

Health Information Technology (HIT) Policy Committee Summary of the June 16, 2009 Meeting

Participants:

David Blumenthal, Chair	HHS/Office of the National Coordinator for Health Information Technology
Paul Tang, Co-Chair	Palo Alto Medical Foundation
Roger Baker	Department of Veterans Affairs
Christine Bechtel	National Partnership for Women & Families
Neil Calman	The Institute for Family Health
Adam Clark	Lance Armstrong Foundation
Jodi Daniel	Office of the National Chairman
Arthur Davidson	Denver Public Health Department
Connie White Delaney	University of Minnesota/School of Nursing
Paul Egerman	Businessman/Entrepreneur
Judith Faulkner	Epic Systems Corporation
Gayle Harrell	Former Florida State Legislator
Charles Kennedy	WellPoint, Inc.
David Lansky	Pacific Business Group on Health
Deven McGraw	Center for Democracy & Technology
Frank Nemec	Gastroenterology Associates, Inc.
Marc Probst	Intermountain Healthcare
Scott White	1199 SEIU Training and Employment Fund

KEY TOPICS

1. Opening

Judy Sparrow, Office of the National Coordinator, welcomed members to the second meeting of the group and noted that a transcript would be available within 10 days.

David Blumenthal welcomed Committee members and thanked them for their dedication and commitment. He introduced Paul Tang as the Co-Chair of HIT Policy Committee. He noted that the work that will be done here today has been prepared by several workgroups that have contributed a great deal of time in intensive meetings on short time frames. Everything that is being discussed here is a work in progress, and the working groups' progress will move forward based on feedback generated during this meeting.

Jodi Daniel then described how HIT Policy Committee's work and how the workgroup reports presented today will fit into the context of the HITECH. She reminded the group that the Policy Committee has established three different workgroups. The presentations today are simply presentations of the workgroups, not recommendations from the Federal Advisory Committee itself. This full Committee will make recommendations to the Office of the National Coordinator (ONC). It will be up to the HIT Policy Committee to recommend the workgroup findings to the National Coordinator. David Blumenthal is both Chair of this Committee and Chair of the ONC, so Paul Tang as the Co-Chair of this Committee will be the one to make the formal recommendations.

The comment period on these recommendations will start today.

All of this will serve as input into the Department of Health and Human Services (HHS). The statute requires that interim final rules be formulated regarding standards and certification criteria by the end of this year. Also, the ONC is working closely with Centers for Medicare and Medicaid Services (CMS) on the Meaningful Use definition, and they will be working on a regulatory process for their incentive programs, including measures for Meaningful Use.

David Blumenthal noted that this is the beginning of a historic discussion, in that it is the first time we will be discussing HIT in the context of aspirations for a higher-functioning health care system. He noted that the government deadlines for policymaking are very tight, and he cautioned the group against allowing those time pressures to short-circuit discussion on difficult questions.

2. Meaningful Use Workgroup Update

John Glaser from ONC, and Meaningful Use Workgroup Co-Chairs Paul Tang and Farzad Mostashari presented the Workgroup's broad and specific charges, and then walked through an explanation of the group's process, and then their draft recommendations as to their vision for Meaningful Use.

An extensive discussion followed, and highlights included the following:

- Connie Delaney referred to slide 11, asking whether they might consider, in addition to advanced care processes, also early care processes? In this way, she said, one would be forced to attend to the preventive nature of health conditions such as the one used in the example. Paul Tang said that the goal is absolutely prevention, and to address the clinical issues as soon as possible. This will require practices to change what they do. For example, currently, few practitioners engage in sending reminders to patients with high blood pressure who haven't been seen, and few monitor medical adherence. These are the care processes and workflows that would encourage such practices. Those are the advanced fixes to the processes, rather than to the care, in this case.
- David Blumenthal noted the inclusion of slide 9, which is called Achievable Vision for 2015, saying that it is rare to stop and ask what could be achieved if we set out minds to it. This is an opportunity to have that discussion here, he said, and to use it as facilitation for what surely will very rapidly become a very detailed discussion of specific strategies and measures. First, he urged the group to stretch themselves about where they want to go and what is achievable.
- Charles Kennedy asked if perhaps it is a worthy stretch to more specifically call out the need for efficiency. He wondered if by 2015 there will be an end-to-end improvement in any disease state. He suggested looking at a specific chronic disease state, and considering the transformation of management in that particular area.
- The suggestion was made to focus more on children, so that in future years the country will be set up for greater health.

