HIT Policy Committee
DRAFT
Summary of the February 4, 2014 Meeting

ATTENDANCE

Members present:

- Christine Bechtel
- Neil Calman
- Terry Cullen for Madhulika Agarwal
- Arthur Davidson
- Karen DeSalvo
- Paul Egerman
- Judith Faulkner
- Scott Gottlieb
- Gayle Harrell
- Charles Kennedy
- David Kotz
- David Lansky
- Devin Mann
- Aury Nagy
- Marc Probst
- Troy Seagondollar
- Joshua Sharfstein
- Robert Tagalicod
- Paul Tang

Members absent:

- David Bates
- Patrick Conway
- Thomas Greig
- Deven McGraw
- Alicia Staley

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 56th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with two opportunities for public comment (limited to three minutes per person) and that a transcript will be posted on the ONC website. She instructed members to identify themselves for the transcript before speaking. Members introduced themselves.

Consolazio announced that ONC will soon solicit applications for several committee member slots. For the HITPC, a public health representative will be sought. For the HITSC, there will be openings for electronic exchange, quality, and consumer representation. People can apply on the ONC website. Beginning with the new appointees, terms will be limited to six years. She noted the importance of diversity in representation and thanked the members for their participation. A forthcoming blog post will contain more information.

Remarks

National Coordinator and Chairperson Karen DeSalvo's remarks were postponed due to her late arrival.

Review of Agenda

Vice Chairperson Paul Tang noted each of the items on the agenda, which was distributed by e-mail prior to the meeting. No additions to the agenda were requested. (Note: A number of changes in the agenda were made as the meeting progressed. This summary will follow the agenda items as they occurred, rather than as they appeared on the distributed agenda.) Tang asked for a motion to approve the summary of the January meeting, saying that he had submitted directly to Consolazio a clarification pertaining to the action item about the quality measures recommendations. His addition noted several changes to the recommendations from the Quality Measures Workgroup prior to their adoption by the committee. A motion was made and seconded to so approve the meeting summary. The motion carried unanimously by voice vote.

Action item #1: The summary of the January 2014 HITPC meeting was so approved.

Data Review: CMS Update

Robert Anthony was absent. His slide presentation was included in the meeting materials.

Data Review: ONC Update

Jennifer King showed slides and talked about the 2013 National EHR Survey conducted by the Centers for Disease Control and Prevention (CDC). CDC published a data brief, which is available on its website. Survey questions differentiated between any EHR, a medical or health record system that is either all or partially electronic, excluding systems solely for billing, and basic EHR, a system with advanced capabilities defined by an expert panel prior to the establishment of meaningful use. She emphasized that some Stage 1 core objectives are not part of a basic HER, and some basic functionalities are not Stage 1 core functions. Seventy-eight percent of office based physicians reported use of any EHR, compared to 48 percent reporting use of a basic system. Use increased steadily since 2001when the survey was initiated. Adoption varied by meaningful use function, ranging from 57 percent who have adopted use of clinical reminders to 83 percent who reported use of CPOE for med orders. Sixty-nine percent indicated intent to participate in the incentive program in 2013. Of those with intent to participate, only 19 percent had adopted all of the 14 Stage 2 capabilities included in the survey. Seventy-four percent indicated capability to comply with Stage 2 med reconciliation, but only 39 percent with immunization registry reporting. The increase in adoption pre- and post-HITECH suggests strong growth in recent years.

Q&A

King said that analysis is ongoing. Information on variation in adoption across specialties, provider size, and geographical location will soon be available to the HITPC.

David Lansky and Paul Egerman referred to the HITECH language as well as statements of President Bush and President Obama that by 2014, "every American" should have an EHR. Members were not sure whether the goal was all persons in the U.S. population, the majority of persons in the U.S. population, all "Americans," or the majority of "Americans." It's possible the presidents stated different goals. Egerman and Lansky emphasized the importance of measuring the extent of goal attainment. They asked about the infrastructure for measurement being in place. Egerman said that attainment should be tracked and reported monthly. King indicated that she is working with CMS on a measurement process. There are obviously many issues with definitions of denominators and numerators and techniques for de-duplication. She reminded them that according to CMS data, more than 90 percent of Medicare discharges occurred at hospitals that had attested to Stage 1 meaningful use.

