

Health Information Technology Standards Committee Summary of the June 23, 2009 Meeting

Participants:

David Blumenthal	HHS/National Coordinator for Health Information Technology
Jonathan Perlin (Committee Chair)	Hospital Corporation of America
John Halamka (Committee Vice Chair)	Harvard Medical School
Dixie Baker	Science Applications International
Anne Castro	Blue Cross Blue Shield
Aneesh Chopra	Federal Chief Technology Officer
Christopher Chute	Mayo Clinic
Janet Corrigan	National Quality Forum
John Derr	Golden Living, LLC
Anita Williams (for Linda Dillman)	Wal-Mart Stores, Inc.
Jamie Ferguson	Kaiser Permanente
Steve Findlay	Consumers Union
Linda Fischetti	Veterans Health Administration
Doug Fridsma	Arizona State University/Mayo Clinic
Cita Furlani	National Institute of Standards and Technology
Kevin Hutchinson	Prematics, Inc.
John Klimek	National Council for Prescription Drug Programs
David McCallie, Jr.	Cerner Corporation
Nancy Orvis	Department of Defense
Marc Overhage	Regenstrief Institute/Indiana Health Information Exchange
Gina Perez	Delaware Health Information Network
Wes Rishel	Gartner, Inc.
Richard Stephens	The Boeing Company
James Walker	Geisinger Health Systems
Jodi Daniel	HHS/Office of the National Coordinator
John Glaser	HHS/Office of the National Coordinator
Judy Sparrow	HHS/Office of the National Coordinator

KEY TOPICS

1. Call to Order and Opening Remarks

Judy Sparrow, Office of the National Coordinator, welcomed HIT Standards Committee members and reminded them that this is a Federal Advisory Committee meeting, open to the public. She conducted a roll call, and turned the proceedings over to David Blumenthal, National Coordinator for Health Information Technology.

David Blumenthal thanked Committee members for their dedication and efforts, and for rising to the very inspiring agenda that this legislation has placed before them. He told the group that the second meeting of the HIT Policy Committee was held approximately ten days ago; at that meeting, the first rendition of the Meaningful Use criteria was discussed. Public comments are

still being entertained on those materials, with listening sessions now occurring through Centers for Medicare & Medicare Services (CMS) regional offices. That Meaningful Use definition will be modified and reviewed again on July 16 by the HIT Policy Committee, and, he expects, will be modified and result in recommendations to the National Coordinator and to the Secretary, Department of Health and Human Services (HHS). Then, the rule-making process will unfold over the following several months.

David Blumenthal reported on other activities at the Office of the National Coordinator (ONC). ONC is working on the optimal allocation of discretionary funds under the Health Information Technology for Economic and Clinical Health (HITECH) Act to provide support for the adoption of Meaningful Use and especially for electronic health records (EHRs). He expressed hope that some of those programs will be announced over the summer. They have already gone public in the *Federal Register* with a description of an extension program, the target of one of the possible spending plans under discussion.

He noted that the successful conclusion of all this work continues to rely on the volunteer work of experts such as the members of the HIT Standards and Policy Committees. The entire IT community and many public and private groups are coming to the assistance of this project. He explained that this is a critical part of the project's success, and in that sense a critical part of the President's and the country's long-term agenda to make the U.S. health care system higher in quality and more productive.

Jonathan Perlin then welcomed the group, and also welcomed new Committee members Linda Fischetti, Nancy Orvis, Cita Furlani, and Aneesh Chopra. He stressed that today's discussion will need to be very granular. At the next HIT Standards Committee meeting on July 21, the group will need to be able to come together to describe standards that will frame the 2011 work, be clear about the gaps that exist, and consider the certification process. He cautioned against over-reading today's discussion as definitive policy.

2. Overview of Preliminary Definition of Meaningful Use

John Glaser reviewed last week's presentation at the HIT Policy Committee on the preliminary definition of Meaningful Use. He noted that the outline of the proposed Meaningful Use approach that was presented last week appears in a wide variety of the workgroup presentations.

Fundamentally, he explained, the idea will be to capture data in 2011, with a core emphasis on moving towards change in 2013 and 2015. The achievable vision for 2015 includes goals in the following areas:

- Prevention and management of chronic diseases (1 million heart attacks and strokes prevented, heart disease no longer the leading cause of death in the United States).
- Medical errors (50 percent fewer preventable medication errors).
- Health disparities (the racial/ethnic gap in diabetes control halved).

