondered about view-only access. Patel said that the survey asked a question about query. Malec suggested that the gap between receive and use be explored. Patel referred him to the slide that showed responses to "information not presented in useful way."

Harrell inquired about the association between hospital characteristics and extent of interoperability. Patel responded that such an analysis is in process. Harrell pointed out that the CIO respondents are not the actual users at the point of care. Patel again acknowledged that the measure is a crude one. The annual NCHS survey of office-based physicians includes questions on use, which ONC staff will analyze and report on. Harrell went on to say that the committees should address some of these barriers, such as patient matching. According to Patel, the Interoperability Roadmap calls for a focus on provider directories and patient matching.

ONC Principal Deputy Coordinator Vindell Washington reported that in his experience with hospital surveys, although the CIO may be the official respondent, other personnel are involved in submitting responses.

Anne Castro asked about the definition of "outside source." Patel acknowledged that it is a catch-all category that extends beyond clinicians to include social services, public health agencies, and others. Castro called for more discrete categories, such as APMs and payers, which will be needed for MACRA. Castro wondered whether a hospital's own physicians are considered an outside source. MACRA implementation will require more categories. Patel informed her that the survey questions differentiate within and outside the system. Castro insisted that the terms should be defined differently.

Patricia Sengstack wondered whether any respondents shared success stories. A better definition of "incorporation" than the one used in the survey is needed. Is a scanned document considered incorporation? Patel said that the survey did not include open-ended questions. Consolazio asked members to be brief.

Chris Lehmann reported that the American Academy of Pediatrics is receiving reports of pediatricians willing to send CDAs but children's hospitals are not able to receive them. The lack of directories and infrastructure is causing problems. The survey should be structured to identify such barriers. He opined that the report over-inflates the degree of interoperability. Patel declared that ONC staff is trying to expand the measure of interoperability to entities not included in meaningful use. One of the briefs

reports on children's hospitals; 55% had adopted a basic EHR in 2015, a much lower rate than in other hospitals. Lehmann reported that pediatricians are often blocked by children's hospitals from using Direct. Troy Seagondollar commented on levels of use and integration, observing that there is much more to be done to incorporate information into the work flow.

HITPC Co-chairperson Kathleen Blake referred to the MACRA NPRM option for reporting quality measures and resource use for hospital-based physicians. She noted that the implication for physicians' use of EHRs is more than reporting since the line between clinicians and hospitals may be blurred.

Derr reported that the Long Term and Post Acute Care (LTPAC) Collaborative has submitted comments on an RFI. He elaborated on the timeliness barrier, saying that when a patient is discharged to an LTPAC facility on a Friday, the digital summary of care is not received until the following Monday.

Josh Mandel asked whether the data displayed in the first bar graph pertained to "routine" functions. He commented that the data on barriers perceived by CIOs should be compared with real-world observations. Patel repeated that qualitative data have limitations. She referred Mandel to *Data Brief 36* and said that the questionnaire items refer to routine use. *Data Brief 37* is scheduled for release this month.

HITPC/HITSC Quality Payment Program Task Force Draft Recommendations

Tang, who also co-chairs the task force, reported that the task force is charged to review the MACRA proposed rule, with a specific focus on how the use of certified health IT by qualified clinicians (QC) can support value-based, quality-focused care under the Quality Payment Program. CMS is seeking comment on policy approaches within the Merit-based Incentive Payment System (MIPS), the Alternative Payment Model (APM) scoring standard, and the Advanced APM sections. Overall, the task force concluded that the NPRM objectives respond to stakeholder feedback, including moving toward measuring and improving outcomes, reducing burden, and increasing flexibility. Nevertheless, the task force concluded that the proposed rule is too complex, hard to understand, and challenging to implement, especially for smaller providers. Tang and Task Force Co-chairperson Cris Ross showed slides and expanded on concerns in three areas: timing, Advancing Care Information (ACI) scoring, and effects on small providers.

The following preliminary recommendations in four areas were presented:

> Simplify and clarify: In order to facilitate a better understanding of the final rule and to simplify its implementation, we recommend including graphical illustrations where possible to clarify the elements of the program and their interrelationships. (Examples were delineated.)
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> Outcomes, not processes: Focus policies more distinctly and clearly on the program's desired outcomes (especially interoperability and patient engagement) and how each component aligns to drive delivery system reform. Ensure that each requirement throughout each program area clearly drives behavior toward care coordination, patient engagement, and meaningful information sharing. Leverage HIE-sensitive performance measures to reward meaningful information sharing. Focus on the outcomes that matter to patients and consumers, and incentivize processes that are most important to them. Motivate clinicians to move towards APMs by more strongly and clearly rewarding innovation and learning, rather than prescribing specific processes and accounting.
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> Tell a compelling story: CMS needs to convincingly explain how participating QCs will be benchmarked and how the payment incentives and adjustments will be applied. Focus ACI on health IT functionality that is clearly connected with interoperability, care coordination, and

patient engagement. The final rule should more strongly reward opportunities for innovation to expand access to care, such as through telehealth, incentives for rural providers, and incentives for those in underserved areas. Simplify the glide path for participation in APMs. Make the APM scoring standard simpler so that substantial education is not required.