Lansky proposed that the committee send a letter to ONC and CMS requesting a full report on the legislative goal and its attainment. Seeking to avoid a formal request, Tang asked King whether she could report back in March. Judy Murphy, ONC, interjected that considerable clarification is required prior to compiling a report. Thought must be given to counting; for instance, people see more than one doctor, so adding the number of EPs using EHRs is not an appropriate measure. Karen DeSalvo, National Coordinator, said that she would be happy to receive such a letter. Even without a letter, she will assign staff to analyze the issue, consider definitions, develop an action plan, and report back. Lansky said that he was willing to hold his proposal until the March meeting.

Judy Faulkner declared that she objected to King's assumption that HITECH caused increased adoption. Many systems were performing these functions prior to meaningful use and were demonstrating growth. HITECH's role as a cause cannot be proven true or false. In order to measure EHR coverage in the population, de-duplication of names would be required.

Meaningful Use Workgroup Update

Tang presented the draft Stage 3 functionality objectives, on which the workgroup has been deliberating since February 2012. The most recent report to the HITPC was in August. To date, the work has involved 112 public calls. The Stage 3 NPRM is scheduled for fall 2014. Stage 3 will commence in 2017. He showed a slide and repeated the six previously agreed-upon principles. Areas of emphasis for Stage 3 are: CDS, patient engagement, care coordination, and population management. Next, Tang and Meaningful Use Co-chairperson George Hripcsak presented detailed functional objectives and functionality goals, domain by domain. The domains are as in previous stages: improving quality of care and safety; reducing health disparities, improving coordination of care, engaging patient and families in care, and improving population and public health. In conclusion, Tang described the workgroup's attempts at deeming, which were eventually found to be impractical at this time. He went on to say that providers and the vendor industry want as much lead time as possible. The workgroup will recommend to the committee and the committee will decide what to recommend to CMS and ONC. ONC and CMS will publish a NPRM, to which the committee can respond.

Discussion

DeSalvo chaired the discussion during which a number of members commented, some speaking at length (and a few repeatedly) about several topics. Many of the comments covered the same points. Nearly all of the members prefaced their comments by saying that the workgroup had done an outstanding amount of work. DeSalvo gave Tang the opportunity to respond to each member's comment individually before moving on to the next comment.

Marc Probst expressed concern about patient consent and sensitive demographic information, such as sexual orientation and disability. Regarding 24 hours for VDT access, he mentioned several process steps, such as the clinician's signature, that are required prior to making information available to the patient. He opined that patient consent for notifications should always be required. Regarding registry reporting, he preferred the term "use" instead of "reuse." Finally, he expressed reservations about being ready for Stage 3 under the current schedule. As he did in responding to other comments, Tang referred to the Word document in the meeting materials that provided more explanation. He said that the demographic data are all optional. They are included for purposes of certification and functionality. These are data that providers will need as they adopt new advanced care models and compare outcomes by demographic status and attempt to reduce disparities. Patients are not required to provide these data. Tang will clarify that the time requirement for VDT begins when the physician has signed off. Nothing is official without the clinician's signature. He reminded Probst that consent is not required for most purposes of care. If it is required, then consent for notification would be obtained. Someone said that the Institute of Medicine's committee on social determinants will publish reports in March and in the fall; the committee should pay attention to the recommendations. Tang said that it will be up to CMS and ONC to incorporate any recommendations from the Institute of Medicine (IOM). He explained that the word reuse was used to indicate that the registry may not occur inside the EHR.

