

Health Information Technology Policy Committee
Final
Summary of the April 4, 2012, Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, 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 meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC web site. She conducted roll call, and then turned the meeting over to HITPC Chair Paul Tang.

2. Review of the Agenda

HITPC Chair Paul Tang welcomed National Coordinator Farzad Mostashari, who was participating via teleconference. Tang reviewed the agenda, noting that the day would be taken up with discussion of the Notice of Proposed Rulemaking (NPRM) regarding Meaningful Use Stage 2. Some of the NPRM provisions apply specifically to the various Policy Committee workgroups, which are engaged at looking at the proposed rule and providing feedback.

Tang noted some misattributions in the minutes from the last meeting. He passed those on to Mary Jo Deering; otherwise, the Committee approved the minutes.

Action Item #1: Minutes from the March 7, 2012, HITPC meeting were approved by consensus.

3. Meaningful Use Workgroup Draft Recommendations on NPRM

Meaningful Use Workgroup Chair Paul Tang thanked the Workgroup's membership, which he characterized as a steadfast group that has been meeting for more than 3 years. They will take the Committee's feedback today, reconcile it with the suggestions they had proposed, and bring back a final response next month, ahead of the May 7 due date. He presented the Workgroup's findings in several areas.

One of their top objectives was to look at Computerized Physician Order Entry (CPOE). In addition to having all the information a physician needs when formulating orders, they want to have that information and the additional benefit of clinical decision support in helping to shape those orders. This is a critical functional piece of the Electronic Health Record (EHR). Meaningful Use Stage 1 proposed CPOE covering all order types. Because of pushback, the final rule started with medications at 30%, which dovetailed with another electronic prescribing incentive program already in place. With Stage 2, this group proposed adding lab and radiology, making the threshold 60% in all areas except radiology. The NPRM puts lab and radiology at 60% in total and changes the denominator. The Workgroup had the following comments:

1. The denominator was all orders, and the numerator was orders entered by CPOE. So, should all orders include those not entered into the system—that is, paper orders? If it is easy to get the number of paper orders, then that is an easy numerator/denominator. A

counterproposal is to make it results-based. There would be a set of results in the EHR; those would be the denominator. The numerator would be the orders being entered via CPOE that would match up to those results. Lab test results that appear in the EHR were a result of some order. This would be an automatic, easy-access denominator. The numerator would be the orders entered through CPOE.

2. The Workgroup has a concern with the 60% overall percentage. An organization could escape one of the categories by having higher percentages in others. They suggest returning to 60% of each order type.
3. They discussed the issue of scribes. In stage 1, the order had to be entered by a licensed professional, because this is where system decision support should be having an influence, at the time the order is written. The professional and legal responsibility of that individual is an important part of the requirement.

Next, Tang discussed drug-drug interactions and drug allergies. He further expanded on the concern about interaction because of the high rate of false positives. If practitioners pay attention to specific drug-drug interactions and hone in on them, then they can affect the false positives and really influence results. Therefore, providers should be able to revise drug-drug interaction rules to heighten the true positive.

The Information Exchange Workgroup will offer an opinion about electronic prescriptions. Regarding demographics, the Workgroup agreed with the proposed rule pushing it from 50% to 80%. Their thought was to get more granular over time with Office of Management and Budget (OMB) categories.

With regard to maintaining up-to-date problem lists, medications, and medicine allergies, the NPRM suggests a consolidation of these as part of the Summary of Care document. The workgroup felt strongly that these are important separate objectives.

The NPRM proposes broadening the clinical decision support (CDS) without being prescriptive in terms of what qualifies as a decision support rule. The Workgroup agrees with the five CDS interventions, linked to clinical quality measures (CQMs). There is a description of some of the attributes in the preamble, but this did not appear in the certification criteria. Some of these attributes should be relisted and become a part of the certification criteria. Drug-drug interaction and allergy information should be included in addition to the five interventions. Additional ones to address efficiency, the overuse of high-cost imaging, or the use of generics would be productive. Evidence supports that it is useful from an appropriateness and an efficiency/cost point of view.

With regard to advanced directives, they proposed moving towards not only indicating whether there is an advanced directive or not, but also having a pointer to access it. State laws complicate this, and they suggest investigating further, possibly through a hearing.

With respect to sending reminders to patients, the Workgroup thought that sending reminders to 10% of all patients sounded reasonable for primary care, but they could imagine some specialists who might not require follow-up, and would have difficulty with that 10% threshold.

The NPRM has a new requirement regarding imaging. The Workgroup supports this, but is concerned that 40% may be too high at this point, especially in areas with more limited suppliers of imaging results. They suggest making it 10% and having an exclusion for those practicing in areas without imaging centers able to do this. The proposed measure of 10% of images being electronically transmitted back to the provider is one the Workgroup agrees with in spirit, but Stage 2 may be too soon for this.