- Another Committee member thought it was wise to reframe the language so that, rather than seeing heart disease no longer be the leading cause of death, therefore switching one leading cause of death for another; they are instead looking at a reduction in incidents of death in particular diseases.
- Several Committee members underlined the importance of privacy as being key to adoption, being foundational to the overall vision.
- Christine Bechtel suggested that access by patients and families to their own health care information is critical to better care, but that we can improve that for the 2015 vision. She also suggested part of the vision should be measurable improvements in patients' experience of care. She further said that it is important to talk to patients about their health care experience.
- Regarding chronic diseases, Marc Probst suggested that rather than setting national goals, it could be more effective to look at them more regionally. Different regions might do better to focus on things differently.
- David Blumenthal noted that what he hears so far is that in both chronic disease and quality of care, the Committee should be thinking more broadly.
- David Blumenthal also noted that there already exist established organizations that track and measure many of the things they are interested in here. To the extent that they want to hitch a ride to other established bodies, he said, the Committee will have to be clear on what things they want to make progress on by 2015, and then draw a line back from each of those to 2011 to make sure it is possible to measure that progress. This points to the importance of early data capture, and to making sure that any measures that are part of HIT work be consistent with those being used by other groups developing measures and policies.
- Charles Kennedy noted that the vision statements are all clinically related, but there is not one technical vision statement. He expressed concern that with the current approach, there will never be a single representation of the patient, depending on who is housing the record. Multiple representations of the truth create significant problems when the data is being used for informatics and analytics, he said.
- One concern raised was whether the current incentive payment methodology will allow for the phased approach that is being advanced here. Will the funding be sufficient in 2013 and 2015? The speaker wondered, if a practice installs a system right away, will it still be certified in 2013 and 2015? Certainly they will have to achieve a different level of Meaningful Use. So is there going to be sufficient incentive in later years?
- There needs to be a roadmap for the various specialty groups in health care, not just for the internist or the medical home.
- Gayle Harrell noted that it will be extremely difficult for providers to meet the timeframes for CPOE, and selecting certified products within implementation timeframes. She questioned if we are making it too difficult for providers to qualify for

incentives and therefore not participate as a result. In addition, the measures are geared toward primary care, and no measures seem to be identified for specialty areas.

- Neil Calman noted that they are actually creating another incentive for people to adopt early. Not only are they saying that early adopters get more money early, but they are also saying, it gets harder to meet the requirements in later years. So first the adoption is captured—and it needs to be captured for a while before there will be any useful information about quality. Then, a set of quality activities is overlaid. Therefore, it will be necessary to look at first year adopters, second year adopters, third year adopters, and so on. In effect there will be two timelines: what will the delivery system be able to do? And, when someone flips the switch, what will be possible in the first year, the second year, and the third year?
- Jodi Daniel clarified that two things have to happen: (1) a practice must adopt a certified system, and (2) they have to be meaningful users. So, the technology might continue to advance but the provider may not have to demonstrate Meaningful Use right away.
- It was noted that inpatient care is very reliant on nursing, and there is surprisingly little about nursing in the 2011 goals. Some 2013 goals could be moved to 2011 to address this. The speaker worried some of the reporting will require a great deal of physician/organization time.
- Art Davidson said he thought the Committee was going to try following David Lansky's idea to take the vision and work backward. He questioned whether it would be possible to change things in 2013 and 2011 unless they have tagged to goals that are being aimed for in 2015.
- Christine Bechtel suggested that in 2013, it should be possible to add information to the record that has been generated by the patient, and also to begin collecting information about the patient's experience of care.
- It was suggested that automating the nursing process in its entirety should be moved to 2011; it is almost all there already, and would be a good enabler. Eliminating manual processes means an improvement in productivity.