Egerman announced his support for dropping deeming, saying that it would not be fair to give some providers a shortcut over others. He insisted that the reporting burden should be reduced further by introducing only a very few new concepts and focusing on information exchange, care coordination, and TOC. Such an approach would be more applicable to specialties. Developers are resisting the technical burdens in Stage 2. Vendors are dropping out, as recent ONC reports have indicated. Loss of a vendor creates many problems for a provider. This trend will likely continue to Stage 3. Egerman recommended dropping certification-only objectives, as well as any items for which standards are determined to be immature. By saying that standards may be ready by 2017, developers will be forced to work on products that may or may not be sold. Consumption of external rules is a really hard thing to do. Health eDecisions is not widely adopted, and the overall goals can be met without its use. The new demographic variables do not apply to all patients; for example, pediatric patients do not ordinarily have an occupation. Gender identify is complicated and has implications downstream, such as the greeting in an automatically generated reminder letter to a patient. Family history does not have standards. Egerman repeated that all of the certification-only items should be dropped, all currently immature standards items should be reviewed, and all low threshold objectives should be reexamined. In particular, the check-off for one non-English language is pointless. Tang replied. He assured Egerman that the same points had been made and discussed within the workgroup. Unless the action resulting from an alert is captured, there is no way to improve the system. He explained again that the collection of demographic data is optional; without the fields, capture will not be possible. He and Consolazio agreed that a mistake had been made on the slide. The mistake will be corrected. Regarding consumption of the rules, he reported that Jacob Reider, ONC, had repeatedly assured him that vendors are working on implementation and the standards will be ready. Culture change is required and it takes time. Secure patient messaging will take time. He explained that his employer began 10 years ago, and now 80 percent of patients are online. Egerman said that from Tang's response it seemed that the recommendations will not be reviewed. Tang said that the workgroup has several meetings scheduled before its report back to the HITPC in March. The reviews suggested by Egerman will be conducted.

Gayle Harrell talked about her list of objections. The entire meaningful use program has been geared to primary care. Specialists' interests are not well represented. The needs and applicability of the CDS recommendations to specialists have been overlooked. Specialists play essential roles in care coordination. They will eventually be subject to negative sanctions. Podiatrists and orthopedic surgeons do not need to concern themselves with immunization history. The important things are closing the loop on consults, dealing with medication reconciliation, and care coordination. Exchange of records and interoperability are important. It is ONC's responsibility to push the exchange element. She described her concerns with PDMP, for which state infrastructures reportedly vary greatly. What works in one state may not work in another. Public health agencies also vary widely. Many do not have sufficient infrastructure and are not ready to receive reports. She receives many complaints from people in Florida. Providers are in rebellion, especially physicians and people in small communities, and the usability factor for many people is very difficult. Vendors are going out of business. Tang responded that PDMP is a priority for the federal and state governments; the recommendation was reduced to a sign-in and check-off. The CDS objective allows choices and some apply to orthopedic surgeons. The CDS rules are expected to cover the National Quality Strategy domains. He told her that the workgroup did attempt to avoid being over prescriptive and to take into account HHS priorities.

Charles Kennedy approved of the focus on outcomes for Stage 3, but he had questions about population health, which requires discrete data to run analytics and algorithms and identify gaps in care. An industry financial risk is increasingly being pushed down to the provider. A provider really needs health analytics to support chronic disease management. Something such as immunization is much less important to an organization's financial risk. Could more be done to assist with management of chronic conditions? Hripcsak said that the registry objective offers a choice; a provider could select a registry to help manage a chronic disease. He asked Kennedy for specific suggestions on functions that are missing. Cardiovascular disease and cancer were mentioned as important conditions to manage. Hripcsak reminded him that cancer is in Stage 2. Kennedy had no specific suggestions.

Devin Mann asked about external consumption of CDS and the case reporting section. He referred to the description of Health eDecisions in the Word document and asked whether the workgroup is trying to push the standard or encourage a plug-and-play approach. Hripcsak reiterated that the HITPC will decide how far to go. The use case was used as an example of something in practice. Keeping the scope small makes it feasible.