There is a new objective for family health, and the Workgroup supports this in spirit, but is not aware of standards that exist for family health. Many EHR systems capture it, but in structure specific to vendors or providers. Also, there are varying definitions of family history, from the simple to the very comprehensive. The industry is also moving from family into genomic history.

The Workgroup recommends progress notes in Stage 2. The NPRM does not include these as objectives because EHRs have them. However, especially in hospitals, not all EHRs have clinical documentation as a primary function; because they are an essential part of information about an individual, the Workgroup wants to be sure all EHRs have that capability, and that it is implemented.

Co-chair George Hripcsak began discussion of the engaged patients and family category. The Workgroup suggests restructuring to deal with questions of timeliness. They suggested one consistent measure, moving to 2 business days as the upper limit for timely responses. They acknowledged that in many cases, the data should be available to patients essentially instantaneously.

The group needs to have more discussion on the notion that for eligible professionals, 10% of patients would have to log onto their system to qualify. Their original suggestion was to have 10% log on, ever. The NPRM has 10% per reporting period, which is a more difficult challenge, and they do not agree with it. The workgroup voted and agreed that achieving secure messaging for 5% of patients was better than the NPRM suggestion of 10%. The preferences for communication were eliminated from the NPRM, and the Workgroup recommends that it be included. Capturing a patient's preferred communication method is needed in order to pick what future non-urgent communication method should be used. The Workgroup agrees with the NPRM's removal of the test of health information exchange, and defers to the Information Exchange Workgroup's alternative suggestion for this.

For medication reconciliation, first, they note that the certification criteria should support the reconciliation process. A number of things must be done, including comparing multiple lists, so this policy objective should trigger that process on the certification side. To support the measure, the system must capture that a transition has occurred. That must be captured manually, so the threshold should remain at 50%. They do not want to create too strong an incentive not to report transitions, for which the organization may not then do reconciliation.

They agree with the NPRM suggestion that for something to count as a transition it had to cross organizational barriers, but not that it must go to a different vendor system. In some geographic

regions, just a few vendors dominate, and they do not want to create an incentive to make fake transitions. Regarding population health, the Workgroup feels that the highest priority is immunization. If it proves too difficult to do three original and two new registries, then immunization should be the focus.

They suggested considering whether sufficient standards exist to support interfaces to various registries, some of which are proprietary, exclusive, and expensive.

Regarding team-based care, the Workgroup discussed how it would work functionally. Should each individual provider be responsible for making Meaningful Use of the EHR? Quality measures are, in a sense, the outcome of the meaningful use of the tool. It is difficult to determine how to measure people as a team or a group and at the same time not let individuals opt out of that group EHR participation.

This group recommended an EHR safety study, and the Institute of Medicine was commissioned to produce a report. Tang suggested forming a Tiger Team dedicated to responding that report.

The Workgroup felt that over-the-counter (OTC) medications should be included; yet, because they can span a number of chemical ingredients, they should not be included in the denominator. Regarding relevant past diagnoses, the Workgroup could not determine how a machine would determine what a “relevant” past diagnosis would be. Additional specification is needed.

General Discussion

Marc Probst spoke about the labs denominator issue, asking whether there was truly a one-to-one relation between orders and results, or if there was variance. Tang acknowledged that there would always be some variance in the number of labs ordered versus delivered; it is not a countable number without manual intervention, so 60% seemed like a reasonable number. Hripesak indicated that the Workgroup feels this is a good alternative solution if it is countable and easy to do.

With regard to scribes, one Committee member commented that there are certain situations, such as in emergency departments, where there are standing orders and there may or may not be a licensed physician reviewing orders—and they probably shouldn’t be. Paul Tang said that anything that is legal in the state would count. That is why they initially used the word “licensed.” More input on this issue is needed.

Larry Wolf said that, on one hand, a scribe could be an escape clause, just someone to deal with data entry. It could also be that there is a team working together to create a health care plan, and one of those team members is interacting with the computer. They want to encourage that kind of teamwork; the principle is to encourage collaborative care and not to force people back into their silos.

Gayle Harrell said that the concept of scribes is fundamental to CPOE and the progress notes issue. They must look at who is liable for the order or progress note, and that will lead to how they must address the whole issue of who uses a scribe. If the provider is liable, then that provider may not be touching the keyboard but must have direct, eye-to-eye communication with

that scribe. Whose license is on the line? Who is ordering, who is liable, and what is the communication between them?

