

Health Information Technology Policy Committee Final Summary Of the January 10, 2012 Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 31st meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting, with an opportunity for public comments, and that a summary and transcript of the meeting would be available on the ONC Website. She called the roll, and turned the meeting over to Committee Chairperson Farzad Mostashari.

2. Opening Remarks

National Coordinator for Health Information Technology and Committee Chairperson Farzad Mostashari remarked that in 2012 meaningful use will soar. Interoperability and exchange will continue to be challenging. The cost and risk of exchange and interoperability are being reduced through standards and services. When the value increases, information will begin to flow at the speed of trust. Consumer health IT is on the agenda for 2012. A healthy apps challenge is being developed in cooperation with the Surgeon General. Much remains to be done in terms of quality measurement. The progress in 2011 was astonishing. He went on to talk about a principled approach. However, an efficient market is the best tool for innovation and creativity and productivity. The interests of the patients are central to all efforts. A public use file is available on healthdata.gov.

3. Review of the Agenda

HITPC Vice Chairperson Paul Tang reviewed the agenda items. He asked for a motion and second to approve the minutes of the December 7, 2011 meeting, which had been distributed in advance of the meeting. The motion to approve without additions or corrections was made and seconded. Members approved the minutes by a voice vote with no objections or abstentions heard.

Action Item #1: The Committee approved by voice vote the minutes from the December 7, 2011 HITPC meeting.

4. Update on CMS' Meaningful Use Activities

Rob Anthony, CMS, introduced the presentation by saying that December was an exceptional month in terms of registration, attestation and payment. Medicaid providers have 90 days after the close of the calendar year; it is expected that the upward trend will continue. ONC and CMS are working with the market on education, training and technical assistance. Robert Tagalicod and Jessica Kahn, CMS, showed slides on trends in attestation and payments, along with the December numbers. Regarding attestation, the meaningful use data pertains to Medicare physicians and acute care and critical access hospitals. It is not a representative sample of EPs, or of eligible hospitals. In terms of early adopters, on average all thresholds were greatly exceeded, but every threshold had some providers on the borderline. There was little difference between EPs and EHs. Little difference was found among specialties' performances, although exclusions varied. 33,595 Medicare EPs had attested by the end of December, 33,240 successfully. 842 acute care and critical access hospitals

had attested, all successfully. 43 states have launched their Medicaid payments. Several large states are ramping up.

They showed slides on the performance (average score), exclusions and deferrals of each of the objectives for EPs, followed by results for EHS. In terms of specialty performance, gastroenterology had the lowest rate for patient electronic access by almost 10%. For providing patient education resources, optometry was nearly 10% higher than others and podiatry was nearly 20% lower. All other measures were consistent across specialties. Family practice, internal medicine, and optometry were highest for CPOE. Optometry and podiatry had the lowest rates of recording vitals. They reminded the group that these results were preliminary and that official data should be sourced and cited from the CMS website, which is updated monthly

http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp).

Discussion

Marc Probst asked about recommendations for the HITPC. Staff said that it is too early for recommendations. CMS staff is investigating barriers and will present the results to the HITPC when data have been analyzed. Currently, high scores are being achieved from the vanguard. A public use file on attestation will be available.

A member asked about factors that contribute to variation across specialties. Staff reminded the member that the N remains small. Staff does not want to draw conclusion based on data from early adopters. There is some qualitative data on obstacles, of which information gap is one.

Larry Wolf observed that the values for information exchange are low and wondered why. Staff replied that the values are actually high. Exchange is more difficult than other objectives. At this time there is not a sufficient mass of providers with which to exchange. Staff expects to see higher performance by Medicaid EPs due to past support from HRSA and medical homes initiatives. Stage 1 does not ask if the test of exchange passed or failed (that is, the information was actually received successfully) although this will be a measure for Medicaid.

David Lansky acknowledged that the release of a public use file is great and wondered why it was de-identified. Staff replied that Medicaid payees are posted by name although amount and scores are not included. Staff encouraged providers to post their own data.

Devin McGraw talked about the infrastructure for exchange. She asked for regular reports on HIE and the Direct project. Mostashari responded that these data are not collected on a regular basis. He offered to provide programmatic updates and said that perhaps comments should be obtained on reporting requirements in the governance Notice of Proposed Rule Making (NPRM). Another member suggested that CDC and CMS should also share programmatic updates.

