

Health Information Technology Policy Committee Summary of the August 14, 2009 Meeting

KEY TOPICS

1. Call to Order

One correction to the minutes from the last HIT Policy Committee meeting was proposed. On page 5, the reference to “an aggressive timeframe” does not reflect the view of the entire Committee. Judy Sparrow took note of the correction. With this amendment, Committee members approved the minutes by consensus.

2. Review of Meaningful Use Definition and Future Plans

Meaningful Use Workgroup Co-Chair Paul Tang introduced his fellow Co-Chair George Hripcsak, who explained that during its last two conference calls, the Meaningful Use Workgroup has worked through the process and timeline. One of their goals is to assign specific measures to different specialty practices. In October 2009, an informational hearing on meaningful use criteria for 2013-2015 is planned. The discussion that followed included the following points:

- The intention of the Meaningful Use Workgroup was for hospitals to achieve a 10 percent use rate, but for doctors’ offices and providers to have a 100 percent rate.
- Tony Trenkle noted that the Centers for Medicare and Medicaid Services (CMS) will make sure that in the rulemaking process, the final rules do not include requirements to send information to CMS that CMS does not have the technological capacity to accept.
- The statute indicates that there are hospital-based physicians who are not eligible for funds. The question was asked, what is the boundary between specialists for which measures need to be developed, and those who will be treated separately because of this statutory language? Tony Trenkle explained that this issue is being addressed by CMS.
- Tony Trenkle also commented that Medicare and Medicaid programs are being harmonized, and it may be that meaningful use objectives will effectively become the base, with states being able to add their own additional guidelines.
- David Lansky expressed a continuing concern about the meaningful use pipeline. He said that the HIT Policy Committee should give direction regarding 2015 as soon as possible, so that measures development and testing can begin now. The Meaningful Use Workgroup has talked about having a hearing on patient-supplied data sources as part of the strategy, he said, and expressed hope that this will still happen.

- Gayle Harrell asked if S-Chip was included in the statutory requirement for 20 percent Medicaid in order to be eligible for stimulus funds. Tony Trenkle said that the law is pretty specific, and CMS is going by what the law says in terms of qualifying for the program.

3. Certification/Adoption Workgroup Recommendations – Specifics

Certification/Adoption Workgroup Co-Chair Marc Probst explained that nothing with respect to the Workgroup’s overall proposed definition of HHS certification has changed—it is still focused on meaningful use, and is still not intended to be a “seal of approval” process. The Workgroup’s five specific recommendations are similar to those discussed at the HIT Policy Committee meeting, though the Workgroup did take into account the Committee’s comments. Workgroup Co-Chair Paul Egerman presented the five recommendations as follows: (1) focus certification on meaningful use; (2) leverage the certification process to improve progress on security, privacy, and interoperability; (3) improve objectivity and transparency of the certification process; (4) expand certification to include a range of software sources; and (5) develop a short-term certification transition plan.

A new concept presented by the Workgroup was Preliminary Certification. Until the regulatory process has been completed, they are proposing a preliminary certification that would not have any statutory standing but, hopefully, when the regulatory process is completed there may only be a small adjustment necessary to proceed from preliminary to final certification.

Also proposed is a set of gap criteria between meaningful use and the Certification Commission for Healthcare Information Technology (CCHIT) 2008 criteria. The CCHIT has already conducted an analysis to map meaningful use back to the CCHIT 2008 certification. So, vendors who are already CCHIT certified will not have to go through the whole process again.

Subsequent discussion included the following points:

- Regarding HHS certification, Gayle Harrell asked whether the certification would actually be administered by HHS. If so, she wondered if it has the manpower to do this work. It was noted that the National Institute of Standards and Technology (NIST) will work with the Office of the National Coordinator (ONC) to identify an accrediting organization to accredit certifiers for the HHS certification and to establish a process for monitoring surveillance.
- Paul Egerman explained that being HHS certified will simply mean that a hospital or physician has everything in place to receive the incentive payments—they must have a certified system, and they must demonstrate meaningful use. Assuming the criteria are approved by the HIT Standards Committee, the CCHIT will start offering the preliminary certification in October. Once the regulatory process is completed, it is anticipated that the National Coordinator will declare that the preliminary certifications are final.