- Care coordination (preventable hospitalizations and re-admissions cut by 50 percent).
- Patients and families (all patients have access to their own health information, patient preferences for end-of-life care are followed more often).
- Public health (all health departments have real-time situational awareness of outbreaks).

John Glaser described the draft Meaningful Use criteria, focusing on 2011, and providing objectives and measures in the following categories: (1) improve quality, safety, and efficiency; (2) engage patients and families; (3) improve care coordination; (4) improve population and public health; and (5) ensure privacy and security protections. He summarized that moving towards a transformed health system requires the meaningful use of transformation-capable HIT. The migration of HIT readiness from the current situation to a fully HIT-enabled ecosystem will evolve over time; this evolution should leverage existing standards and identify missing standards for an improved health care delivery system. John Glaser explained that the proposed Meaningful Use criteria for 2011 and beyond provides escalating capabilities while balancing the need for reform and the feasibility of what is achievable. The meaningful use of HIT is a precursor to effective health reform, and is contingent on health care financing reform.

Points made during the discussion included the following:

- James Walker noted that the way this information is going to be presented to health care organizations is as a project plan, with timeline, costs, etc. The better this group can do in terms of designing this so that it can be transformed into a realistic project plan, the more likely small practices and hospitals will actually follow through with this.
- It was suggested that it would be helpful to develop some estimate regarding the percent of organizations that are likely to succeed in 2011. This could be a measure of success for the project.
- Jonathan Perlin noted that the tension between Meaningful Use and the federal incentives is a hurdle; predictions about percentages of 2011 adopters have not been made. In a broad sense, he said, the goal is to provide the framework for the most people to succeed in supporting not only Meaningful Use, but also this Meaningful Use pulling toward improved health care.
- John Glaser suggested that in the early fall, it may be appropriate to examine how success is measured and how best to gauge traction in the industry. The best approach for carrying out these activities is unclear, however.
- David Blumenthal urged the Committee not to take the “weight of the world” on its shoulders. He said the immediate task is to write the standards that are required to implement the definition of Meaningful Use, which is an evolving definition. This group does not have to decide the mega-policy of health reform, how many must adopt, or make a specific determination on the definition of success.

- Anne Castro commented that the Meaningful Use description as it stands today looks like a 2015 goal that is being pushed for 2011. In her workgroup, she said, she is only responding to privacy and security issues, but she has a big concern about the whole context of Meaningful Use by 2011.

3. Clinical Operations, Clinical Quality, and Privacy and Security Workgroups: Introduction and Charges to the Workgroups

John Glaser walked through the broad and specific charges of each workgroup, and then reviewed the membership of each group. Collectively, the workgroups' broad and specific charges have many parallels, and are focused on the near-term work.

Clinical Operations Workgroup

Jamie Ferguson, Chair of the Clinical Operations Workgroup, presented an idea they have been discussing which relates to the tasks and deliverables of the three Standards Committee workgroups. He presented a slide illustrating how each workgroup's efforts support the others, and how all three contribute to the sum of all Meaningful Use standards and certification criteria.

He also proposed using a four-category taxonomy for all of the workgroups based on the maturity of standards and the estimated ability of industry to deploy the standards.

A discussion followed, including these highlights:

- Jim Walker made the distinction between “deployable” and “deployed” standards and technologies. Some standards can be implemented and they just run. Others are more complicated because they rely on many people adopting them in order for them to be effective. He used e-prescribing as an example.
- David Blumenthal recognized that the insights into what is deployable and what is not are important, but urged the Committee not to put off writing standards because they do not think a certain standard is currently deployable. He asked Committee members hold open the notion that incentives and support might be more quickly deployable in the future.
- John Halamka indicated that the next steps are to come to an agreement on taxonomy and the use of extended columns in the Meaningful Use matrix to include those, and to agree on deliverables and tasks and how they should be divided across the three HIT Standards Committee workgroups.
- Dixie Baker noted that there must be best practices standards as well as technology standards, to account for the fact that a perfectly secure technology might not work correctly to ensure privacy and security if it is being incorrectly used. She also noted that the Committee must be mindful of the fact that best practices for a small office might be different than those that apply to a large organization.