Judith Faulkner reported that when a vendor works with two or more providers, the barriers tend to be that the organizations do not have the latest releases from their vendors to support exchange. Then, following the necessary upgrades, lawyers and compliance officers must form agreements. All of this takes considerable time. She inquired about national rules for cooperation. Mostashari said that this will be addressed in the governance NPRM.

5. Preliminary Framework for HITPC 2012 Workplan

Jodi Daniel, ONC, presented many topics on which ONC staff may want to seek input from the HITPC. She organized the topics into the following categories: regulations, adoption and use of IT, strategy, continuing discussion, and emerging issues. Considering regulation, staff is working on meaningful use stage 2 NPRM, meaningful use stage 3, and an Advanced Notice of Proposed Rule Making (ANPRM) and NPRM on governance. She acknowledged that the Meaningful Use Workgroup has started to work on stage 3. Various other workgroups may have relevant input. ONC staff determined that additional input is needed on governance, which is the rationale for issuing an ANPRM, likely before the end of March.

Josh Seidman, ONC, pointed out that the HITSC must have more advance time than was allocated for stage 2. Also, ONC is planning to convene a public hearing on the incorporation of patient-generated and reported data. Moving to the category of adoption and use, Daniel delineated topics of accelerating attestation for meaningful use stage 1, quality improvement, engaging non-eligible providers, HIT workforce, and consumer e-Health. She said that ONC is interested in determining what differentiates providers that are implementing and those that are not. Also, staff wants to go beyond measurement of quality to real time improvement. The usefulness of the quality measures must be examined. Seidman talked about the interest in HIT enabled measures and HIT sensitive measures as well as the use of data for accountability by purchasers and providers themselves. Daniel referred to the need to engage non-eligible providers, some of which are essential for coordination. She specifically called out behavioral health, long term care, and the role of nurses, saying that she hoped the HITPC would advise on strategies.

According to Daniel, the workforce is another issue due to the expected end of funding for direct support of workforce development. Consumer e-Health was launched in September and is intended to offer easy access of information on patient-generated data. A pledge program was launched today—a challenge to produce a video on the use of HIT to manage New Year health-related resolutions. She also commented on the need to update and iterate transparently and interactively the strategic plan, which was released in September.

Another set of topics was categorized as continuing discussion. Staff is working on a security action plan to enhance HIT safety. The Certification and Adoption Workgroup has considered anti-fraud needs and concluded that at this point there is no need for recommendations. Staff will keep the workgroup informed of CMS' and Inspector General's (IG) efforts. A member of the workgroup indicated that the issue of what constitutes a legal EHR may require discussion; perhaps a gap analysis should be conducted. Liability, including the use of information in provider decision making, may be entertained by the Certification and Adoption Workgroup. Staff wishes to encourage greater collaboration on priorities by the HITPC and the HITSC. Daniel also mentioned emerging issues and new technologies. They included the end of the American Recovery and Reinvestment Act (ARRA) grant programs; genomics, mHealth, predictive analytics, data ubiquity, "gamification" and consumer-directed care; clinical decision support and consumer decision support; innovations and Strategic Health IT Advanced Research Projects (SHARP); and the learning health care system.

Discussion

Tang declared the need to prioritize the topics. Lansky said that from a purchaser's perspective, communication of the net value proposition must be considered. Other important topics include an architecture roadmap and data integration platforms across settings.

Charles Kennedy talked about a personal experience of receiving a discharge summary that he could not interpret. Therefore, he suggested focusing of the usability of metrics: Are the meaningful use requirements driving action? He also requested more consideration of the intersection of Accountable Care Organizations (ACOs) and HIT, saying that providers have reported that technology is not helping with organization of ACOs.

Wolf voiced support for the topic of non-eligible providers. The S & I Framework staff is working on standards for transitions of care. He indicated his approval of the use of social media to disseminate information.

Neil Calman talked about his interest in consumer e-Health and the integration of IT into workflow, a topic that may fall under usability. Regarding e-Health, he pointed out that since people get care in many different places, provider-based EHRs are not sufficient for capture and use of information. He suggested consideration of the consolidation of information across multiple sources.