Action Item #1: The Committee tabled the recommendations of the Meaningful Use Workgroup, and asked them to bring back a revised set of recommendations to the next HIT Policy Committee meeting, to reflect the comments made at this meeting.

2. Acceptance of Minutes

The committee accepted the minutes from the last HIT Policy Committee meeting.

3. Certification/Adoption Workgroup Update

John Glaser, Paul Egerman, and Marc Probst presented a series of slides outlining the Certification/Adoption Workgroup charges, and showing the questions that the workgroup is asking of various groups relating to certification.

The group's next steps are to hold a meeting July 14-15 to hear testimony relating to the various organizations that would be applicable to do certifications. The Certification/Adoption Workgroup's next meeting will be on July 16.

Committee discussion followed, including these highlights:

- Gayle Harrell proposed adding more questions to the workgroup's list. She asked, what will happen if there are not certified products out there for specific groups looking for an EHR? For example, she said, there are no certified systems out there that meet the needs of an ob/gyn practice, or a pediatrics practice.
- The question was raised, what is the process for certifying the certifier? Who will authorize certifying bodies?
- Marc Probst acknowledged that the certification process might cause a bottleneck to entry by new players. He asked for feedback about whether there is more that could be done to address this.

4. Information Exchange Workgroup Update

Kelly Cronin, Deven McGraw, and Micky Tripathy presented an update on the work of the Information Exchange Workgroup.

The dichotomy with health information exchange (HIE) is to make sure that there is interconnectivity with flexibility maintained, so that states and local regions can connect at some point. So with respect to Meaningful Use—and this is where it connects with HIE—will there be the need for direct connectivity to achieve Meaningful Use? The Information Exchange Workgroup needs some direction from the Meaningful Use Workgroup as to how that timetable needs to be set up, and how to make it incremental to achieve Meaningful Use. By 2011, there will not be the infrastructure in place for complete interoperability.

One person wondered if there are people in the HIE Workgroup that have different visions than the traditional regional model tying into a national exchange. He said he is among those who have less confidence that a regional vision such as that is the model that will actually rule the day.

Deven McGraw indicated that she does not think the Workgroup is tilted toward one model. She noted that there is an evolution for the governance model. So, discussions have focused on what forms of governance will mature over time, and what privacy/security policies will enable not only exchange of summary records, but connectivity that works across regions and across time. David Lansky asked for a high-level overview of the entire HIE landscape. What is meant by exchange: point-to-point sharing of documents, or sharing of data? Also, he noted that the Meaningful Use Workgroup's efforts on connectivity are skeletal. It would be helpful for the two workgroups to get together on this. Also, he suggested that it would be helpful to create a

part of the vision statement around a technical layer. He said there is no statement of what the technical picture is going to look like.

Action Item #2: The Health Information Exchange Workgroup will offer input to the Meaningful Use Workgroup as the Meaningful Use group revises its recommendations.