Clinical Quality Workgroup

Janet Corrigan, Chair of the Clinical Quality Workgroup, thanked the workgroup members for their work and explained that during their two conference calls to date, the work has focused on identifying those standardized quality measures that can be used to operationalize the concepts that the HIT Policy Committee put forward. The National Quality Forum endorses standardized quality measures, but for the most part those measures have not been specified properly to be used in an EHR environment. Over the last year and a half, the Health Information Technology Expert Panel (HITEP) has been working to identify not only what data types need to be captured within EHRs to support quality measurement, but also to define quality measure and its various characteristics. Therefore, there is a parallel effort and large amount of ongoing activities to retool and operationalize for Meaningful Use.

Janet Corrigan specifically acknowledged Floyd Eisenberg, who leads HITEP, and who carried out a large amount of work on the Clinical Quality Workgroup's initial evaluation of the Meaningful Use matrix.

The following are highlights from the discussion that followed:

- Chris Chute said that he is impressed with degree of organization and thought that has gone into the HITECH specifications. However, it does raise, from a technical standards perspective, the dissonance between what is being characterized as data types, and what is being called quality data units. He asked, how do these data types correspond to electronic medical record specifications, which get down to value sets, units of measure, and very detailed information. Treated as large aggregates, these are very complex entities that have within them specified data types and components, and there is no clear path connecting this level of specificity to clinical operations.
- Janet Corrigan noted that there is an entire set of issues related to attribution. The process is carried out differently by different payers, and for different reasons. She used high blood pressure as an example. If a patient is not following up with care that has been prescribed, how is this measured? It can be done in different ways, and this is a hot-button topic.
- Janet Corrigan also noted that issues such as patient engagement, care coordination measures, and handoff are important to measure whether in primary care or specialty practices. There has been considerable progress made on measures having to do with specialties. She acknowledged that the Clinical Quality Workgroup will have to go back through and take a pass at measures using the lens of specialty care.

Privacy and Security Workgroup

Dixie Baker, Chair of the Privacy and Security Workgroup, noted that the work of this group is very different from the efforts of the Clinical Quality and Clinical Operations Workgroups. However, security in particular is absolutely essential to people actually using a system in a meaningful way, as those other two workgroups are laying out. In the two conference calls of the Privacy and Security Workgroup that have been held to date, the Workgroup has developed the following workflow steps to guide their efforts:

- Review and comment on the privacy and security policy priority in the meaningful use matrix, focusing on goals, 2011 objectives, and 2011 measures. Present recommendations to the HIT Standards Committee for conveyance to the HIT Policy Committee.
- Map the 2011 measures into specific features and functions within the following three categories: (1) the products that can be purchased (certified by the Certification Commission for Health Information Technology outside of the real-life setting); (2) the IT infrastructure necessary to enable the product to be meaningfully used; and (3) the operational environment in which the product will be used meaningfully.
- Map the features and functions to standards and certification criteria.
- Recommend standards and certification criteria to ONC.

The Privacy and Security Workgroup made specific suggestions regarding changing the language of some of the goals, objectives, and measures found in the Privacy and Security Policy Matrix.

Action Item #1: The Committee accepted the modifications of the Privacy and Security Workgroup to the Meaningful Use matrix language, with further technical amendments to be made as necessary by ONC.

4. Approval of Minutes From the Last Meeting

The HIT Standards Committee approved the minutes from its May 15, 2009 meeting.

5. Identification of Major Standards Gaps

John Halamka led a discussion to begin to identify gaps and grade deployability. He asked if the group was in agreement about the taxonomy proposed earlier by Jamie Ferguson.

The discussion included the following points:

- It was noted that the Healthcare Information Technology Standards Panel (HITSP) has been looking at transactions between organizations, not within organizations. Laboratory ordering was identified as a specific gap.
- John Halamka noted that developing an electronic measure of non-electronic performance represents a specific challenge.
- One Committee member acknowledged that reporting will be a problem in 2011, but despite these issues, it would still be helpful to get organizations to start capturing data and self reporting. The fact that their information is being looked at will cause a material step forward.