Neil Calman said he does not think they are going to know who is entering orders, and he doesn't even know how they will measure this. They know who has the legal authority to sign or countersign an order, though. His suggestion is to put the decision support at the point where the order is signed off, not necessarily at order entry. In that way, someone could enter a group of orders, but the provider or responsible party, in the process of signing off, would be the one receiving the decision support.

Hripacsak said they must look at specific workflows and see how things are actually implemented. They don't care who does the typing; they just want the effect. They should look more specifically at how the work gets done in order to put together the policy.

Judy Faulkner emphasized that workflow is important. It used to be fast—the physician would tell the nurse, “order this.” CPOE by itself doesn't work well; it must be embedded in all of the other activities to give the physician value. Her observation in looking at various EMRs and scribes is that, although this Committee thinks it's a team effort, that is not necessarily the way it works. The reality is that organizations have to do CPOE, so some of them hire scribes. Faulkner also pointed out that a new physician joining a practice straight out of school is probably comfortable with the computer, and not at all comfortable with paper. Perhaps they ought to just let it be, and the transition to the computer will happen naturally. It is hard to track, but organizations will figure out the best workflow for themselves.

David Lansky asked whether this is a good point in the meaningful use process to ask whether they are building the capabilities that will help them achieve the four goals of quality, safety, efficiency, and reduction of disparities. Should the Committee look at this in the aggregate to determine whether this work doing enough to drive these? This is not translating to clinical efficiency in many cases. He noted that there are remarkably few references to disparities in the NPRM. He hopes that as a policy Committee they will have a discussion to raise the visibility of some of those capabilities that have been underplayed so far.

Mostashari said that they are going to raise that issue later. One of the comments around Stage 1 has been about why providers are being asked to collect a lot of information that is not being used. One of the primary reasons is to look at disparities. Tang suggested that perhaps a way to introduce this concept would be to make disparity one of the variables they use.

Calman said that this goes back to quality measures. This is an opportunity for them to call out for the development of a quality report on something where they know there are lots of disparities, like diabetes or hypertension. They could call out a very specific piece that would need to be reported by race, ethnicity, or whatever other area they decide. On the issue of efficiency, he said that a multi-specialty group is about to make recommendations on 46 different items on which physicians currently overprescribe. That gives this group an opportunity to go back to Mostashari's previous critique of the article that came out saying that EHRs are going to increase costs. To counter that would be to build in places where EHRs can reduce cost. They could build in quality measures to look at over-use areas, like the use of diagnostic chest x-rays

for coughs, or antibiotics for sore throats. They could think of different ways that these 46 agreed-upon specialty items could be tied into quality measures to use EHRs to improve efficiencies.

Harrell addressed the issue of e-prescribing thresholds for electronic health transmissions. There are rural and inner-city communities where this is not available, so 65% is too high. She very strongly recommended going back down to original recommendation of 50%. She urged the Committee not to knock some providers out of qualifying because of something beyond their control.

Marc Probst questioned the notion of providers being able to revise drug-drug interaction (DDI) rules. Paul Tang said some studies show that out of the box, providers will overrule something like 81% of alerts, and this decreases the value of decision support. However, when they focus on specific, high-priority drug-drug interactions, it flips around and 67% were acted upon. That's where they want to go: the provider group should take responsibility to figure out what the good DDIs are, and have the capability to insert their own DDI rules. Hripcsak said that this is a temporary provision until the industry comes up with DDI rules that really work. Probst's suggestion is that they probably need more research around this. There may be better practices, and he is not sure about having the requirement there unless it is beneficial and has sufficient capability.

It was noted that the CMS included some opt-outs in their rule related to electronic prescribing, and it may be helpful for the certification criteria to be consistent with what CMS used. CMS has worked a lot with this issue, and it was suggested that the Committee be consistent with CMS's final language.

Discussion on Engaging Patient and Family

Christine Bechtel suggested a two-part secure messaging threshold. The provider must do the patient-specific messaging, but there would also be timeliness requirements for responses to any messages the provider receives from the patient in regard to the messages sent. That begins to address whether systems can easily measure response timeliness. The impetus is on the provider, and it can be tailored to individual circumstances. This would be very useful for patients.

Larry Wolf said that the goal is really to engage patients, and that happens best live, in the office. It is better to be handed a summary right then and there, when the patient can read over and confirm or correct things. That is much better than sending it two days later via e-mail, which creates a situation involving "phone tag" and the like. The spirit is about engagement and he is concerned that they make the distinction between regulation and best practice. Tang concurred, and said that their comments make clear that the outer limit was a response in 2 business days, but that it is best to provide clinical information right on the spot. Wolf also noted that whatever materials are supplied to the patient should be in "both languages." That is, they should be clear for the lay person, and should also include the clinically specific language that would be useful if they take that information with them to another provider.

