HIT Policy Committee
DRAFT
Summary of the March 11, 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
- David Kotz
- David Lansky
- Devin Mann
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Joshua Sharfstein
- Robert Tagalicod
- Paul Tang

Members absent:

- David Bates
- Patrick Conway
- Thomas Greig
- Charles Kennedy
- Aury Nagy
- Alicia Staley

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 57th 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.

Remarks

National Coordinator and Chairperson Karen DeSalvo announced several appointments: Acting Principal Deputy Jacob Reider, Acting Chief of Staff Josh Brammer, and Special Assistant to the National Coordinator Ayame Dinkler.

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. Tang asked for a motion to approve the summary of the February meeting. A motion was made by Paul Egerman and seconded by another member to approve the meeting summary. The motion carried unanimously by voice vote.

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

Meaningful Use Update – Stage 3 Recommendations

In his role as Meaningful Use Workgroup Chairperson, Tang showed slides to describe how the workgroup used the feedback from the February HITPC meeting to reduce the number of objectives, tighten their focus, reduce burden on providers, and rely on more mature standards. As a result, the workgroup deleted the following objectives: reminders, amendments, eMAR, case reports, medication adherence, syndromic surveillance for EPs, imaging, and family history. Tang and Co-chairperson George Hripcsak methodically reviewed slides for each of the 19 recommended objectives, explaining the changes from Stage 2, edits from the previous meeting, and certification criteria. The recommended objectives were: improving quality of care and safety—clinical decision support, order tracking, care planning and advance directive, electronic notes, hospital labs, unique device identifiers, and demographics and patient information; engaging patients and families in their care—view and download and transmit, patient-generated health data, visit summary and clinical summary, patient education, and secure messaging; improving care coordination—summary of care at transitions, notifications, and medication reconciliation; and improving population and public health—immunization history, registries, electronic lab reporting, and syndromic surveillance. The NPRM is due for publication fall 2014.

DeSalvo said that meaningful use is one of many tools to advance HIT. The need for standardization and data capture should be balance with other factors, such as burden and patient engagement. She called for discussion.

Discussion

Most of the members prefaced their comments by saying that they appreciated the efforts of the workgroup. Paul Egerman, a member of the MUWG, acknowledged that the workgroup members felt passionately about particular objectives, making the work very difficult. After Stage 3, which begins in 2017, penalties will be introduced. HHS delayed the start of Stage 3 so that Stage 2 experience could be taken into account in defining requirements. However, Stage 2 data did not inform the MUWG's recommendation. For instance, the impact on registries was not considered. Tang responded that prior to the final rule CMS and ONC will have time to examine the data from Stage 2. Providers and vendors say that they want signals well in advance. Egerman repeated his comments.

Deven McGraw said that the recommendations represent the best possible compromise of the different interests represented. Each member had to give up something. She asked that members accept the report without quibbling.

Marc Probst pointed out that the timing of the stages is not set in law. Perhaps one of the learnings is that more time is needed. Hripcsak noted that it will be easier for ONC and CMS to take out objectives than to put in additional objectives at a later time.

Christine Bechtel informed Egerman that by Stage 3, providers will have received considerable amounts of payments.

Neil Calman declared that meaningful use is going too slowly. Much innovation is occurring, and developers should be pushed in the direction of standardization. National standards for public health are

needed. To slow down is to waste money. Vendors as well as providers have benefitted from the incentive program.

David Lansky expressed concern that in the aggregate the recommendations do not really focus on longitudinal outcomes and the establishment and use of an information management system. The registry requirements and the quality measures objectives are not adequate. Tang responded that over the coming months the HITPC will entertain such longer range efforts.

Probst wondered whether the workgroup is listening to what CHIME and HIMSS are doing. A lot is happening, but without Stage 2 data. DeSalvo repeated her statement that meaningful use is not the only tool available to advance HIT.

Judy Faulkner said that the real question is right or wrong. Some of the specifics are wrong. This is regulation of HIT, and thus regulation of health care. The MUWG members are not the right people—actual users or developers. The people who make up the rules should be the ones who must implement the rules.

Gayle Harrell agreed with Faulkner about users. She hears from users. Providers are struggling with ICD-10 and many other initiatives.

Troy Seagondollar reflected from a nursing perspective, which is particularly relevant to care coordination and population outcomes. The nursing community is prepared to assist with the objectives. Turning to specific slides, he noted that the CDS certification criteria of track interventions and response would be improved by replacing the word "response" with "action." The language on demographics and disparities could be clarified. He suggested that the workgroup review the statement on ability and collect, which do not necessarily go together. He indicated that he appreciated the changes made as the result of feedback. Tang and Hripcsak responded that they will clean up the language referenced.