Terry Cullen urged caution about consent on gender preference and sexual orientation preference. Answering a question does not necessarily indicate consent. She expressed concern about co-dependencies and the amount of work that must be done on standards and interoperability for Stage 3. Although a public health objective refers to bi-directionality, what is actually stated is unidirectional—reporting to the state health agency. Hripcsak explained that the first objective is sending to the health department. The second objective is for the public health agency to be able to report back, making it bidirectional. The patient who provides information on her demographic characteristics is allowing the provider to use that information to stratify analyses.

Faulkner once again talked about efforts to regulate the HIT industry, something that she opposes. Benefit and harm must be taken into account. She has yet to encounter a physician who is happier with meaningful use than without it. Too many health care organizations are putting in systems too fast, doing such a poor job that it will take years to recover. Small vendors are being pushed out, resulting in fewer choices for providers. Across-the-board documentation will hit specialties, and will compromise patient care as a result. Providers may be so preoccupied with meaningful use requirements that their attention to patients will be affected. Regarding the provision of a visit summary, she reported that her personal physicians do not have printers in their exam rooms, meaning that she would have to wait at the registration desk, which she considers a waste of her time. Concerning the 5 percent secure messages, some providers are staging raffles in order to get patients to sign up. Every patient who sends a message gets put into the raffle. She has heard that some physicians withhold information in order to initiate an e-mail query. She went on. The track changes function in documentation would make a huge job for developers and take them away from functions that would actually improve care. Standards are not in place for electronic interaction between the centralized public health entity and an individual EHR. Standards for drug monitoring registries may not be available. The requirement to submit data to a registry is too much for small-scale EPs. Registry participation is costly. Requiring information about occupation for each patient is not appropriate for all areas. She shared that when she went to an ophthalmology clinic, she would not have wanted to be asked about gender identity or sexual orientation. Referring to the slides and the recommendations, she wanted to add four columns: addition to physician burden, applicable to which specialties, availability of standards, and estimated software development effort. She agreed with Egerman about dropping the certification-only requirements. Interoperability should be the focus. Tang reminded her that it is typical to resist change. Implementation of meaningful use is difficult, but it will become much easier over time. Faulkner said that her objections were specifically to meaningful use, not to EHRs. Tang said that without the incentive program, many providers would not be using EHRs. There is no current requirement for use of secure messaging. In

Stage 3, providers will be expected to push their patients into a more active role. The track changes concept was included in the RFC and received considerable support. Participants in a hearing also indicated support. Although it may be a heavy lift, the benefits would be great. He referred again to the explanation in the Word document. Tang said that the workgroup membership was diverse, and most of the concerns brought up in the HITPC had been raised during workgroup discussions. The HITPC will rule on the draft recommendations. Track change applies to accuracy, quality and readability of notes so that the reader can understand their history and provenance. The example was given to help understand the functionality, but there may be several ways to do it. For example, two versions of the notes could be shown.

Art Davidson, Meaningful Use Workgroup member, spoke in opposition to the proposal to delete the certification-only items. Certification presents the opportunity to push standards and move the industry. Tens of billions of public dollars have been invested in developing these standards. Rather than each provider and vendor developing their own knowledge, there can be one place to go to get the rules for consuming external knowledge. Rather than each state health agency building its own system, these recommendations will help states to better prepare. State health departments are building a common platform. It makes sense to place the burden on the vendors because they are the ones that are profiting from the incentive program.

Egerman said that he did not object to certification-only that involves information exchange, coordination of care, and transition of care. But consuming external rules is not part of coordination of care. He objected to any certification where standards are not mature. States' capability to consume data is a legitimate issue. He related that someone had complained to him about the PQRS report, which is required to be electronically sent to CMS. But CMS cannot receive the information. As a result, one must build the technology, which cannot be received. Thus, the credibility of the vendor is destroyed.