David Lansky suggested that recording patient preferences about method of communication could be a way to give visibility into how many patients are choosing electronic delivery, and

could be used as a revised measure. Tang acknowledged that they did have a lack of consensus in the Workgroup about the 10% threshold for viewing information electronically. Harrell pointed out that this holds the physician responsible for things totally beyond his or her control. Bechtel said that there are federally designated areas of low penetration, and they could use that information.

Discussion on Care Coordination

Regarding care summary transmission, Christine Bechtel said she is not sure that the certification criteria and the meaningful use policy rule will foster the ability not just to transmit and receive a care summary but actually to incorporate that data automatically into their EHR. That is a critical capability that needs to occur. They ought to think about how they are fostering the technical capability for EHRs to be able to do that.

Larry Wolf suggested that how they do messaging may be a way to think about care coordination. There should be no “walled gardens;” they should be facilitating communication among all the relevant providers, not just the ones that a particular provider chooses to include in the dialog. From an IT side, they cannot dictate organizational structure. But if someone asks for something, can the physician provide it? Perhaps a provider without certified EHR technology needs the information. Wolf said he would like a certified EHR to be able to send information in whatever way the receiver needs it. That should count towards meaningful use for the sender: they sent the information in a way that works for the receiver. The rule talks about certified EHR technology on the receiving end, but they should consider broadening that.

Bechtel said survey research shows that online access is something that two-thirds of Americans really want. In interviews with providers who have online access, they say it makes their job a lot easier, and it puts patient workflow at top of mind. They have gotten past the debates around provider accountability by putting the right exclusions in place. Now, they need to address consumers’ low expectations and the way they communicate, with the appropriate exclusions around broadband access. If someone asks, a provider has to send; that’s the way it should go. There should be no artificial discrimination when sending out summaries; there are multiple ways to send. E-prescribing is a good model for this.

Bechtel also commented on the need to do more than just receive a document. She is unhappy with the slow adoption of smart receipt, structured documents. Even with coding issues, there are still ways of looking at the document. Those are very important things to set as guidelines and to be looking to vendors to provide. With notion of sending directional signals, this is what they need to be indicating. Harrell emphasized the need to set certification standards for exchanging data now, otherwise a tremendous amount of time and money may be wasted.

Discussion on Population and Public Health

Joshua Sharfstein said that the value of an EHR is improvement in the care of the patient in front of the provider through care coordination. The population health component and registries are one mechanism to accomplish that. He asked whether the concept was limited to propriety registries, and said there is an enormous amount of potential for public registries. Many potential registries could be set up, other than for immunizations and cancer. In Maryland, a contest is going on now to come up with useful concepts for these. A good standard for what

would be an important registry would be what kind of support that registry has from a public health department or a federal health agency.

Tang said that the Workgroup's comments address specific comments from the hearing about proprietary databases, and Sharfstein is right in that they are not paying enough attention to the other registries. Registries have a lot of data elements and there are not standards to describe all of them. If these were turned into certification requirements, then every EHR vendor would have to interface with every registry. Sharfstein suggested that a standard could be set up for an advanced directive registry.

Terry Cullen said that Indian Health Service is up to 22 different interfaces for state registries. They have developed different ways of submitting to the different agencies, and she wonders whether they are doing a disservice by saying that providers should submit to this particular registry, and now that one. Instead, they should take a step back and try to figure out a longer-term solution, with an interim step that would make sense. Asking people to send to five different proprietary registries is going to be difficult. She is concerned about doing one-offs that are disease-specific.

Sharfstein acknowledged that there is a lot of workflow involved in entering the information about patient immunizations. It's a challenge, but there is such potential for medical information and so many different ways it can be used, he would hate to think the fear of figuring out the standards would stop them. It will be very useful where the exchange can do it, with no extra work. Even when that is not the case, this information could save people's lives. Another committee member agreed that there is so much value in this area that they should come up with a standard, rather than building a lot of interfaces not based on standards.

Art Davidson said that they are working toward that standard, and this NPRM will not get them there. In Stage 3, the S&I Framework will, hopefully, get them to where they won't have proprietary standards, but rather one standard that will facilitate communication with Exchange and Direct. They are short on this for stage 2, and it will be a stretch to have some of the things in here, but they are working towards achieving standardization.

Judy Faulkner said that a lot of countries overseas are looking to the United States for standards. If they do not have standards, then more multiples will proliferate overseas. They should set an example for other countries.