Improve the CPIA category: CPIA should avoid being prescriptive, since it is a process requirement. CPIA could serve as a test bed for innovation for activities that might later be incorporated in APMs. (Several examples of flexible options were suggested.)

Interoperability: MACRA offers an excellent opportunity to promote widespread interoperability among multiple stakeholders in health care, which could be more prominently promoted by the proposed rule. Encourage private payers to construct value-based programs that align with the Quality Payment Program and to build in incentives to submit electronic clinical data. Facilitate greater partnership among providers and public and private payers to reward information sharing by building a common infrastructure for data submission and standardizing quality measures. Create a pathway for providers to move toward wholly electronic information collection—one that allows for equivalent information to be widely distributed to all qualified entities that request it. Make sure the most important information for quality measurement and Improvement is submitted to QCDRs.

Ross said that the committee members' questions and comments will be used by the task force to formulate final draft recommendations for action at the next joint meeting.

Discussion

Blake observed that the implementation schedule is an aggressive one. She indicated agreement with the task force's observations. Harrell reported that providers in her jurisdiction are overwhelmed by the proposal. Implementation should be delayed by at least 6 months to explain the programs and educate providers.

Paul Egerman declared his agreement with the general observations and recommendations. He said that the recommendation for CMS to set quality measurement standards and encourage commercial payers to use them is very important and should be amplified in a separate recommendation. Ross agreed to consider the suggestion.

According to Rich Elmore, recommendations must be specific to get interoperability to the national scale in a short period. He observed that there is often a desire to move to the next step before accomplishing the prerequisites. The task force should refer to ongoing work on standards specifications and other aspects of interoperability.

Blake observed that MIPS participants will be required to report on all patients regardless of payer. This is de facto reporting of non–CMS-covered patients. The task force should wait to see the results of current efforts to harmonize reporting. Egerman said that much reporting is duplicative. Blake suggested that the task force consider the burden of reporting across the landscape. Tang said that CMS contracts for the development of measures and could work toward more common outcome measures that payers would use. Blake reported that the American Medical Association Core Measures Collaborative is working on common measures applicable to both CMS and private payers. Egerman recalled that at one time, each payer used a unique claims form. It took a long time to obtain agreement on a common form. Harmonization of quality measures will require a similar effort. Ross said that task force members are interested in standardization across payers.

Malec said that he agreed with the task force report. He observed that much of the complexity of the proposed rule is due to trying to make the rule applicable to as many providers as possible. Perhaps this could be addressed by showing how each program would apply to specific types of providers. Malec went on say that he wants a softer on-ramp for 2017. MIPS will require more time. The Advanced APM tracks should incorporate more flexibility. Tang responded that some of Malec's comments have been agreed to by the task force but are not included on the slides.

Next Meeting

An in-person meeting is scheduled for June 23.

Public Comment

Two members of the public submitted comments via the Web meeting chat function.

David Tao, ICSA Labs, wrote, "The difficulty 'integrating' external information was said many times. and other FACA meetings. Up till now, the problem has been associated with summary of care records (C-CDA) because those are the main vehicle for exchanging information, through Meaningful Use Stage 2. However, the same difficulties in integration may continue even with APIs such as FHIR, since the data values coming from external EHRs will be the same, just in a different format. EHRs have challenges incorporating, deduplicating, translating, and reconciling data today. Widespread progress needs to be made in algorithms and best practices to automate integration AND to help clinicians quickly and easily review the most relevant external data. I recommend that research and pilots be funded to stimulate a major leap forward in integration and reconciliation of external data, and that the research not be limited to medications, allergies, and problem lists."

Stanley Nachimson, Nachimson Advisors, wrote, "There is a long time period between when information is collected and when providers actually get feedback. This causes a disconnect between provider actions and risk/reward. CMS should look at ways to provide ongoing feedback to providers, or encourage vendors to create products to help them monitor their performance on a more current basis."

The meeting adjourned early at 12:20 p.m.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the May 2016 joint meeting was approved unanimously by voice vote.

Meeting Materials

- Agenda
- Summary of May 2016 joint meeting
- Presentations and reports slides