Egerman said that ONC should assign categories for gender identity and sexual orientation. Patient's occupation is meaningless without historical data. Communications preference is not technically demographic information and could be captured in another section. Hripcsak reminded him again of a forthcoming IOM report, which staff can use to inform standardization.

Devin Mann agreed with the need to take into account data from Stage 2. Regarding the 24-hour time for VDT, he anticipated difficulties. He wondered about the source of the number. On disparities, he recognized the letters from the U.S. Senate and the House of Representatives and talked about the importance of incorporating smart phone users. Tang clarified that the 24-hours requirement refers not to all information, only to what is handed out at discharge. He said that he saw no need to regulate mobile technology at this time.

Bechtel talked about wanting more input from patients and families. Her organization has commissioned a consumer survey on Stage 2. She disclosed that as a member of the MUWG, she disagreed with the decision to cut reminders, which are so important to families, and is an option for specialists. She said that she also was opposed to the removal of preference for communication. She called attention to the letters from senators and representatives and their requests to include mobile access and granular standards for ethnicity and race. Regarding race and ethnicity, she wanted to move from OMB to HHS standards. The letters also asked for stratification of QMs and demonstration of reduction of disparities. She declared that patients and families also want these objectives.

Lansky said that if the removal of family history was based on the thinking that after Stage 1 and 2, there would no longer be a need to monitor to ensure that family history continues to be collected. He wondered why the same logic with UDI was not applied to advance directives. Menu credit should be available. Tang and Consolazio responded that family history is in VDT. Tang explained that advance directive is a challenge for providers because they want to ensure that they have the current version.

Egerman said that storage of the directive is not a good idea. Lansky wondered why credit would be given without access to the document.

Faulkner admitted that the MUWG did a good job. There is good family and patient representation on the workgroup since all members are patients. She commenced to comment on each objective. CDS may be useful, but the direction is not the best one. If a result of order tracking is not auto-generated, it should be stamped. In any case, auto-generation should be emphasized. Regarding UDI, place should be clarified. She liked the objective on demographics and disparities. Tracking of secure messaging would be tricky; she asked for a reexamination. As stated, it may require extra effort for providers. Tang provided an explanation that resolved her concern. She went on. The four-hour notification may present many interoperability challenges; it should be dependent on having a link. She expressed concern about selfies, stating that some EPs are getting credit for sending CCDAs to themselves. DeSalvo assured her that at the April meeting, interoperability will be a topic for discussion. Faulkner went on to say that the CCDA is not a great way to transmit to registries. Hripcsak pointed out that concern with the CCDA is a standards issue.

Art Davidson commented to Faulkner on the need for involvement of many different people in addition to users in regulation. He acknowledged that he had learned something about CCDAs and registries when his state attempted to use CCDAs to refer to quit lines. He found that the CCDA is inflexible; there are no templates for selection. One would not want to send the entire medical history to a quit line. He asked that consideration be given to making the CCDA more flexible.

Egerman complained that proposals were being made without practical implementation experience, such as Davidson's example with CCDAs. These registries have not been tested for the capability to handle increased traffic. He went on to list comments on specific objectives. He was opposed to increasing the threshold on electronic notes. Patient education is no more than checking the box. On secure messaging, there are challenges with providers having multiple Direct accounts and messages remaining in inboxes. Tang said that workgroup members represent a vast breadth of experience.

DeSalvo acknowledged a conundrum. Meaningful use is only one of many tools to advance HIT to improve health care. This is not the last chapter. After making recommendations, there are many steps to go to Stage 3. A listening session will be held in May, and then the NPRM will be published. She told them that she was trying to anticipate the outcome of a vote in order to know whether to push for a vote. There are several options—calling a vote, postponing a vote, or declaring unanimous support with a list of areas for further thinking and/or areas of dissent. Bechtel declared that she wanted a vote, but she was unsure whether some changes had been accepted. She called for a list of amendments, but no such list was available. McGraw voiced opposition to postponing the vote. She suggested that the transmittal letter should capture the richness of the discussion and areas of dissent. She reported that the PSTT reviews and approves letters on difficult issues before they are signed. A staff member said that a transmittal letter could be composed and circulated to obtain track changes prior to its finalization. There could be an e-mail vote on the letter. Various participants emphasized that the MUWG had spent two years formulating the recommendations.