- Judy Faulkner noted that in some instances, the actual topics relating to meaningful use are much broader and deeper than the proposed measurements. Paul Eggerman concurred, and explained that in both the summary and the detail recommendations, it was made clear that the certification process cannot focus solely on the measurements; it must also take into consideration the objectives.
- Neil Calman warned against allowing too many accrediting agencies—this would risk confusion, and care must be taken to make adoption as simple and understandable a process as possible.
- David Blumenthal confirmed that the ONC will be responsible for organizing the educational outreach regarding certification.
- It was noted that very little is covered in this round of criteria regarding interoperability. There was a request for more guidance and detail around interoperability for 2013 and 2015. Also, the question was asked whether the Certification/Adoption Workgroup needed more input from the Meaningful Use Workgroup.
- Marc Probst discussed the lack of standardization in the marketplace and called for a greater focus on improving interoperability between systems.
- Christine Bechtel commented that if the process of getting data to follow patients could be improved, it would be extremely helpful.
- Roger Baker noted that the Department of Defense (DoD) and the Veterans Administration (VA) have a tremendous amount of experience with the issue of defining what interoperability means. The law requires these organizations to have interoperability between their systems by September. They had clinicians develop their working definition of interoperability and identify what would be useful. They found that for the most part, visibility into what is in the other medical record system is needed most. He said they can lend the help and expertise that they have gained over the last 10 years to help determine what needs to be computable, and what just needs to be viewable.
- Christine Bechtel noted that the Meaningful Use Workgroup and the HIT Policy Committee at large have been hoping that each provider type can see themselves in this arena. She does not think it is acceptable to hold up the entire process to wait for every single specialty to catch up. She also reminded Committee members that specialists and primary care practitioners operate in different payment environments. She advocated for continuing to accelerate the progress that is being made in supporting adoption for primary care physicians, while keeping up the process of driving towards specialties.
- It was noted that the concept of adoption year may help specialties. Built into the process after the final rule comes out, this will continue to be responsive to the industry.

- David Blumenthal noted that he heard the need for a definition of interoperability and noted Gayle Harrell’s concern about the ability to execute a short-term transitional process.
- The group decided that there should be a change in wording of the proposed definition of HHS certification to indicate that “the system should be able to support the achievement of Meaningful Use.”

ACTION ITEM #1: The Committee accepted the recommendations of the Certification/Adoption Workgroup.

4. Information Exchange Workgroup – The Scope of Federal Activity

Micky Tripathi, Co-Chair of the Information Exchange Workgroup, presented described the state of health information exchange (HIE) today as well as barriers that prevent the market from moving forward. He also noted that if implemented judiciously, American Recovery and Reinvestment Act funding can help create a value proposition for health exchange. Of all the tools provided by ARRA (ARRA), meaningful use incentives are the most powerful lever of change. Mr. Tripathi, along with fellow Co-Chair Deven McGraw, presented the Information Exchange Workgroup’s recommendations as follows:

- Information exchange requirements: There should be core information exchange requirements that are technology- and architecture-neutral and would apply to all participants seeking to demonstrate meaningful use to CMS.
- Core Requirements: Consistent with the recommendations of the Certification Workgroup, these core requirements should be focused on the capability to achieve meaningful use and include interoperability, privacy, and security.
- Certification of interoperability components: The federal government should certify EHR and health information exchange components on these core requirements to ease burden on eligible professionals and hospitals for meeting and demonstrating adherence with meaningful use requirements.
- Aligning federal and state efforts and bringing existing efforts into alignment: Federal and state-government approaches should be complementary, and grants to states should require alignment with federal meaningful use objectives and measures.

The ensuing discussion included the following highlights:

- The Information Exchange Workgroup will next address privacy and security issues.
- One committee member asked if the Information Exchange Workgroup was going to be making recommendations about what triggers or authorizes one institution to share data with another. This would have to be harmonized with privacy laws.

- A distinction was made between patient control and privacy/security. In 2015, the requirements may have progressed as far as patient-to-patient exchanges, but there must be a start in 2011 on the core requirements. The Information Exchange Workgroup was encouraged to strongly consider meaningful use criteria related to patient control.
- Gayle Harrell suggested that the Workgroup hold some public hearings so that it can truly understand the public's view on the exchange of their personal information.
- Neil Calman noted that the opposite side of the privacy/security concern is the extent to which consumers need to see a benefit to exchange. A consumer imperative is the benefit component that balances the privacy/security concern. The public have not really been sold on the benefits of exchange, their ability to see everything that is being exchanged, their ability to vet that information, and to make sure it is accurate.
- Roger Baker noted that the Workgroup has discussed certified and uncertified systems. He expressed concern because currently, the VA has an information exchange agreement with everyone with whom it exchanges information. If his organization is going to share information in the many-to-many world of information exchange, he said he must know that whoever is receiving it is authorized to receive it and protect it. If he does not know that everyone on a network will protect the information as he is required to protect it, he cannot participate.
- Deven McGraw acknowledged this point, and explained that this organization does not have the policy lever that would require everyone to be certified. At a minimum, everyone must comply with the law. The VA has very specific requirements; she noted that the policy tools that they have to work with do not apply to everyone.
- Jodi Daniel said that the ONC will be administering state grants regarding health information exchange; these grants could be used as a lever for interoperability.
- Judy Faulkner noted that some potential customers don't participate because their lawyers and other advisors are hesitant due to privacy laws. The laws around interoperability must be clear so they can be followed. In addition, systems need to be sustainable, or else a situation will develop in which the government must support systems for interoperability.
- Judy Faulkner also wondered about the practicality of a patient hiding particular diagnoses, or facts about their medical history. Physicians can look at medical records and see things beyond what the patients can see.
- Christine Bechtel noted that the perspective of patients and families needs to be included as these recommendations move forward.
- Neil Calman noted that if this group really believes that it is important not to be technology-specific, then there needs to be a requirement that this be brought down to the