Neil Calman announced that he agreed with Davidson about accountability for public monies, which have driven an entire industry. He told Egerman that he was over-reacting to certification. The reservation of fields for certain data means that the data can be obtained and used as necessary or desirable. Those for whom the data are not of interest are not required to capture the information. He acknowledged that capturing information on occupation and gender identity in his practice, in lower Manhattan, is really critically important. There is a need to be able to create more functionality than is required for use in order to have the kind of flexibility that people want. To say that standards are required before ways of capturing information are created sets too high of a bar. Family history is a great example; there is no standardized way for capturing family history but a start must be made. Calman opined that many providers have success stories regarding achievements due to meaningful use. He went on to CDS. Capturing the information about the use of alerts is a critical step in moving this science forward. He informed Faulkner that all of the exam rooms in his organizations have printers. The after-visit summaries are discussed with patients. Clinicians circle things, annotate, and draw pictures. He suggested that he agreed with Davidson about using external-decision processes. Clinical content is continually developing.

Troy Seagondollar clarified that although he is employed by Kaiser Permanente, he does not represent Kaiser Permanente on the committee. He represents non-physician health care workers, many of whom are greatly affected by meaningful use requirements. It is the ancillary staff that obtains and enters much of the data. Staff captures the demographics and gender identities. They have a difficult time asking these questions of the patients. There is an ongoing debate about who does the med reconciliation. The dependencies associated with achieving objectives are huge and cause a lot of downstream problems. He referred to the objectives about care coordination and sharing information among the health care team. The composition of the team is not defined. Regarding care plans, nursing care plans are well recognized, but there seems to be a movement away from the use of the term "treatment plan." Clarification is much needed. Tang replied that the health care team goes beyond the physician and nurse. A lot depends on the individual provider organization. The new models of care are team-based, and patients and caregivers are team members. With respect to the care plan, there is currently no standard. The standards development organizations and professional associations have been contacted for advice. Seagondollar referred to VDT and pointed out that the objective puts a burden on providers for something that they have absolutely no control over. If it is changed to enable, how can it be measured? Tang explained that transmit is a recommended Stage 3 addition. One of the workgroups is convening a hearing to better understand the meaning of transmit.

Devin Mann said that he agreed with Calman about external consumption. Regarding the copy and paste functionality for documentation, providers are worried about becoming stenographers. Other efforts to improve documentation are underway, such as problem-oriented charting and the use of scribes. He said that in his organization, copy and paste is prohibited. It does not make sense to expend vendor effort trying to block something that is already changing. The reality is a much bigger problem of readable notes.

Christine Bechtel, a member of the Meaningful Use Workgroup, said that meaningful use will help providers to deliver care in a more coordinated and outcome-focused way and be better positioned for new models of care. She agreed with Calman that certification-only is good. Although patients do not want to supply the same information repeatedly, sexual orientation and gender identify data are very important in many care delivery situations. She noted her disagreement with the low threshold for exchange of care summaries. She requested a re-examination. She said that she agreed that one non-English language for patient educational material was not meaningful. She requested that members submit suggestions for a more meaningful approach.

Curren spoke again. She referred to work on criteria for selection of measures by the Accountable Care Quality Measures Subgroup. The impact on interoperability, on standards, and on infrastructure should also be taken into account with the Stage 3 objectives. The opportunity to crosswalk should not be missed.

Faulkner was recognized again. She said that the purpose of meaningful use was to bring jobs back and to help organizations purchase EHRs. She questioned being true to those purposes. She questioned Calman's statement that the funding drove the vendor industry. According to Faulkner, the same curve was seen with billings and labs. Everyone would have eventually had EHRs. Internationally, there is a huge movement to adopt EHRs without meaningful use monies. She questioned whether meaningful use had any effect on speed of adoption. It has had some negative effects. She objected to the implication that due to the funding, the industry owes something to the government. Regarding track changes, she restated her objection, saying that it may not be desired by users. It overlooks the crowd sourcing that vendors use to identify perceived needs. She requested that Davidson get immunization standardization throughout the country so that communication will be possible.