Jodi Daniel, ONC, reminded them that the HITPC can comment on the NPRM. Information from the listening session and Stage 2 data will be available to staff prior to writing the NPRM. There are many opportunities for input before the Final Rule. In response to a question, she said that the pace of Stage 2 attestation has yet to be known. She hoped that some information will be available by the end of the second quarter. Calman announced that he was in favor of voting. The NPRM can call out specific areas for comments, areas in which there is some dissent.

Lansky suggested that dissenters compose part of the transmittal letter, something like a minority report. Although he was not opposed to the recommendations, he considered them insufficient, something that cannot be captured in aye or nay.

Seagondollar declared that he was ready to agree with the recommendations with the understanding that they are not finished. Many groups are waiting for this step in order to move on with their work. Bechtel said that she wanted to vote on adding reminders and more granular standards for race and ethnicity.

Probst expressed willingness to vote on whether this is good list of recommendations, but he was concerned about the lack of opportunity to vote on proceeding with Stage 3. He may be forced to vote no because of the lack of facts and the timing being undoable.

DeSalvo indicated that she was in favor of putting the recommendations out there in order to obtain feedback on feasibility. She was also eager for the FACA to finish this work and take up broader issues. She reminded them that health care constitutes 20 percent of the U.S. economy. She called the question (to accept the MUWG recommendations on Stage 3). Bechtel then made a motion to put patient reminders back in the objectives. Her motion was rejected by Egerman, who referred to many reasons for removing the objective. One reason was the unreasonable burden on providers. Hripcsak said that the MUWG, of which Bechtel is a member, went through an extensive process, which resulted in the removal of that and several other objectives. DeSalvo called for a show of hands in favor, and opposed. Two members participating by phone voted no. Consolazio announced that the motion did not carry. The count was not announced.

> **Action item #2: A motion by Bechtel to return the objective on patient reminders to the list of recommendations was defeated by a showing of hands.**

Bechtel moved to use HHS instead of OMB standards on race and ethnicity for certification. Someone seconded. Calman pointed out that the committee had not seen that vocabulary. Doug Fridsma, ONC, agreed, declaring that it was an HITSC decision. Hripcsak suggested putting the topic in the letter as something to consider once the relevant IOM report is available. Bechtel withdrew her motion.. DeSalvo called for a show of hands in favor of advancing the MUWG recommendations. Staff announced that the recommendations were approved.

> **Action item #3: The Stage 3 recommendations presented by the MUWG were approved by a show of hands and voice votes of two members who were participating by phone.**

CMS Data Update

Elisabeth Myers, CMS, presented the monthly report on the meaningful use incentive program. As of January, the total number of active registrants was 488,750. The percentage of EHs registered is 93.8, and 89 percent have been paid. Approximately 60 percent of Medicare EPs are meaningful users of EHRs. Seventy-nine percent of Medicaid EPs have received an EHR incentive payment and 21 percent of Medicaid EPs are meaningful users. About two-thirds of Medicare and Medicaid EPs have made a financial commitment to an EHR. Over 347,000 Medicare and Medicaid EPs have received an EHR incentive payment. This quarter is a period of heavy attestation. CMS recently published adjusted deadlines for hardship exceptions. Information and applications are available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/paymentadj_hardship.html. Not being able to implement 2014 Edition software is another option for a hardship exemption; more information is forthcoming on required documentation for not being able to implement. There is a gap between certification date and availability date.

ONC Data Update

Following up on a request from the February meeting, Jennifer King reported on the achievement of the HITECH goal for the utilization of an EHR for every person in the United States. From the provider perspective, 78 percent of office based physicians and 93 percent of hospitals use EHRs. Fifty-three percent of office visits and 97 percent of hospital admissions are at providers with any EHR. A survey

commissioned by ONC in 2012 found that 65 percent of U.S. adults responded that at least one of their medical providers uses an EHR. But the 2012-13 HINTS survey reported 88 percent for a similar indicator. She emphasized that these data are on the use of any EHR, not advanced EHRs with meaningful use functions.

Q&A

Egerman wondered about ways to use the extant data to estimate population coverage with EHRs. For instance, patients of specialists that do not have records may indeed have EHRs from another provider. He opined that penetration may be more than 90 percent.