Another member noted the importance of mobile applications, referring to the VA and DoD efforts on consumer management of PTSD symptoms.

Someone inquired about a target date for the publication of governance rules. Daniel repeated that the target was before the end of March. Responding to a question about the use of HIT and EHRs as anti-fraud tools for Medicaid and Medicare payments, Daniel said that ONC is working with the IG and CMS. To date, there is no evidence that EHRs are being used in fraudulent activity. Therefore, there is no area to target.

Connie Delaney indicated her support for workflow, non-eligible providers and information exchange as priorities. CTSA, governance work and full clinical data sets are related; she said that she would prefer less emphasis on the IT workforce insofar as many other entities are moving that agenda.

Paul Egerman asked who is included in the HIT workforce. Daniel responded that she was referring to technical staff. ONC has worked with community colleges, certification programs, and on curricula development. Mostashari said that ONC had to consider the role of government in the accelerated demand for HIT workers. He suggested that professionalism pathways may be another avenue; perhaps meaningful use should be incorporated into the training and certification of physicians and nurses. If any member is interested in working on this avenue, she or he can contact Daniel. Someone wondered what will happen with HIEs when their grants expire. Daniel agreed to collect and present information to answer the question.

Probst mentioned starting to formalize and examine outcomes and consequences. Art Davidson asked that public health officials and agencies be added to the list of non-eligibles.

Christine Bechtel suggested that topics be prioritized in accordance with a review of ONC goals and consideration of ways in which HITPC can provide support. Tang asked workgroup chairpersons to submit their priority areas to Tang and Daniels no later than January 16.

6. Update from HITSC on 2012 Workplan

John Halamka referred to the meeting materials and very clearly listed activities by quarter. In the first quarter, HITSC will:

- Review stage 2 NPRM comments
- Consider quality measurement standards

Measures are dynamic, not a fixed set. There is a need to develop capability to define them ad hoc.

- Refine NwHIN Exchange

HITSC has examined strengths and weakness of the NwHIN software, is requesting information from users, and will attempt to simplify.

- Examine value sets and vocabulary mapping in the context of content, vocabulary and transport NLM work to support stage 2 is critical as is one common source.

In the second quarter, the HITSC will discuss NwHIN supporting components including provider directories for which pilots and guides are needed, Query Health, image standards and how to reduce redundancy of standards making (governance). Third quarter plans consist of work on detailed clinical or reference models, consumer-mediated health information exchange to enable patients to route their data, one-stop shop for resources such as vocabulary and sample data tools, and Green CDA. He explained that the CCR and CCD require technical language and referred to the need to develop something simple.

Halamka said that he expected to focus in the fourth quarter on maintenance strategy for post grant funding, public health standards for new approaches, and standards for EHR portability across products.

Discussion

Lansky asked about an interstate provider directory. Halamka said that there are several alternatives. In a recent meeting, vendors asked that someone invent a directory that they can use. The S & I Framework staff is working on an approach that may be ready by the end of 2012. Nothing is available off the shelf. Responding to a question about simple query language for quality measures, Halamka said that the HITSC will break the required tasks down into components for a workplan for query response. Completion of all of the work will extend beyond 2012.

Bechtel referred Halamka to a map partnership and work on data models. She opined that consumer mediated-information exchange may place too much work on patients. Halamka explained that there are numerous mechanisms for sending information to PHRs. Providers can send data to a Microsoft PHR and the patient can then send the data on to the next provider. There are existing standards that leverage Direct in which the patient simply facilitates the exchange. Many EHRs generate information for continuity of care, which is a good starting point for view and download.

Wolf approved of the emphasis on getting the data right. He said that many potential users do not understand the complexity of the CCD and its use. Guidance is needed on how the CDA and others

are evolving and the differences among consolidated CDA, CDA plus, complex CDA, and others versions. Halamka rapidly replied that the CCD was invented first and after several steps (which this writer failed to capture) will soon be revised and consolidated into Green CDA.

Faulkner commented on consumer health exchange adjunct to EHRs. Not all patients can afford the technology that was referenced. Additionally, what about access to information in the emergency department? Revenue to support keepers of the information must be identified. The sale of data and pay for data should be avoided. Halamka clarified that although provider to provider exchange is important, many patients will want to be stewards of their information.