Discussion on Team-Based Care

Bechtel pointed to the need to figure out how to support team care, and recognized the difficulty in measuring it. She asked about attesting under team-based care (by team she meant as few as two providers, such as a physician and a physician assistant). Perhaps the response could be structured as giving an answer to something about your team, and then providing aggregates for the team. CMS is also struggling with how to support team-based care. Tang said that they are looking for more ideas that would be novel but simple.

4. Information Exchange Workgroup Draft Recommendations on NPRM

Information Exchange Workgroup Chair Micky Tripathi explained that the group has had at least first-level discussions on everything explicitly related to information exchange, with the exception of view/download and secure messaging. The requirement for structured lab results for hospitals is one that was not taken up in the NPRM, but the Workgroup suggests that it be restored. The NPRM notes that it would be a burden on hospitals, but the Workgroup felt that the reverse might be true. Hospitals might find it beneficial to have a standard, versus the optionality that exists today. That view was expressed by Workgroup members who work in the hospital sector. Also, by not having the requirement on hospitals, they are requiring EHRs to receive by a certain set of standards, and requiring clinicians to have structured labs, but not the last piece of the puzzle, the results deliveries. This directly affects the eligibility professionals to meet that demand, and will really slow us down.

The Workgroup supports the removal of the test of HIE for Stage 1, and the option not to replace it with anything else. On public health, they reached consensus that syndromic surveillance should be kept as a menu item and not moved to core.

More conversation is to come in the Workgroup about transition of care summaries, but they had consensus on the notion of removing the cross-vendor requirement to meet the 10% electronic exchange threshold. They want to create an incentive for vendors to incorporate standards deep in their products. Requiring a cross-vendor situation could create a second tier, or a lower level of integration for the national standard. Also, they do not want to force providers to do artificial things to force the issue.

The Workgroup felt that the e-prescribing threshold may be high given state of the market. Patient preferences are a significant driver; there is also wide geographic variation in penetration, and low penetration among mail-order pharmacies. They are waiting on more information from Surescripts on the penetration of mail order and geographic pharmacies. One thing to consider is that if they set it to 65%, it might set a goal for mail-order pharmacies to increase their penetration. They do want to try to create those inducements, but they must make sure it is genuinely achievable.

In the public health area, there was a general concern about too much discretion left to state and local health agencies. There is a lack of definition of an ongoing successful submission, and a lot of optionality in the standards that did not make sense given the requirements that are being put on transitions of care electronic transitions. Also, there should be greater alignment among standards.

In terms of immunizations, more specificity is needed. Which would be covered? Those immunizations given in the provider's own practice? Every immunization they have on record?

Regarding registries in general, the Workgroup has a concern about definitions. More specifics are needed on the definition of a qualifying registry, and whether these are proprietary or state registries.

The 65% requirement on transition of care summaries caused concern about excluding cases where access is already provided through an EHR. Also, they need exclusion criteria that would relate to small numbers of qualifying transitions: not zero, but low.

Finally, with respect to medication reconciliation, there is a general concern that 65% might be too high for specialties. The Workgroup wants to check what those exclusion criteria are, since the requirement is moving from menu to core. For certain specialties, medication reconciliation could be challenging.

Discussion

Bechtel expressed concern that there is no building block to get to Stage 2 with regard to information exchange, without the requirement to perform a test of HIE. She said it would make sense to require one successful transmission. She also asked about the transmission of care summaries for Stage 2 and how they could begin to foster meaningful exchange outside of organizational boundaries at a higher threshold than 10%.

Tripathi said that with all of the confusion around trying to parse out what is a qualifying transition, it seemed appropriate to keep it relatively low for now to get people started. Also, they need to consider how to count polls. There are certain exchange settings, and nothing right now would allow an emergency department, for example, to count an instance where they could query and get the information back. There is a precedent with regard to the 65% measure, which allows users to remove cases where they have provided access to the electronic record and therefore do not have to provide a formalized summary.

One Committee member discussed aggregate publishing of data to the various registries, saying they wondered about splitting out the transactional exchange information from the aggregate reporting function in order to populate the record for the providers, and thinking about them as two separate functions. They should start to think of these as a class, not as individual cases. They must have at Stage 2 the invitation to capture the data that later will be needed for these other functions.

Gayle Harrell asked whether they are going to make specific statements that will make it clear that they have got to move to national standards, and that the product must have those embedded in them to allow for exchange. As the HIEs stand up, they are having a difficult time with cross-vendor communications, and the interfaces are very expensive and are creating a barrier.

Mostashari said that the NPRM, as part of the rationale for the cross-vendor requirement, talked about the fact that if they could meet the 10% threshold within a single vendor, that this could create the walled garden scenario that Larry Wolf talked about. Mostashari is hearing the Committee say that certification should take care of that. He asked for any thoughts on how to make sure that the EHRs are not just technically capable of exchanging in terms of standards, but also in business practices.

