HIT Policy Committee
DRAFT
Summary of the December 5, 2012 Virtual Meeting

ATTENDANCE

The following members were present:

- Farzad Mostashari
- Paul Tang
- Arthur Davidson
- Charles Kennedy
- Christine Bechtel
- Christopher Boone
- Connie White Delaney
- David Bates
- David Lansky
- Deven McGraw
- Gayle Harrell
- Judith Faulkner
- Marc Probst
- Neil Calman
- Patrick Conway
- Paul Egerman
- Scott White
- Theresa Cullen for Madhulika Agarwal
- Thomas Greig

The following members were absent:

- Richard Chapman
- Frank Nemec
- Joshua Sharfstein
- Latanya Sweeney
- Robert Tagalicod

KEY TOPICS

Call to Order

MacKenzie Robertson, Office of the National Coordinator (ONC), welcomed participants to the 43rd Health Information Technology Policy Committee (HITPC) meeting. She reminded the group that this was a Federal Advisory Committee (FACA) meeting with an opportunity for public comment and that a transcript will be posted on the ONC website. She called the roll and reminded members to identify themselves for the transcript before speaking. She turned the meeting over to HITPC Chairperson and National Coordinator Farzad Mostashari.

Remarks

Mostashari related a recent personal experience with registering his parents at MyMedicare, a Blue Button service with three years of information on services received. He described pages and pages and codes that were difficult even for someone with medical training to understand. He obtained the Blue Button app, which was designed with ONC support, and the indecipherable text document was translated into a highly usable list of problems and diagnoses. When he discovered at the site that the parents were not registered for Medicare Part D, he signed them up. When his parent needed urgent eye care the next day, they were able to go online to make an appointment in Mostashari's city within 15 minutes. They showed the blue button data to the new physician and the parent's problem was resolved. This service is available to 38 million beneficiaries. Mostashari acknowledged that although he was well informed about MyMedicare, his own personal experience greatly enhanced his awareness of its value. He gave thanks. Christine Bechtel asked whether the Centers for Medicare and Medicaid Services (CMS) site provides a link to the app. Mostashari said that it did not, but he had sent emails requesting it be done. More outreach is needed to help beneficiaries make use of the information.

Review of Agenda

Paul Tang, Vice Chairperson, noted that they were trying a virtual meeting. He mentioned each of the items on the agenda, which had been distributed in advance of the meeting. There were no changes in the agenda. He referred to the summary of the November 2012 meeting, which was circulated with the meeting materials, and asked for a motion and a second to approve the summary. He informed the members that he had sent minor edits and clarifications to Robertson. Devin McGraw moved to approve the summary. Several members seconded the motion, which was approved unanimously by voice vote.

> **Action item #1: The summary of the November 2012 HITPC meeting was approved as circulated.**

Update from CMS

Robert Anthony presented slides showing the most recent numbers on registrations and payments for the EHR incentive program. Active registrations through October are in line with previous months in the year. Registrations are expected to increase at the end of the calendar year. Reports are available on the CMS Web site. The report formats were changed to show an overview along with a Medicare summary and a Medicaid summary. The latter was changed to differentiate bet AIU and MU. In total, 165,000 unique providers have been paid to date. 64% of all eligible EHs have received a payment and 83% have registered. Approximately 26% of Medicare EPs are meaningful users of EHRs. Approximately 31% of Medicare and Medicaid EPs have made a financial commitment to an EHR. 58% of Medicare EPs receiving incentives are specialists, a stable proportion over past months. He reported that although on average all thresholds were greatly exceeded, every threshold had some providers on the borderline. Drug formulary, immunization registries and patient list were the most popular menu objectives for EPs. Advance directives, clinical lab test results, and drug formulary were most frequently selected by EHs. Transition of care summary and patient reminders were the least popular menu objectives for EPs; transition of care and reportable lab result were least frequently selected by EHs. The most recently available data indicated that 117,514 EPs had attested, 117,284 successfully. 214 of the unsuccessful attesters successfully resubmitted. 2,558 hospitals had successfully attested, more than half of all eligible hospitals. When complete data are available for 2012, CMS staff will analyze differences in reporting on and achieving objectives between 2011 and 2012.