- Mark Overhage reminded the group that HITSP does not write standards. He indicated that HITSP recommendations may not be deployable. It is challenging in that in many ways it is easier to think about the focus being on the data, and the patient that the data represents. He also noted the elasticity in the current system and pointed to the tremendous forces pulling it back to the way it is today. He commented that just because it is possible for something to work does not mean that it will, and suggested setting the bar a little lower to make sure goals are actually achieved.
- Kevin Hutchinson commented on the major standards gaps with regard to e-prescribing. Some manner of implementation guide is needed so that there is not a huge gap between standards and their implementation.
- James Walker observed that the beginning of any implementation is difficult. At the onset, if there are only very simple things to learn, it starts slow. Once users start to sense the benefits they can achieve, then fairly rapidly they are willing to take on more. A pressure grows to increase what is available and change the process. He suggested that Committee members consider that if users get “hooked” with an early positive experience, the process will move much faster as these users drive it.
- Jamie Ferguson noted that the taxonomy that has been proposed does not distinguish between what is deployed and what is deployable. He suggested that a Category 0 could be added for the already-deployed measures.
- Janet Corrigan commented that structural measures and personal attestation are visible gaps. Also, the pace at which the selected measures can actually be retooled using the HITEP data types concerns her.
- Dixie Baker noted that Health Insurance Portability and Accountability Act (HIPAA) standards already exist and are being used for security. Consent management, however, is just starting to get some standards.

Action Item #2: Committee members agreed to the proposal to add a column in the matrix that would label items using the taxonomy created by the Clinical Operations Workgroup to identify standards maturity and industry readiness.

6. Develop a Workplan for Generating Deliverables

Jonathan Perlin noted that the workgroups are going to have to triangulate with one another in order to get through all of the standards that have been identified. The discussion focused on generating a workplan and included the following points:

- Janet Corrigan suggested that in the next week, the Clinical Quality Workgroup could review the available measures regarding specialty care, and also consider whether there is a common classification and definition of the units of analysis, as that relates to the definition of a small versus a large practice setting.

- Dixie Baker indicated that the Privacy and Security Workgroup will be examining how to interpret the requirement of complying with HIPAA, along with the freedom to constrain the applicability to Meaningful Use.

Action Item #3: The Clinical Operations and Clinical Quality Workgroups agreed to meet jointly to address the many overlapping issues of these two groups with regard to the Meaningful Use Matrix.

Action Item #4: The three HIT Standards Committee workgroups affirmed that they will completely populate the Meaningful Use Matrix and have it ready for review by the full Committee's next meeting on July 21.

7. Public Comment

- Richard Eaton from the Medical Imaging and Technology Alliance offered the assistance and input of his organization. He said he is confused about the fact that those from the Clinical Operations Workgroup push radiology reports into the foreground in terms of when they will be implemented. However, there is a disconnect between that and the first draft recommendations of the HIT Policy Committee, in which radiology is pushed back to 2015. He explained that the Digital Imaging and Communications in Medicine (DICOM) standard is already deployed, so it does not appear logical to push this off to 2015.
- Dan Rode with the Health Information Management Association asked the group to keep in mind that the industry already has coming up an implementation of HIPAA standards upgrade and ICD-10 standards. It would be extremely beneficial if those could be integrated into the Committee's work.
- Consultant Gary Dickinson noted that with regard to standards gaps, the biggest gap he perceives is the issue of EHRs. Standards that are coming forth are focused on point-to-point interface with transient documents or messages. However, the discussion of EHRs must include a focus on end-to-end systems. In order for people to trust what they are using, there needs to be an end-to-end system integrity.
- A primary care physician from Florida asked if the Committee had studied European HIT systems, since many of these issues have been faced and addressed there.

SUMMARY OF DECISIONS AND ACTION ITEMS

- **Action Item #1:** The Committee accepted the modifications of the Privacy and Security Workgroup to the Meaningful Use matrix language, with further technical amendments to be made as necessary by ONC.

- **Action Item #2:** Committee members agreed to the proposal to add a column in the matrix that would label items using the taxonomy created by the Clinical Operations Workgroup to identify standards maturity and industry readiness.
- **Action Item #3:** The Clinical Operations and Clinical Quality Workgroups agreed to meet jointly to address the many overlapping issues of these two groups with regard to the Meaningful Use Matrix.
- **Action Item #4:** The three HIT Standards Committee workgroups affirmed that they will completely populate the Meaningful Use Matrix and have it ready for review by the full Committee's next meeting on July 21.
- The HIT Standards Committee approved the minutes from its May 15, 2009 meeting.