Tripathi said that the idea is that regardless of which platform a provider is on, if they send or receive to an unaffiliated organization, then there should not be any difference in the diligence of the testing, monitoring, enforcing, or the standards to which they must adhere. On the other

hand, if the rule says that, for example, transmission from EClinical Works to AllScripts is acceptable, and so is AllScripts to AllScripts, then AllScripts could create a proprietary solution. That would create a second tier for AllScripts that is not as deeply integrated.

Judy Faulkner pointed out that there is a significant difference between registries that are more like repositories and the registries from associations. As the Workgroups on both meaningful use and interoperability work on these they should keep in mind that some of the associations have significant fees. If they require these, they must know what financial burden is. Also, some of the contracts put restrictions on the data collected that prevents the provider from sending it somewhere else. If they make up rules saying providers must use these registries that say they cannot send the data anywhere else, that is counterproductive.

5. Privacy & Security Tiger Team Draft Recommendations on NPRM

Tiger Team Co-Chairs Paul Egerman and Deven McGraw presented a response to privacy and security issues in the NPRM, and also talked about new ONC guidance to state grantees that builds on this Committee's recommendations. McGraw said that the work that the Tiger Team and the Policy Committee did over last summer was incorporated to a very large degree in the guidance issued by ONC to state grantees. The guidance incorporates ONC's articulation of fair information practices and nationwide data sharing principles. It requires grantees to submit their policies to ONC and recognizes that the architecture of HIE matters, especially with respect to the policies having to do with consent.

Next, McGraw walked the group through the status of the privacy and security recommendations that were adopted in the NPRM, those that they are not sure about, and those that were not adopted, either expressly or by silence. She listed a series of suggestions for HITPC comments on the proposed rules, characterizing them as getting through some low-hanging fruit that was relatively easy. What remains are some issues that may be more difficult to resolve about whether to continue to press for what they initially pressed for, or whether in fact new information has come to light that makes it less sensible to continue to press, or to recommend something different. The Tiger Team is working in alignment with the Standards Committee's Privacy and Security Workgroup, so the two are in alignment.

McGraw discussed the rule relating to EHR modules, which a number of vendors asked to be removed, and it was. However, there is now a new concept called a Base EHR, which is all of the basics of EHR functionality needed to meet meaningful use, and which can be done with a single product or a series of modules. The question is, if there is an EHR module that is not part of the base and isn't required to be certified for any of the security functionalities, is that module going to create a vulnerability? Will users have the assurance that they will meet meaningful use requirements with this module included in their system? Other areas discussed include portals, e-prescribing of controlled substances, digital certificates, and patient matching, all outlined in the slide deck.

Discussion

Larry Wolf said that as they look at data exchange and collaboration, data provenance becomes more important. Historically, record systems did a great job of tracking who did what, by walling it off in the "got this from outside" section. As data are integrated to a greater and

greater extent, how will a user know where a particular data point came from? This is the next tier of how data elements are tracked.

It was noted that every state has its own narcotic and controlled substance prescribing, and it does not interact at all with the EHR. This goes back to the issue of what to do with all those registries. Also, when they talk about address standardization, it assumes everybody has an address. This ignores the issue of homelessness. She urged the group to be attentive to the work that has been done in this area, as this is a population that does not have a voice.

6. Quality Measures Workgroup Draft Recommendations on NPRM

Quality Measures Workgroup Chair David Lansky explained that the group clustered the couple hundred measures into three or four categories. Things that keep surfacing in this discussion are alignment, and the fact that they need to see more of it; vendor platform design; and the basic question, how are we doing? Stage 3 is the time when they would like to evaluate on outcomes. The emphasis is less on prescribing functionality and more on outcomes. Is appropriate progress being made on that? Several other topics, such as group reporting, were also discussed by the Workgroup.

On the topic of alignment, they heard that Meaningful Use Stage 1 has been challenging, especially for smaller practices. They may not have the capability or the expertise to do many of these things, and they are relying on vendors to generate quality measures. Currently there are 125 or so potential measures for EPs, and about 60 for hospitals. That implies that vendors have to be coding for maybe 200 measures to be generated from EHR products. It is quite burdensome to make sure this group is aligning their work with the other outputs that providers must generate.

They support alignment to reduce burden, but they do not want to take the lowest standard of all the programs and make that what they align to. Naturally, the measures that are e-enabled may not match to legacy programs that the government may still be operating. So, how do they keep the process moving forward? For example, they could say that a provider passes on the traditional PQS requirements if they submit data using an EHR. Alternatively they could say, if one is a meaningful user then they are automatically PQS-certified. They want the platform everyone is using to support the data that will work with those government programs.