Health IT Workforce Standard Occupational Classification (SOC) Codes Update

Certification and Adoption Workgroup Co-chairperson Larry Wolf and Workforce Development Co-chairperson Norma Morganti reported on the activities of the Workforce Development Subgroup. Wolf explained the Standard Occupational Classification (SOC) and the role of the Department of Labor and OMB in classifying occupations. Classifications are based on a four-tier hierarchy. The subgroup is preparing to comment on the forthcoming proposed SOC revision and to offer specific recommendations on a new minor occupational category for health information technology workers. The current codes do not account for IT workers in the health care industry. The subgroup has yet to complete the detailed occupational descriptions. Members are currently collecting information and seeking advice from experts. Although Wolf was unable to answer a member's question about how the occupational data are obtained and used and the impact on an individual provider, he offered to return to the HITPC with answers. A member noted that defining and classifying occupations in the rapidly changing technology industry may be unrealistic.

Morganti showed slides on findings from the NORC evaluation of ONC-funded workforce programs. The slides were prepared and presented by ONC staff at the most recent meeting of the subgroup. The university based programs trained 1,704 students. The community college consortia trained 19,733 students, the majority online. Twenty curriculum components were designed and are available to the public. More than 9,500 proficiency exams were administered, but no information on pass-fail rates was compiled. Several conclusions were drawn. The rapid implementation posed challenges for structured communication channels. Developers said that more communication with the colleges and the HIT Pro Exam developer would have helped them better target the materials. ONC's decision to allow grantees flexibility was a great asset, according to grantees. The community colleges and universities were afforded significant latitude in structuring their curricula to meet their needs, capacities, and programmatic priorities. Participants appreciated the opportunity to use online learning platforms. Schools' efforts to forge connections with the employer community were of paramount importance to graduates' satisfaction and employment prospects. Many employers were unaware of the training programs; however, once they learned about them, they felt confident the training could fill gaps in the workforce. Programs with well-developed employer partnerships were better able to support students. The full report will soon be released and posted on the ONC website.

Morganti went on to report on a grant with which she was involved. Key competencies for patient centered medical homes were identified, followed by the design of tools and training. A practice fitness assessment and roadmap to practice transformation in Stages 1 and 2 were developed. These resources are available to the public. Wolf urged the members to examine the available resources.

Discussion

Terry Cullen said that the Veterans Health Administration (VA) is using the training resources. Fridsma said that E.U. representatives are working on occupational classification. This work can have an impact beyond the United States. Seagondollar asked about a category for analytics or analysts. Morganti said that one component of the training was population management and analytics.

Wolf reported that unpaid family care workers were not included, but the training resources can be used by anyone. He speculated that someone needs to attend to the training of family caregivers. Tang said that family caregivers should be in the classification system so that they can be counted.

Public Comment

Dan Rody, an independent consultant, reported that vendors sometimes remove functions certified at an earlier stage when they are not called out in the current stage. Physicians who have adopted these functions want to keep them. Specific instructions should be given to vendors. Another concern is that output given to patients may not be understandable. Understandability should be tested. He recommended conduct of an environmental scan prior to the 2017 Edition; functional codes are beginning to be used with Medicare patients and international standards are becoming available. He went on to say that the workforce educational materials should be made available through CBOs to family caregivers.

Mark Segal, EHR Association, advocated a more focused approach in Stage 2. The learnings from Stages 1 and 2 show that a prioritized approach using robust capabilities certified in Stage 2 is needed for Stage 3. The Stage 3 recommendations will impose burdens with uncertain value. Certification only is not cost free. He urged ongoing consultation with the vendor community. Tang thanked him for the EHR Association's assistance in estimating development efforts during the MUWG's deliberations on recommendations for Stage 3.

Diane Jones, American Hospital Association, called for a focus on implementation and action and less on aspirations. Attestation seems to be going slowly, indicating problems. EHs must implement so as not to endanger patients. ARRA does not specify a timeline. Therefore, the program should wait for data prior to proceeding with recommendations for Stage 3.

Martha Philastre for Bob Cline, Baylor Healthcare Systems, described advance directive efforts in that system. Everyone over age 18 should have a directive, which can be reviewed and updated in the event of serious illness. In the event of terminal illness, more care planning is required. Many advance directives come in formats that cannot be easily transmitted within or out of the system. Digital documents can be more easily transmitted. Version control is easier with digital directives.

Scott Brown, MyDirectives.com, read a statement urging the committee to take advance directives into the digital environment. He urged the removal of "or" in the recommended objective. Also, he cited several reasons for recommending advance directives for all patients over age 18—an August 2008 HHS report to Congress on advance directive, the HITPC September 23, 2013 hearing, and the position of his organization. He called for a more robust approach to digital directives, saying that according to the January 24 meeting of the HITSC, the necessary standards exist. He emphasized that the current age threshold is one of the reason for the failure of the widespread use of advance directives. If the age cannot be extended to 18, at least the objective should be applied to all Medicare patients. Consolazio called the three-minute limit.