Anthony also described challenges for EPs as reported (available http://dashboard.healthit.gov/data/) by regional education centers (REC) to ONC. RECs reported challenges experienced by providers. The 10 most challenging measures reported were, according to Anthony, also reflected in attestations and

deferrals reported to CMS. Most challenging were clinical summary, medication reconciliation, security review, patient reminders, summary care record, educational resources, immunization, smoking status, electronic exchange and CQMs. RECs work with providers to overcome challenges, which typically go beyond understanding meaningful use. In addition to provider engagement and administrative challenges, vendor issues were common and consisted of problems such as delay in implementation or upgrade of product and access to reports. Challenges vary by practice type, size and location of practice. For small 1-to-10 physician practices, meaningful use measures are the greatest challenge. Across all settings, the clinical summary constitutes the greatest challenge. CMS will use these finding to inform its outreach.

Q&A

Tang concluded that there was a remarkable uptake in meaningful use over the past two years.

Bechtel observed that they should examine the measures with high deferral rates and use the information to reconsider objectives and thresholds for Stage 3. For example, she noted that contrary to an earlier assumption, smoking status was apparently not topped out.

Neil Calman observed that in mission-driven organizations, meaningful use does not show up at the top of the list of challenges. Non-profit organizations tend to buy in to what is good for the public.

Anthony and Mostashari acknowledged that the data on challenges submitted by RECs were based on data submitted in their grantee reports. But more recently, a standardized data collection process for tracking challenges was put in place. Grantees submit information on the number of providers assisted so that data can be aggregated across centers.

Trusted Identity of Patients in Cyberspace Hearing Report Out

Deven McGraw, Chairperson, Privacy and Security Tiger Team, and Paul Egerman, Co-Chair, reported on the hearing convened November 29 in partnership with the HITSC Privacy and Security Workgroup. The focus was limited to view, download and transit from portals in Stage 2. Following the hearing, the team met to deliberate on the testimonies and associated blog comments. They drafted principles and preliminary thoughts and will submit recommendations at the January meeting of the HITPC. Principles consist of the following:

- Protections should be commensurate with risks
- Simplicity and ease of use
- Consistent with what patients are willing to do
- Flexibility in methods offered
- Accompanied by education that makes these processes transparent to the patient
- Build to scalable solutions (greater use of voluntary secure identity providers)
- Solutions need to evolve solutions over time as technology changes and leverage solutions in other sectors such as banking

The Tigers have identified "best practices": For view, download and transmit accounts, providers have an obligation to identity-proof and can choose among several methods. In-person ID-proofing provides the most protection. However, remote proofing is highly desired by some patient populations (veterans, rural, elderly) and is needed to enable more patients to use these accounts. In-person proofing is typically performed by the provider where the relationship/trust exists; provider employees should be trained on the basics of identity-proofing. Proofing may be performed by others, such as notaries public. Possibilities for remote proofing include re-use of existing credentials and third party, knowledge-based answers to questions. However, the latter is dependent on the quality of the data and the questions, as well as the cost involved. Public data on which to base questions are not available for minors. Patient education is critical to address privacy concerns. For knowledge based or demographic data ID-proofing solutions, the best

practice is to use some data fields not known to others, including family members. To further manage risks, proofing should be coupled with out-of-band confirmation (e-mail or letter to confirm account establishment and access by the right person).