Regarding vendor platform, Lansky said that there is a concern that the vendor approach has been to hard code each of the measures. They have heard why that is beneficial, but it is hard to see the future from here. Vendors will have to program all of them, and this will increasingly become a bottleneck. How do they not allow the technology to become the bottleneck for improving value in health care?

If vendor platform capability was more flexible, it would be more useful to drill down and use the data. Option 1A in number 11 out of the 125 proposed measures would reduce the probability of hard coding, and would force more flexibility from vendors. There is also a lot of Committee support for a link between clinical decision support choices and the quality measures that users would choose. If vendors built in these links, it would be a powerful enhancement to EHR capabilities.

Regarding outcome goals, they support the six domains for reporting. Option 1A requires EPs to pick at least one measure from each domain, which keeps everyone's attention on at least one measure in each of the domains. Although there was support for alignment, the Workgroup asked for the proposed measures to show how different programs' requirements can be satisfied.

Whether they now have in Stage 2 certification requirements for all of the information capture that they will need for Stage 3 is not clear. They are trying to discourage measures that are simply checking boxes; that is, answering the question of whether they have the technical capability to do something, but not actually doing it.

Lansky said that available measures for care coordination are pretty thin, and they will not see many improvements if this is the best they can do in terms of available measures. How can they as a Committee encourage attention to this dearth of measures in the measurement pipeline?

The hospital approach has been well supported, and hospital quality measurement is satisfactory. The question is whether there should be fewer measures versus more but with the ability for people to choose their own. The results would be more comparable and useful if there were fewer measures. More measures would mean specialists could find more for their practices. They did not resolve this debate in the Workgroup.

There was an extended discussion of what to recommend to CMS if they want to reduce the number of measures, and diverse opinions in the Workgroup about what that process should be. They need tighter specifications and more implementation guides. With regard to group reporting, in general, they agree that group reporting would be a good way to go. There are three different options in NPRM, and it is confusing to track back what each of them really implies. The consensus is, they are concerned about situations where a group of professionals are simply sharing a Tax ID number and reporting together. It is not possible to know how they interact and what is being measured. CMS must be careful not to lose track of measurement of one physician's performance or group performance. Lansky said PQRS group reporting is a very close mapping to the option 1A approach.

Discussion

Mostashari asked for comment on the impact of Option 1B if there are 11 core requirements proposed across the domains, but many are the exact ones where development is now occurring, and others that may not end up being in the final rule, perhaps because they are new measures. What would be the impact if it ends up that only a portion of the 11 that are put in as core and required actually end up in the final rule?

Lansky said that the ideal of having many physicians find something for them on the chart is the good thing about the long list. More of a core list permits comparability, and robustness of comparison is also beneficial. Maybe the group should discuss some kind of a blend before the May deadline.

Bechtel said that she agrees about the direction of alignment, that if a practitioner can meet the meaningful use requirements then they should get the PQR credit. However, she does not think it should be the other way around, because PQRS only requires the reporting of three measures,

and allows reporting on a family of measures. That is a nice approach, but the denominator is only 30 patients. The origins of PQRS are sufficiently different that they keep getting stuck looking at meaningful use through the lens of the current quality measure enterprise.

With respect to new measures being developed, or adapted for potential use in Stage 2, she would be interested in understanding potential for the meaningful use program as a proving ground for new measures. They cannot look at meaningful use as a performance program because it is not such a program. People just have to report the measure; it doesn't matter how bad or good they did. They may want to use meaningful use as a proving ground for much more advanced measures that they hope to see in the future.

Mostashari said that the measures recommended by the Tiger Team were mostly in the gap areas, where there are no existing measures. Those may be the ones most at risk of falling off, because if development and testing is delayed, those are the ones with the least robust track record. Bechtel puts forth a different view on meaningful use, putting a greater emphasis on laying the foundation for future cycles in health IT. One of the axes in this Committee's thinking is going to be how broad-based, how parsimonious, and also how mature those measures are.

Bechtel suggested that perhaps there could be an option for a provider to get some extra credit for choosing some of the newer measures for reporting. There would need to be some capacity to report that the measure just didn't work, without penalizing the provider. This would incentivize them for choosing measures that would foster the work around improving quality, but if there's a problem, they would not get dinged. Tang agreed that this was a fascinating idea. They do not want to promote something before it is tested, but on the other hand, they could give credit for what is important to a provider that they may have wanted to do anyway, in order to get the ball rolling for innovation.

Lansky pointed out that most of the payment reforms underway for 2015-17 are focused on achieving goals in these domains that are gap areas. There will be problems all over if they do not address these. EHRs are hopefully one of the tools that will be able to support meaningful improvements in these areas.