state level. To the extent that a state adopts a single model, it would be violating a federal guideline. States should not be able to dictate a specific technology any more than the federal government. Deven McGraw agreed that this is a good point, and that the Workgroup's recommendations as they now stand do now preclude a state from doing just that.

- Jodi Daniel noted that 42 states and territories are examining the variability of state policies and laws. The last phase of the project pulled states together to come up with common approaches for dealing with some of these issues, and some have started to be implemented. Some interesting ideas have been developed on how to bridge variations in laws from state to state.

ACTION ITEM #2: The recommendations of the Information Exchange Workgroup were accepted by the Committee.

5. HIT Standards Committee – Update on Progress

Clinical Operations Workgroup

Jamie Ferguson, Chair of the Clinical Operations Workgroup, described recommendations related to primary content exchange and vocabulary standards. The Clinical Operations Workgroup is recommending standards for definitive implementation of the 2011 measures. He also noted that there are standards that are allowable during the transition to the recommended standards that are not allowable for 2013 and beyond (e.g., ICD-9, CPT-4, and other legacy, local, and proprietary coding systems).

Roger Baker asked if there is general agreement that by 2013 people can get away from text and PDF images. Jamie Ferguson indicated that this is the case; Roger Baker commented that this may be overly aggressive in terms of timing.

David Blumenthal reminded the Committee that it does not have to take a position on the recommendations/information presented by the HIT Standards Committee Workgroups. The HIT Standards Committee will make recommendations based on input from the Clinical Operations, Clinical Quality, and Privacy and Security Workgroups, and the ONC will react to those recommendations.

Clinical Quality Workgroup

Janet Corrigan and Floyd Eisenberg presented the progress report from the Clinical Quality Workgroup. The Workgroup strongly urges that a very detailed timetable be developed, and that some serious thought be given to the rulemaking process for the next 5-7 years. By 2011, there will not have been much time for development; the timeline is still tight for 2013. However, by 2015, it is hoped that enough time will have elapsed for development.

Floyd Eisenberg presented a grid developed by the Clinical Quality Workgroup that uses the framework established by the Health Information Technology Expert Panel (HITEP). It identifies all of the individual data elements for each measure so that the Clinical Quality

Workgroup can work with the Clinical Operations Workgroup to identify standards to represent those elements. David Blumenthal asked about the availability of standards for specialty-specific measures. Floyd Eisenberg noted that asthma was included in the grid as a way to introduce specialties and pediatrics. Stroke and atrial fibrillation measures also address specialties

Janet Corrigan indicated that the Clinical Quality Workgroup has started to focus on measures for 2013 and to identify what other future activities are needed. Many of the 2013 measures are specialty measures, but there few available standards. The Workgroup needs to start sooner rather than later to identify the specific types of measures that are needed so there is adequate time for standards development. David Blumenthal noted that this will be a project for the National Quality Forum (NQF), which has other work too. He said they need to have some discussions in the next month to consider how to keep up with the demand in the pipeline.

Privacy and Security Workgroup

Dixie Baker summarized the Privacy and Security Workgroup activities to date, including the generation of recommendations for EHR product certification standards and the development of privacy and security measures for demonstrating meaningful use of an EHR product (to be presented to the full HIT Standards Committee on August 20). After an update on the standards and discussing the challenges associated with defining meaningful use measures, meaningful use measures to be recommended were discussed. These include measures: (1) representing value that EHR adoption is contributing to HIPAA compliance, (2) representing changes in the approach to HIPAA compliance as a result of EHR adoption, and (3) that can be objectively assessed. Deven McGraw and Dixie Baker agreed to discuss how some of the Privacy and Security Workgroup recommendations or future directions may be impacted based on discussions at this meeting.