7. Update from Meaningful Use Workgroup on Quality Measures

Tang used slides to report. He reminded the members that he had reported on the October 5 public hearing at the November 9 HITPC meeting. On November 30, HHS announced its intent to delay stage 2 to 2014. Therefore, if one were to assume stage 3 begins 2 years after stage 2, meaningful use recommendations would be needed by mid-2013. The HITSC will need sufficient time to work on standards that may be required. Tang identified the fourth quarter 2012 for HITSC-sensitive meaningful use recommendations and the second quarter 2013 for policy-only recommendations. With these targets in mind, the Meaningful Use Workgroup drafted recommendations to the HITSC related to quality measure development. And a joint workshop with HITSC, ONC, and CMS on quality measures is being planned.

Tang announced the draft recommendations for HITSC, saying that the first recommendation—certification for clinical quality measures (CQM) reports—had implications for stage 2 and, therefore, is an immediate recommendation. He talked about the problem. Many health care organizations use reporting systems rather than the EHRs to generate quality reports for public reporting and quality improvement. But the certification rules state that the health care organizations must use the certified EHR to report the CQM measures to CMS. As a result, EHR vendors hardwire CQM calculations without knowing local clinical workflows, thereby causing workflow work arounds. Furthermore, not all CQMs are relevant to all certified HIT systems. He presented the solution proposed by the workgroup. HIT vendor products should be certified for all CQMs relevant to the scope of the product. Providers should be permitted to use non-certified systems to generate CQM reports as long as all the data used in the calculation of the measure are derived from certified HIT systems. He reminded the members that all submitted CQMs are subject to audit and said that CQM reporting systems should be tested (subject to audit) based on a standardized test data set.

The second and third recommendations have a longer lead time. Recommendation #2 dealt with a CQM platform. Tang described the problem. CQMs are being “hard wired” into EHRs, which require upgrades in order to implement or revise. EHR vendors are pre-defining data elements used in calculating CQMs and clinical workflows are affected. Health care organizations do not have an easy way to report on quality improvement measures in addition to CQMs. He proposed a solution: By stage 3, EHR vendors should develop a “CQM platform” onto which new and evolving CQMs can be added to EHRs without requiring upgrades to the EHR systems. Longer term, such platforms should be capable of incorporating CQM “plug-ins” that can be shared, and that allow organizations to localize data fields that fit local workflow. The workgroup recommended that HITSC develop certification criteria to encourage or require this CQM platform as part of meaningful use.

The third recommendation focused on patient-reported data and CQMs. The problem is that most CQMs are written for clinicians and pertain to diseases. They do not incorporate information meaningful for consumers. As a solution, some CQMs should incorporate patient-reported data and outcomes. HIT vendors should develop secure, patient-friendly systems that allow direct entry of patient-reported data that can be incorporated into CQM reports. Patients should be able to access CQM reports.

The fourth recommendation—on delta measures—is an immediate one. Most CQMs report risk-adjusted population means. However, patients seek measures that would apply to them. The workgroup proposed that some CQMs should report on percent of patients improving (delta measures) in addition to or instead of reporting risk-adjusted population means. The EHR vendors should be able to calculate delta measures.

Tang concluded by delineating several follow-up actions including forming a joint HITPC-HITSC workgroup on which CMS, ONC, and CQM stakeholders are represented and conducting a hearing on longer term CQM actions. He summarized:

- Clinical quality measures should be based on clinical data from certified EHRs, and reported using standard definitions, subject to audit. CQMs can be reported to CMS from non-certified systems as long as the above is true.
- Vendor-neutral CQM platforms that accept “CQM plug-ins” should be developed to support evolving quality measurement
- New CQMs that are meaningful to patients should be developed, and patient-reported data should be captured and reported using HIT.

Next, George Hripcsak reported on the work in progress of the Meaningful Use Workgroup Specialist Subgroup. He noted that the topic of images is particularly relevant to HITSC. It is necessary to continue working on standards to promote the sharing of images and to promote the ability to view images from a common viewer. He said that the Meaningful Use Workgroup members want to collaborate with the HITSC to determine a next concrete step for imaging beyond common standards, which will affect progress in stage 3. Collaboration should extend beyond standards. He referred to convening a joint hearing.