Regarding authentication, McGraw said that the team is leaning toward recommending that ONC strongly encourage providers to use more than user ID and password (Level of Assurance—2.5), and drive toward protections analogous to those used in online banking. The team is considering whether technical capabilities for higher level authentication should be included in Stage 3 certification. At a minimum, ONC should disseminate the latest best practices in password management. Technology options for authentication continue to evolve; ONC should continue to monitor and update policies as appropriate to reflect improved technological capabilities. She noted that previously accepted recommendations on the transparency of view, download and transmit would be re-emphasized. The team has yet to thoroughly discuss patient participation in Direct. She noted the relevance of on-going work on NSTIC in which ONC is participating.

Q&A

Mostashari announced that the automated Blue Button staff has been working on simple implementation guides on automating Blue Button for the vendors and providers. The guides discuss actually workflows for view, download and transmit. McGraw indicated that the team will inform itself of these ongoing efforts prior to finalizing recommendations.

Ensuring the Quality of Quality Data Hearing Report Out

Larry Wolf, Co-Chair, Certification and Adoption Workgroup, reported on the hearing convened November 30. He summarized barriers to good quality data as reported by panelists:

- Extra work for users, especially physicians
- May not be of immediate value to the clinician (and therefore not done consistently)
- No good feedback loop to the clinicians (and therefore difficult to improve outcomes)
- Different EHR vendors code the data differently resulting in different calculations of the CQMs
- Different implementations of the same EHR product code the data differently, resulting in inconsistent reporting
- Multiple ways to document something with different coding (or no coding), undermining the value of extracted data
- Inconsistent use of data fields within an EHR
- Data extraction is difficult and may require special staff and add-on software, sometimes can only be done by the EHR vendor per contract

He used slides to describe potential solutions or improvements in quality. Several solutions applied to the EHR products themselves and to the use of certification and standards to influence products, for example, to require data validation checks and to standardize query and extraction tools. Other suggested solutions pertained to measure selection and specification. For example, several panels emphasized that data are more likely to be collected properly for measures that have recognized value to the providers themselves of care. If clinicians perceive that quality measures are valuable for understanding and improving clinical processes, they will be more thorough and precise in capturing and correcting data. If these measures are used for payment, everyone will be motivated to manage data quality more carefully. Wolf noted that several panels had argued that EHR data today are not good enough for payment. He presented an emerging vision:

- Quality measures are integral to the care process whether or not analyzed in external systems
- Data are collected as part of the care process without any extra clicks
- Data are available from the EHR without extra programming
- Data are aligned with standard vocabulary without extensive mapping tables
- Data are available for aggregate analysis and benchmark development without needing custom transport

After summarizing actions suggested for improving quality of data, Wolf delineated several potential next steps, including:

- A Data Intermediaries Tiger Team to describe new "ecosystem" and policy actions needed to get there
- Certification criteria and testing methods to increase consistency of data capture, coding, and extraction, with an initial focus on likely stage 3 CQMs
- Greater focus on standardizing the data that underlies the quality measures
- Analysis of the current state of the data (for example, what is contained in the CCDs being exchanged today) to improve utility of standard data extraction records and tools
- Focused review with CMS and private payers to map data pipeline that supports emerging value-based payment models and ensure EHR functionality

Q&A

David Lansky, Chair, Quality Measures Workgroup, emphasized the importance of measures that are perceived as relevant by the persons who are required to collect them.

Mostashari inquired about any suggestions for minimizing the number of required measures and exclusions. Lansky responded that panelists did not particularly express concern about the number of elements. He assumed that if the entire development cycle were revised as needed and recommended, the number of measures and the burden would take care of themselves. Mostashari observed that the entire burden cannot be placed on vendors and providers. More focus should be placed on measure development. Wolf urged an emphasis on simplification. Tang declared that agile development should move upstream to developers. Kevin Larsen, ONC, reported that ONC staff is working on an ecosystem. Mostashari observed that it is not totally a technical issue; emotions are involved in capturing clinical scenarios. A different paradigm is needed to recognize that every measure is not relevant to every individual patient. Lansky commented that one can go too far in that direction; allowing providers to decide for which patients a measure is not useful could have adverse effects. However, end users should be involved in measure development; currently no financial incentives are offered for rigorous data capture.