Tang thanked the members for their comments. He assured them that the comments will receive consideration in the workgroup. DeSalvo said that ONC has been working for 10 years on how technology can improve health care and health. She said that she appreciates the representation and the candor of the members. There is much more to accomplish.

ONC Standards Update

Doug Fridsma showed slides and talked about plans for standards development to support a learning health care system. Vocabulary and code sets, content structure, transport, security, and services are building blocks to interoperability. The HITPC can contribute by identifying priorities. He described what must be done in the long term to standardize meaning, structure, transport, security, and APIs. Moving to certification and testing, ONC will continue SITE support for broader testing methods and tools. He also intends to expand the portfolio based on new use cases with the addition of scenario-based testing and certification and testing criteria based on Stage 3 priorities. He expects to move from interoperability based on conformance to specifications to demonstration of interoperability. This will involve test for conformance to specification on send (OR for options) and test for robustness to interoperability on receive (AND for options). The S&I Framework specifications will be expanded to include testing methods as part of a comprehensive implementation guide with a pivot to a more community and industry-led testing approach. And there are additional considerations, such as structured and unstructured data, device interoperability, and refinement of an iterative, incremental approach that leverages real-world experience.

Public Comment

Mark Savage, National Partnership for Women and Families, asked that slide 28 on the meaningful use priorities outcome goal also list patients and the public.

Thompson Kuhn, American College of Physicians (ACP), read a prepared statement outlining concerns about the direction of Stage 2. The delivery of products is already behind schedule. Therefore, the time period to begin reporting should be extended. The ACP advocates switching to a scoring system that recognizes variation in practices and the difference between incentives and penalties. Less prescription regarding workflow is needed.

Jess Smith, College of Healthcare Information Management Executives (CHIME), acknowledged that adoption and payment trends indicate the overall success of meaningful use. Nevertheless, capital costs are skyrocketing and providers are forced to change workflows, creating concerns about the viability of the program. CHIME members are also concerned about timing of the stages and reporting.

Mark Segal, EHR Association, thanked the Meaningful Use Workgroup for soliciting advice from his association. There are many concerns with Stage 2. Learning from Stages 1 and 2 should be applied to a more robust focus in Stage 3 on interoperability and care coordination. If that were done, vendors can focus on what customers want and usability. New technology for value-based care should advance outside of meaningful use regulation.

Daniel Barchi, CIO, Yale Health System, agreed with Calman regarding Stage 3. Organizations have limited resources, and the scope of Stage 3 should be limited accordingly.

Lee Burchell, Allscripts, agreed with the Stage 3 priorities, but she is very concerned about the burden for both providers and vendors. Certification-only is not cost free to providers. Standards are not sufficiently mature for certification. She indicated agreement with Egerman’s arguments and the EHR Association’s previously submitted position, which she repeated.

Chantal Worzala, American Hospital Association (AHA), expressed concern about the scope and pace of Stages 2 and 3. Vendors are behind in the delivery of certified products. Requirements must be changed to provide more time. She referred to a December 19 letter to CMS and ONC describing members’ concern with risk of failure.

Mari Savickis, American Medical Association (AMA), gave assurances that the AMA is committed to the success of meaningful use. However, there is a lack of flexibility. Many EPs are dropping out of Stage 1 due to problems with usability of certified products. The AMA agrees with AHA.