Discussion

Lansky observed that more thinking was needed on recommendation #1. He commented on the murky line between noncertified systems to generate reports and certified systems that produce the data. He went on to describe concerns with the third recommendation, saying that it deals with policy and architecture problems, not standards. EHRs are not an appropriate platform for capturing patient-reported data. Tang explained that the reference to noncertified systems was only for the system reporting on the quality measures, not the EHRs, and Hripcsak said that the intent is to accommodate users who are ahead of the curve and had developed reporting systems external to the EHR. Lansky indicated that he did not understand what HITSC would be asked to do.

Doug Fridsma, ONC, reported that ONC is working with MITRE on the use of its popHealth tool with a test data set. The challenge is the lack of an unambiguous way of representing the quality measure. Similar issues are being encountered with Query Health. CMS is thinking about HQMF as a standard for quality measures.

Referring to the second point under recommendation #1, Kennedy inquired why such a level of specificity was needed for the use of a noncertified system. He also asked about a CQM platform. Tang said that the platform would be embedded in EHRs. Plugs-ins can perform calculations.

Bechtel observed that the recommendations were difficult to understand. Longitudinal and multi-setting measures and the calculation of measures that do not live in EHRs are needed. She voiced concern with saying “as long as all the data ...”. Tang pointed out that all the data used in reporting needs to be available to clinicians making patient-care decisions, but not necessarily stored in the EHR. Bechtel agreed to having all the data available through the EHR. Reporting mechanisms do not have to be certified.

In response to another question about the need for a “CQM platform,” Tang recalled that during a public hearing, a provider reported that 75% of total meaningful use expenses were due to the tethering of quality measure reporting to the EHR. Therefore, reducing the cost is important to implementation.

Faulkner was concerned about vendors interpreting requirements differently with some interpretations requiring less effort. The calculation should be visible.

Neil Calman described his version of the ideal world for a provider. The vendor creates a reliable and flexible reporting system and generates example reports. Then meaningful use indicates which reports to use. In addition, there would be a test to run against flexible systems. Although the recommendation will lead to a flexible system, the integrity of the reporting systems should be the priority.

Fridsma pointed out that Halamka had reported on the interest in a query language. Query Health is being developed. Queries will be used in quality measurement. Someone asked about a need for an intermediary system that can look across multiple measures and systems.

Egerman observed that the recommendations tend toward design, which is not within the purview of policy. He said it would be preferable to say that we need a flexible reporting system. Tang responded that that approach was used in stage 1 but the feedback is that something more is required. The recommendations address the challenges that users reported. Someone said that platform is too technical of a term. Hripcsak suggested that the goal was to have a system with flexible reporting. . Egerman said the problem is lack of flexibility. He recommended letting the HITSC figure it out.

Referring to recommendation #3, McGraw requested that this not be the final word on patient-reported data. Tang concurred. Probst declared that reporting solutions do not need to be part of the certification process. In terms of the second point on images and common viewer recommendation by the Specialist Subgroup, he stated his preference for “should” instead of “require”. Hripcsak reminded him that it was not a recommendation.

Bechtel announced her unease about all data coming through and residing in EHRs, which she said was a departure from previous policy. She wondered what difference it made as long as data are accessible. She went on to ask whether, if using a separate model, the data must live in the EHR.

Hripcsak explained that “derived from” is not equivalent to “stored in”. Tang offered to change the word to “through”. Then Bechtel objected to “all data”, which according to Tang is the current situation. McGraw suggested “available to”. Various examples were described. Tang attempted to revolve Bechtel’s objection by changing the language so as not to require storage of all data.

Wolf opined that flexible was the right approach, saying that building a detailed data model to accommodate numerous needs is the goal. He said that although he approved the intent of the recommendations, he opposed the wording.

Tang summarized the changes recommended by committee members. He agreed to revise recommendation #1 to avoid the impression that all data must be stored in the EHR. He agreed to delete platform and plug-in from the second recommendation and to refer to flexibility. He agreed to clarify #4 regarding McGraw’s point. He asked for a motion to accept the recommendations with the agreed-upon revisions. A motion was made and seconded, and, the discussion continued.