Tang asked about a recommendation to convene stakeholders to work on measure development. He talked about a culture of measure development. Patrick Conway, CMS, reported that his agency had discussed similar ideas with Mostashari. Finding a proper balance will be tricky. Many stakeholders, such as professional organizations, want all of these exclusions to make the measures accurate.

Terry Cullen said that discussions have taken place for years. The federal government has an opportunity to play a critical role. Everyone wants both good data and to reduce reporting burden.

Bechtel reminded the members that in discussing Stage 2 criteria, they spoke about leveraging meaningful use as a pathway for innovation. The concept is to give providers guidelines and then to let them do something new with measures. She had something written up that she will circulate. Tang said that the innovation idea is included in the Stage 2 Request for Comment (RFC). But that approach may not be sufficient. The problem of exclusion is one of removing confounders, which then results in information on a very homogeneous population that is of limited use.

Wolf talked about the difference between a keyhole and a door, suggesting that they follow up on innovation in analysis rather than in data collection and capture. Tools can be used to report data, not simply numbers.

Lansky advocated for a focus on an ecosystem for using data – in particular, longitudinal data.

Mostashari spoke on the concept of intermediaries and community data services and their roles in an ecosystem. They could interplay with other CMS programs. A market for such services should be considered.

Conway agreed that data intermediaries have a role. Their services can add value through the provision of feedback and data validation. Currently, CMS funding is focusing on the development of de nova measures.

Larsen talked about the need for data standards. A data intermediary group may make recommendations to HITPC, after which the HITSC would work on data standards. Conway said that CMS staff has worked on registries and data validation. The HITPC could help regarding the similarities of intermediaries in calculation of measures and certification requirements. Mostashari noted the importance of auditability. He announced that he would take as an action item for himself to coordinate with Conway on the FACAs and data intermediaries. He indicated that he will ask Conway how ONC and the FACAs can be the most helpful on measure development. Conway observed that a switch in the cultural ecosystem may be required; the issues are complex and the HITPC's input may be useful. Mostashari wondered about the role of the NQF mapping process. Conway responded that the current priority for the measures application process (MAP) is gaps in measures. However, that work could be aligned with this issue. It should be discussed with the MAP people. But the HITPC is the place to start.

Tang announced that although the discussion exceeded its allocated time, the topic is hugely important and requires additional work. He indicated that ONC should bring back proposals to the committee.

Clinical Decision Support: The S&I Health eDecisions (HeD) Project

Jacob Reider, ONC, presented an update on the S&I Framework Health eDecisions. He explained that effective CDS interventions require availability of computable biomedical knowledge, person-specific data, and a reasoning or inference mechanism that combines these elements to present actionable information to clinicians, individuals or caregivers in the right way and at the right time. The project is organized around six workgroups and two use cases. One use case is CDS artifact-sharing, and the other, on which work will commence in 2013, is CDS services. The goal is that the CDS be sharable and implementable. HeD is a harmonization of existing approaches, such as Arden Syntax, Arden ML, Gello, GEM and CDSC XM. All of these existing approaches (and many of the authors of these standards) have been represented in the S&I community. The first use case schema was submitted for HL7 balloting this week. The pilot will commence within the next few months.

Q&A

Chris Boone asked about the expected outcome. Reider talked about a technical foundation for sharing CDS artifacts. Although there are existing standards, none are widely available. The S&I community recommended simplification and harmonization of existing standards. The result is standards to share content. Judith Faulkner inquired about the accommodation of the individual physician, who knows what is best for her patient. CDS can be done by embedding or externally; the latter slows response time. CDS is incorporated throughout the EHR. Reider indicated that variation depends on the granularity of the intervention and the complexity of the system. Knowledge is consumed by the EHR, assembled, and then the results are exposed to the user. The HeD focus is on standard methods so that innovation can occur. Variation can occur when necessary.