Privacy and Security Update

Joy Pritts, ONC, showed slides and gave a summary of the Privacy and Security Tiger Team’s activities from July 1, 2010, through September 30, 2013. The report was compiled by MITRE staff and Kathryn Marchesini, ONC. Early on, the team agreed to use the Fair Information Practice Principles (FIPP). The team held six public hearings and made 160 recommendations of which 154 were accepted by the HITPC and transmitted to ONC. Six recommendations were withdrawn prior to action. Recommendations spanned the eight FIPPs. Fifty-five percent of the recommendations had to do with consent and meaningful choice. In terms of the status of the recommendations, 4 percent have been adopted, and 49 percent have been partially adopted by HHS. Action is pending on 14 percent and 33 percent are "in process" (undefined). These recommendations not only pertained to the meaningful use stages, but also to the Common Rule ANPRM. They helped to inform the Office of the Chief Privacy Officer's (OCPO) comments on proposed federal rulemaking during the clearance process and are used in guidances and technical assistance to grantees. In 2013, the OCPO commented on more than 200 rules. Pritts referred to a new rule published in the *Federal Register* on February 3, 2014. She read from the preamble, which referred to the work of the HITPC, saying that it demonstrates the impact of the HITPC. An executive summary of the privacy and security report and a visual overview will soon be published on the ONC website. Pritts thanked the committee, Tiger Team, staff, and MITRE for their outstanding work.

Q&A

Egerman thanked Pritts for her expertise and patience. Harrell talked about the importance of the team's work in building public trust.

2014 Workplan

Tang showed and read through a slide that listed the six active workgroups, one team, and one task force and the topics assigned to each per quarter. DeSalvo reported that better harmonization of the HITPC's and HITSC's work will be incorporated into the plan. She wishes to strengthen communication between the two bodies at the committee, workgroup, and staff levels. The effective use of staff and other resources must be taken into account for prioritization. She encouraged the members to think about ACOs and beyond. Although safety and usability could possibly be embedded in the topics described by Tang, she wishes to see them pop out more. Information exchange is the priority. She observed that the workplan matches fairly well with ONC strategies. An exact match is not necessary, but adjustment and coordination are required.

Discussion

Kennedy wondered what happened to the goal of a learning health system. He observed opportunities with pharmaceutical development and interaction with FDA to make products and devices consistent with new payment models.

Egerman declared agreement with information exchange as a priority. He questioned the assignments of the Vendor Task Force, saying that certification should be the responsibility of the Certification Workgroup. (The Vendor Task Force currently reports to the Quality Measure Workgroup.) Someone said that the HITSC will be primarily responsible for responding to the 2015 Edition. Consolazio agreed to review the assignment. Tang said that hearings are planned.

Probst observed that the focus should be on interoperability, which is broader than information exchange. Harrell wanted to add topics to the workplan—continuum of care, care coordination, and non-eligibles. Ineligibles want to participate. Their representatives should be included on workgroups and, perhaps, as ex-officio on the committee.

Calman suggested becoming informed about state and regional efforts on information exchange. Data warehouses are combining data from various sources: What capabilities are needed by EHRs to support use of data from other sources? Also, data segmentation is an important topic. He wondered about the process for not sharing responses on gender and sexual identity. Other topics are the use of data for research and connections with genomic data. There are many remaining big policy issues on which the HITPC should set direction.

Lansky noted that the workplan is little more than a roll-up of separate workgroup activities. The HITPC should identify its broad topics, such as direction beyond meaningful use, information exchange and interoperability. With regard to the Quality Measures Workgroup, what will be the source of the measures menu? Pertaining to plans for a hearing, he advocated for expansion to include a purchasers' panel. Kevin Larsen, ONC, reported that the Quality Measures Workgroup has focused on delineating criteria for CMS and ONC to use in selection of specific measures, not the measures themselves. He offered to modify that direction.

Fridsma and DeSalvo conversed about HIE being used as both a noun and a verb. Fridsma urged precise definition of the terms. He went on to say that exchange is necessary but not sufficient. He recommended a focus on achievement of interoperability. The HITPC's goals should be clearly tied to interoperability.

Davidson pointed out that public health agencies and schools are important ineligibles that should be included. Harrell said that, although key, usability is absent from the workplan. Referring to a learning health system, a member said that thought should be given to bringing research and operations together.

David Kotz urged greater attention to mobile technology.

Faulkner opined that although discussion of genomic policy is fine, genomic structure is not within the committee's purview. Since usability is a difficult topic, and is approached differently by vendors, the committee should not get involved. Innovation should be allowed.