Neil Calman said that the most important issue is to create a platform that people can use in their own specific community, giving them tools so that they can develop measures in a flexible way through the systems without having to go back to the vendors. The other side of it is like trying to use meaningful use to vet specific measures and perfect them, and that is contradictory. They could potentially do both, but he is putting in a vote for trying to maintain the greatest amount of flexibility. They constantly neglect to think, what are they testing the measurements for in the future? Is it to meet some new government or health reform regulation, or to test performance? The flexible platform enables people to develop measures for all those things, and focuses on what the measures are for rather than what they are. They must think in terms of fewer measures and more specificity around using a reporting platform in a health care system.

Calman pointed out that aligning to other government programs does not make sense because those will be gone in 2 years. Right now they are aligning to yesterday's PQRI measures. If they keep aligning to the past, they are not aligning to a future vision.

Terry Cullen said that despite what they think, the vendors are going to hard code every one of the performance measures. The real issue is capability, and she is concerned that that's not in this dialog, because the pressure is on the providers to report the latest and greatest, and get a little bit more money. To steer the IT agenda, they could say that a provider's ability needs to include this measurement capability, this equation. If they are looking at 125 measures right now, next time it will be 400. Think about those small practices that are going to have an incredible financial burden. Judy Faulkner asked whether they have software developers reviewing this to say whether it could be written in such a way that it can get revised, or if there is no way to do it but to hard code.

Mostashari said that it is naïve to assume that they can have a platform designed to take any measure and rework it for an EHR. There must be quality measures built from the ground up to take advantage of the strength of EHRs, rather than adapting from chart measurements. What they are talking about is automating quality measurement, instead of having a chart reviewer look at 35 pages of charts. They should not underestimate the importance of getting to the point where EHRs can serve as a platform, and the concept of having a quality data model that is actually constrained not to what is possible but what is feasible is an important part of that conversation. That said, they must start developing these quality measures that don't exist. They do have to worry about what the measures are. If they don't move on this soon, they will not have them five years from now.

Terry Cullen agreed, but said she did not want to end up with unintended consequences. There are 125 measures; they could be going down a rat hole here. The vendor community could provide guidance from a software programming standpoint and help determine whether it is economically doable.

7. Update from Certification/Adoption Workgroup

Certification/Adoption Workgroup Co-Chair Larry Wolf said they were asked to look at the ONC rule on standards. They have a work plan and broke the work into three calls. The topics were listed in the slide presentation. On April 9th they will be looking at safety enhanced design and user-centered design, which is a hot topic and one that ONC, National Institute for Standards Technology, and Institute of Medicine have all worked on.

He asked the group to comment on whether there are things that would help them stay focused on the policy side of the house. Are there particular areas that are particularly policy sensitive?

Discussion

Deven McGraw said that accounting of disclosures would definitely be policy sensitive. There must be a sweet-spot intersection between the technology and the policy and it must be an automated function.

Christine Bechtel suggested questions around gender identity standards. There is more work to do there, but it may be worth looking at whether there are standards out there for disability status. There is increasing activity around the need to develop technical standards and also workflows and toolkits similar to those done with race and ethnicity data.

8. Public Comment

Tom Bizzaro from First Databank spoke regarding the issues raised about revision of drug-drug interaction rules. Initially those databases were used almost exclusively in pharmacies, but now they are being used by other health care professionals. He endorses the suggestion that customization of drug-drug interaction rules makes sense, as long as those rules are managed well and the result of some thoughtful presentations.

Carol Bickford from the American Nurses Association said that when they come forward with a definition of group measures, it would be helpful to clarify who would be a member of that group. What happens to the members who are not physicians? With group practices in the Medicaid space, there will need to be a clear delineation as to who the practitioners are. Also, she expressed concern about the movement forward on the measures being proposed. Just counting them does not make any quality initiatives effective or improve care.

Mostashari introduced MacKenzie Robertson, who will be transitioning into the role formerly held by Judy Sparrow with the help of Mary Jo Deering, who has worked extremely hard to make sure that all of the important work of these groups went ahead without skipping a beat. He thanked Deering for adding to her long and storied federal service and being such a critical part of the success in this really critical phase.

Len Bose from Intermountain Health Care spoke regarding the immunization registry issue that Marc Probst raised. Some institutions use a Web tool provided by the state to enter immunizations. It is certified in their EHR, but the data goes directly to the state and resides in their database. So they are required by the rules, even though the data is at the state, to resend it again over an HL7 message. He urged the group to consider an exception for modules whose data are already going to an immunization registry.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the March 7, 2012, HITPC meeting were approved by consensus.