Charles Kennedy asked about data architecture and a consistent understanding of the patient, saying that the CCD is frustrating. A common shared understanding of the patient is important. Reider indicated that the background of the project included consideration of the QDM and VMR, which was based on an HL 7 standard. VMR was preferred for the project use case.

e-Quality Measurement and Delivery and Payment Reform State Actions Plans

Kelly Cronin, ONC, and Kevin Larsen, ONC, described the HIT Trailblazer States, a project being conducted with the National Academy for State Health Policy and RTI. The purpose is better alignment of state-level HIT activities with health care delivery system transformation efforts. The project leaders in the four pilot states reportedly agree that the underlying goal for all HIT and transformation initiatives should be to change the basic structure of the delivery system to result in high quality care, affordable costs, appropriate incentives, and a healthy population. A sustainable business model is essential. The project supports the states' delivery and payment reform efforts through strategic and tactical planning on the necessary e-clinical quality measurement and improvement infrastructure. The innovation center is involved in a project with governors. Staff is assisting the project states on action plans and with alignment across federal programs. Larsen reported that similar stakeholder groups are represented in the teams across states. The teams want to coordinate with federal plans. Cronin said that the certification of intermediaries is a concern for the project. State teams are also interested in how to include private payers. Larsen informed the members that they will report back to the committee on relevant lessons learned.

Q & A

Regarding alignment with QIOs, the state teams have assessed the resources in their states and included organizations that can contribute. The QIO mission is relevant. Several state representatives are trying to link with claims data. Kennedy warned about the challenges in the integration of clinical and claims data.

ONC Update

Jodi Daniel informed the members that the Stage 3 RFC is open for comment until January 14. A webinar on the RFC will be hosted December 7. The ONC annual meeting will take place December 12. She announced that an interim final rule in conjunction with CMS with a 50-day comment period was recently published. The interim rule makes several technical corrections and very modest changes to the meaningful use and certification rules. Because it is an interim rule, it is in effect immediately. It refers to an updated version of the data element catalog to ensure capture of CQM data and the QRDA 3 to include HL 7 validation of a measure. CMS made a minor change for EH lab results, adding an alternative measure of all orders. Also, for EH view, download and transmit, "all patients" was modified to read "all unique patients." The case threshold exemption for CQM reporting was moved to 2013. She told members to read the rule themselves. The rule gives an email address for sending any errors in specs to CMS.

Janhavi M. Kirtane, ONC, reported on the 17 Beacon communities, for which funding will end in 2013. Highlights from the past 30 days include the following: Greater New Orleans Health Information Exchange launched with a focus on safety net providers; San Diego Beacon connected with Kaiser Permanente for HIT; keystone technology will allow any skilled nursing facility to share a patient's information inexpensively and securely without an EHR (MDS-to-CCD Transformer aka the "gobbler"); and the Central Indiana Beacon remote monitoring technology helped slash re-admissions rates. Eight communities are using HIT to connect a broader group of care and wellness partners. She described many other activities and talked about dissemination plans to make findings available to a broader community, particularly to ACOs. She announced that ONC intends to convene a subcommittee on ACOs. This new group will be charged to recommend how HIT can support the business needs of accountable care

models, specifically on ways in which ONC can align with and support the business needs of accountable care models.

Q&A

Tang referred to Kirtane's preliminary recommendation or proposal for a HITPC subcommittee to focus on ACO. He asked what she wanted from the HITPC. Cronin declared that staff is examining the idea. An ACO-focused group would have more of a business perspective, including market gaps, than a policy or technical focus and would include CEOs and CFOs among its members. Jodi Daniels interjected that staff is working on the concept but has yet to work everything out.

McGraw responded that such a group was a good idea for focus. People resources may be an issue.

Public Comment

None

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the November 2012 HITPC meeting was approved as circulated.

Meeting Materials

- Agenda
- Summary of November 2012 meeting
- Presentations slides
- Tiger Team report
- Trailblazers report
- Beacon Community report