6. Public Comment

[Name unclear] noted that he presented a letter after the last meeting, and asked that it become part of the record. He said that with regard to the important task of verification of identity, he has flash memory, and he does not understand why this is not being considered. He said he can demonstrate how to solve the identification issue efficiently and effectively.

Lynn Scheps, Vice President, SRS, wanted to personally deliver the book *The Voice of the Physician* to the Committee. She asked that they listen to the daily realities of practicing medicine. The book is an indication of the deep level of concern pervading the physician community—physicians will not adopt technology that compromises their effectiveness; they will not become data entry clerks and they will not do things to compromise patient security, nor will they be swayed by financial incentives or penalties.

Mike Koppel said that it is gratifying to see the level of commitment here to HIT and health outcomes. But, sometimes actions can have unintended consequences. One of those could be in the transition strategy for the certification process. He commented that the current strategy that was approved today has a serious flaw that is likely unintentional but significant. The 2008 CCHIT+ gap approach may work in the ambulatory setting, because more than 70 vendors have

CCHIT 2008 approval. But in the hospital segment, only one vendor currently has CCHIT certification for 2008. Many vendors could not address the 12-month time period for increases, so they planned on applying for the more stringent 2009 criteria. He also noted that 2008 certification is no longer available. So, this Committee's approval of the 2008+ gap seems to be favoring the only approved vendor, and a member of that company sits on this panel. This distorts the market in the hospital space. Mr. Koppel asked that the ONC or Tony Trenkle, in the development of regulations, would consider a review process that would prevent such things from happening.

Ruth Perot of the National Health IT Collaborative for Underserved, applauded the addressing of health disparities in the meaningful use draft. She commended the Committee for addressing the importance of race, ethnic, and language data in the first year of adoption. She also noted that her group celebrates the patient-centered focus of entire document. Seventy percent of California patients say they want HIT. During the public comment session, she shared three of her 29 recommendations with the Committee:

- Look at safety net clinics. There are as many free clinics in operation as there are federally funded health centers. She urged that support for such safety net providers be broadened.
- This effort is as important as the CMS outreach campaign to get beneficiaries of Medicare to adopt prescription drugs. There needs to be that level of investment to make sure that word gets out.
- She hopes that the ONC plans to monitor the participation of safety net providers.

Richard Eaton from the Medical Imaging and Technology Alliance said he was struck by how often the issue of interoperability has come up in this meeting. His organization has more than 80 years of standards development testing experience, and he offered their services and knowledge during this crunch time.

Robin Rayford from Eclipsis made a comment about more detail regarding interfaces and interoperability. In the new IS107, there are 443 interfaces linked to 7,000 pages of documentation. She expressed hope that this is enough. With regard to HIOs and HIEs, she worries about cherry-picking of privacy items by patients. She said it would be an IT nightmare.

Dr. Peale, a practicing physician and founder of Patient Privacy Rights and the Bipartisan Coalition for Patient Privacy, said she sent two letters, and she is not sure that the Meaningful Use Workgroup has seen them. In the October hearing, for example, there is no place for consumers to be heard. Her group sent a detailed letter recommending that federal policy be used for meaningful use standards to ensure the privacy and trust for the exchange for mental health and addiction records, and they recommended an open-source consent system that is being used effectively in eight states. She noted that her organization would be happy to provide input at the workgroup level. She said that legal concerns regarding HIE could be solved if there was simply informed, robust patient consent. She also noted that depression would be listed among the top 20 most common serious conditions, but many people refuse treatment because they

know that information is not private. She commented that probably one-third of the patients are “off the grid” because of privacy issues.

Tom Leary commented that the HIT Policy Committee is addressing the appropriate policy issues and encouraged its members to continue moving forward. He noted that the predecessor organization tended sometimes to back away from policy discussions. In concluding his remarks, he noted that National Health IT week is September 21-25, 2009, and that approximately 100 organizations have signed up to be part of this.

SUMMARY OF DECISIONS AND ACTION ITEMS:

- **ACTION ITEM #1:** The Committee accepted the recommendations of the Certification/Adoption Workgroup.
- **ACTION ITEM #2:** The Committee accepted the recommendations of the Information Exchange Workgroup.
- With one correction (i.e., noting that the page 5 reference to “an aggressive timeframe” does not reflect the view of the entire Committee), Committee members approved the minutes by consensus.
- Deven McGraw and Dixie Baker agreed to discuss how some of the Privacy and Security Workgroup recommendations or future directions may be impacted based on discussions at this meeting.