Faulkner voiced concern about the “doability” after speaking with her colleagues by phone. Hripcsak reminded the members that these are recommendations to HITSC and they deal with feasibility. McGraw suggested passing the recommendations on to HITSC and acknowledging the concern with feasibility. Tang concurred.

Lansky indicated that for him the concern went beyond feasibility because the recommendations lack a policy framework. He said that he intended to abstain from a vote. Tang proposed adding a preamble to the recommendations referring to conceptual approval and requesting the HITSC to address the readiness of and standards for implementing these policies.

Tang called for a hand vote on the motion to accept the recommendations revised as indicated. Tang announced the results of the vote—11 in favor and 4 opposed.

Action Item 2: The Committee approved by 11 to 4 the four recommendations on certification and quality measures presented by the Meaningful Use Workgroup and revised per discussion.

8. Update on Vocabularies and Value Sets for Meaningful Use

Doug Fridsma, ONC, showed slides and talked about the general mission of his office. He reminded members of the definition of NwHIN and said that vocabularies and code sets are key components of the interoperability stack and NwHIN building blocks. He elaborated on a use case that required a vocabulary as well as other building blocks for information exchange, saying that ONC is flushing out all of these building blocks so that they can be assembled in different ways to solve problems.

Then Betsy Humphreys showed slides that listed the NLM portfolio and the numerous ongoing and planned activities. NLM has an interagency agreement with ONC to support meaningful use, including additions to SNOMED CT, LOINC, and RxNorm; high priority subsets and mappings; tools for value set development and maintenance; and enhanced APIs. She went on to slides that described issues with and resources for the problem list such as migrating from Uncontrolled or Local Vocabulary +/-OR ICD-9-CM, adding value to free text notes, and implementing ICD-10-CM in 2013.

Humphreys also referred to the many NLM assets for medications and medication allergies targeting RxNorm. Regarding tests and measures, she noted that significant progress had been made in getting labs to report using LOINC. Recent expansions have been made in the coverage of patient assessment instruments, genetic tests, newborn screening, and public health surveillance. The latter is challenging because it requires action by providers, vendors, and public health agencies. CDC is working with NLM and Regenstrief on efforts such as updating LOINC to reflect currently recommended tests and a newborn screening guide. CDC and NLM are discussing how to avoid duplication of effort.

Q and A

Someone inquired about the proper site for curating and maintaining vocabularies. Humphreys acknowledged that one factor is the design of measures, which is in the purview of the profession. But there is also the issue of how to accurately reflect measures for measurement. The effort to develop a quality measure must be multi-disciplinary. Standards developers should be part of the team. A more consolidated approach is required.

Tang inquired about a website for information about and training related to ICD 10 conversion issues (e.g., ICD9-ICD10 mapping, SNOMED-ICD10-CM mapping, etc).. Humphreys said that there is one but it is not easily accessible. Staff is working on making information more useful and available. According to Fridsma, ONC is also working on links.

9. Public Comment

Shelly Spiro, representing a collaboration of national pharmacy groups, advocated for pharmacists to be recognized as important non-eligible providers. Pharmacists are integral members of health care teams. Her group recently published a road map on meaningful use as well as another report on utilization of pharmacists. Pharmacists are the largest provider of immunizations and are critical in care coordination. Visit www.pharmacyhit.org.

Allison Viola referred to the discussion on usability and workflow, which is expected to affect the use of data for improvement of patient safety. She asked that the evaluation of data as captured be considered as well.

Carol Bickford, American Nurses Association, referred to Daniel's presentation and urged the inclusion of non-physician providers.

SUMMARY OF ACTION ITEMS:

Action Item #1: The Committee approved by voice vote the minutes from the December 7, 2011 HITPC meeting.

Action Item 2: The Committee approved by 11 to 4 the four recommendations on certification and quality measures presented by the Meaningful Use Workgroup and revised per discussion.

Meeting Materials

Agenda

Summary of December 7, 2011 meeting

Tang's MU WG report presentation slides

EHR Incentive Program presentation slides

HITPC Workplan

HITSC Workplan

Update on Vocabularies and Value Sets for Meaningful Use presentation slides

John Halamka's blog excerpt