DeSalvo stated that the members' comments indicated that policy questions for 2014 and beyond should be identified to ensure that the workgroups are working on major policy issues. Tang said that he and DeSalvo will continue to develop the workplan.

Regional Extension Center (REC) Update

Kimberly Lynch, ONC, said that currently 62 RECs are in operation, covering the entire area of the United States. They offer coaching, privacy and security information, and other supports needed by providers. The goal is to have 100,000 priority primary care providers achieve meaningful use by 2014. Currently, more than 85,000 have demonstrated meaningful use. RECs are part of the overall transformation and reform efforts, providing assistance beyond meaningful use.

While RECs are encouraged to work with all providers, they focus on individual and small group primary care practices, public hospitals and CAHs, community and rural health centers, and other settings that serve medically underserved populations. Many RECs are also working with specialists and LTPAC and BH providers. Each REC has a defined service area and serves as a two-way pipeline to federal and local resources. An October 2013 GAO report found that Medicare providers working with RECs were over 1.9 times more likely to receive an EHR incentive payment then those that were not partnered with an REC. Regarding penetration, 83 percent of FQHCs and look-alikes are enrolled as are 79 percent of CAHs. Forty-five percent of all primary care providers, including 53 percent of rural providers, are enrolled with an REC. Of comprehensive primary care initiative sites, 53 percent are enrolled as are 82 percent of advanced sites. Lynch referred to a recent article in *Health Affairs* on the achievements of RECs. REC staffs are working to prepare their clients for Stage 2 functionalities. ONC staff uses the experiences of RECs to develop TA resources. Using relative risk (RR) to compare the likelihood of being paid for meaningful use when compared to the non-PCMH/non-REC enrolled providers, among REC-enrolled providers, those that are PCMH-certified were 8 percent (p=0.0008) more likely to be paid for meaningful use than those not certified. Among PCMH-certified providers, those enrolled with an REC were 76 percent more likely to be paid for meaningful use than those not enrolled with an REC. PCMH-certified providers not enrolled with an REC were more likely to be paid by Medicare for meaningful use when compared to REC providers not certified for PCMH. Lynch closed with examples from Iowa, New Jersey, Arkansas, Minnesota, and North Dakota.

Q&A

Lansky asked about the end of ONC funding and sustainability strategies. He also wondered what will happen to small rural providers given the push to ACOs. Can they be successful without ACOs? Lynch responded that funding for RECs ends in 2014, although they have the option of a no cost extension into 2015. Staff has worked with REC staffs on sustainability plans. ONC staff told them to think of the grants as venture money. There are Medicaid funds and private and hospital funding. Direct payments from providers are another source of revenue. But they cannot sustain the scope and scale of their work without external funding. Rural providers will need support in whatever arrangements they make. They need TA and coaching.

Seagondollar pointed out that although EHR adoption is about 90 percent, meaningful use achievement is only 40 percent. Now that the education and training grants to community colleges have ended, what is the effect on the workforce? Are the trainees employed in public programs? Lynch acknowledged the lack of a tracking system. But there are anecdotal reports of success in retaining persons employed in HIT. Incumbent workers have been retained or have progressed. She talked about the extended period of time necessary for the RECs to build trust with their providers. Now there is trust and the providers seek them out. ICD-10 is an area for which support is frequently requested.

Public Comment

Consolazio announced the three-minute limit.

Jeff Kaufman, HIMSS, read a prepared statement, saying that EPs and EHs are citing challenges with certification. The first year of Stage 2 should be extended through April 2015 for EHs and June 20 for EPs. HIMSS remains committed to meaningful use.

Michael Peters, American College of Radiologists, reinforced Harrell's comments about specialists. The specialties that least resemble primary care work flows are at the greatest disadvantage as documented in a GAO study. Only 12 percent of radiologists have qualified. He requested more accommodation for specialists.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the January 2013 HITPC meeting was approved.

Meeting Materials

- Agenda
- Summary of January 2013 meeting
- Presentations and reports slides