5. Public Comment

- Ruth Perot spoke from the National HIT Collaborative for the Underserved, which is a public/private partnership that was established in 2008 with the goal of leveraging access to advances in HIT and eliminating disparities in communities of color and underserved populations. The 50 members recommend that it is essential that the Meaningful Use definition state that certified Electronic Health Records (EHRs) should be patient-focused, and that the definition should underscore the need for HIT to help reduce or eliminate disparities in treatments and outcomes, and delivery of culturally appropriate and higher quality services. The ONC should have a clear vision and goal of the public's health in order to monitor and track care. There is a need for definitional language that is easily understandable by all stakeholders, highlighting value propositions for stakeholders. She said that the definition of Meaningful Use should be integrated into health care reform. She is concerned that there be a phased, incremental implementation to inform providers about incentives and penalties. She believes that safety net providers, including Medicaid providers, should get additional compensation for adoption, given the fact that Medicaid providers get even more limited funds than others for the services they provide. She also noted that she has a document outlining the National HIT Collaborative's concerns that she will share with the Committee.
- John Hodden, who identified himself as a physician, engineer, son, and parent, explained that ICD-10 may fundamentally change the architecture of electronic health care systems. So, will potential buyers go through a thought process that would include questions like, if I'm buying something, am I buying it once and it will evolve over time? He also commented that certified records, if they are shown to improve care, could be tied to Meaningful Use because of that fact.
- Anthony Guerra from Health Care Informatics noted that workgroups are making their best efforts to move forward while making their best guess at meaningful use. He asked if was possible to change the process so that the definition of Meaningful Use can be finalized before the workgroups begin. David Blumenthal explained that they do not have the luxury of waiting for Meaningful Use to be defined, given the statutory time constraints.
- Anthony Guerra also cautioned against comparing hospitals and health care providers with systems like Kaiser, because Kaiser's system is so unique. David Blumenthal acknowledged that the challenges of the individual practitioner do need to be kept in mind, but that Kaiser is a good example of what is possible, technologically speaking, in health care delivery.
- Charles Carson from GE Healthcare, and a Healthcare Information Technology Standards Panel board member, asked if there could be a link between the HIT Standards

Committee and the HIE workgroup. Jodi Daniel noted that the ONC supports both workgroups, and is bringing information from one committee to the other.

- Claudia Williams from The Markle Foundation asked about the deadline for public comment on the Meaningful Use definitions presented today. When does the clock start ticking? Jodi Daniel said that the comment period will be open for 10 days. The Meaningful Use Workgroup will present their revisions at the July meeting, and whatever recommendations are generated will be made to the HIT Policy Committee then. At the end of the year, there will be another comment period.
- A member of the public suggested that there should be an incentive to include coded nursing terminology in the systems, to get at the Meaningful Use information being discussed here.
- Brad Roarke from the Williams Group, an EHR vendor for eye doctors, made a suggestion with regard to the certification process. He said there are probably thousands of vendors, which is going to create a challenge/potential bottleneck for the certification process. He suggested an alternative process similar to the way in which the public files its 1040 forms. Providers could submit an attestation form that would outline two things: (1) that the EHR meets the certification standards, and (2) that the EHR meets the definition of Meaningful Use. He said that if each and every vendor requires certification, there certainly will be a time crunch for the 2011 certification, at least with the EHR vendors. He said such a burden could effectively prohibit all but those vendors who got to the front of the line.
- Frank Kyle from The American Dental Association pledged the assistance of the ADA to this process.
- Rick Blake from Strategic Health Resources urged the certification working group to avail itself of minority- and women-owned businesses in the certification discussion.
- Amy Verstappen with The Adult Congenital Heart Association said that if the goal is to find markers that are not disease-specific but span disease states, then addressing health care transition issues between the pediatric and adult cohort would provide an opportunity to both engage pediatrics specifically and also give a potential for a very measurable outcome. She also asked how disease advocacy groups might partner with this Committee to offer it assistance.
- Josh Seidman from The Center for Information Therapy supported Christine Bechtel's comments regarding timely messaging, patient-generated data, and the use of consumer information tools. He urged the Meaningful Use Workgroup to think about care coordination. Engaging patient families leads to better quality of care, he said. So as the group is thinking about some of the specific measures, and how those things are shared with the full care team, he urged including the patients and families.

SUMMARY OF DECISIONS AND ACTION ITEMS:

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to the next HIT Policy Committee meeting, to reflect the comments made at this meeting and public comments received.

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