Jeff Smith, CHIME, called for a prioritized approach. Only those measures that are tied to prioritized use cases for interoperability should be included in Stage 3. He called for less prescriptive means of attaining objectives. Although he appreciated the hardships announcement, hardship categories should be expanded to deal with timing, complexity and availability, which are fundamental deficiencies. He referred to a letter of February 21 to HHS.

Mari Savickis, American Medical Association, commented that she appreciated CMS' announcement on hardship exceptions, but they are not sufficient. The data presented by CMS on attestation do not take into account drop outs. A recent GAO report commented on the significant number of drop outs. In 2012, 61 percent of Medicaid and 16 percent of Medicare EPs dropped out. The government needs to assure providers that there is flexibility to prevent them from dropping out completely. She went on to comment about a need for increased interoperability.

Julie Wineberg, College of American Pathologists, said that the program still assumes that all specialists are the same. CMS gave pathologists some relief for the first year of Stage 2, but more time is needed. Only 4 percent of pathologists have attested, primarily those who work in large organizations; others have no control over decisions about EHRs. She asked for more consideration for the role of pathologists.

Lisa Connelly said that she is a patient who carries her paper record with her because the EHs in her area do not communicate. She requested that the committee listen to patients.

Jeff Coughlin, HIMSS, affirmed his organization's commitment to interoperability and HIE. Benefits and burdens must be balanced. HIMSS supports a less prescriptive approach for Stage 3. It is conducting a survey to identify Stage 2 hardships. He invited attendees to visit the new HIMSS value suite, which describes 1,000 case studies highlighting return on investments.

Tang thanked everyone.

Behavioral Health (BH) and Long Term and Post Acute Care (LTPAC) Certification Update

Steve Posnack, ONC, introduced the topic. ONC has released the NPRM for the 2015 Edition. The proposed rule was published in the Federal Register in February. ONC will accept comments on the proposed rule through April 28, 2014. The final rule is expected to be issued in summer 2014. The rule will allow for more flexibility and offer certification for BH and LTPAC EHRs.

Certification and Adoption Workgroup Co-chairpersons Larry Wolf and Marc Probst presented the report. Probst acknowledged that Wolf did most of the work. Wolf reminded the members that the workgroup was charged by ONC to recommend a process for prioritizing health IT capabilities for EHR certification that would improve interoperability across a greater number of care settings and that the recommendations shall take into account previously adopted ONC certification criteria and standards and identify the key heath IT capabilities needed in care settings by providers who are ineligible to receive EHR incentive payments under the HITECH Act. As previously reported, the workgroup recommended a five-factor framework for ONC to consider in determining whether to institute a new certification program:

- Advance a national priority or legislative mandate: Is there a compelling reason, such as a National Quality Strategy Priority, that the proposed ONC certification program would advance?
- Align with existing federal or state programs: Would the proposed ONC certification program align with federal/state programs?
- Utilize the existing technology pipeline: Are there industry-developed health IT standards and/or functionalities in existence that would support the proposed ONC certification program?
- Build on existing stakeholder support: Does stakeholder buy-in exist to support the proposed ONC certification program?
- Appropriately balance the costs and benefits of a certification program: Is certification the best available option? Considerations should include financial and non-financial costs and benefits.

After applying the framework to BH and LTPAC and as shown on the presentation slides, the workgroup concluded that voluntary certification of BH and LTPAC EHRs would be beneficial. Information on adoption and meaningful use certification of these EHRs was compiled by staff and considered by the workgroup. Two hearings were convened in December – January. The following certification criteria principles were used in formulating recommendations: leverage the existing certification program; voluntary, modular, interoperability (exchange and use across organizations); privacy and security (with enhancements); setting-specific needs (assessments, code sets, group documentation); alignment across state and federal programs; minimum burden; limited funding; and very heterogeneous provider group.

Wolf paused for questions on the approach. Sharfstein said that it is not clear what problems certification would alleviate. Certification would not help with public health issues such as abuse of prescription drugs. Much BH takes place in primary care settings, where integration is the objective. Wolf said that certification could contribute to coordinated care and ToC. Probst repeated that the said charge was to recommend on certification criteria, not to determine what would advance BH and LTPAC.

Cullen declared that she was fascinated by slides 10 and 14. She wondered whether certification would increase these numbers. Wolf responded that certification may have some effect on adoption, but most likely not a major impact. There is always the possibility that it could hinder adoption.

Egerman repeated an argument he made in the workgroup (slide 19). Care coordination is currently the only driver to adoption since no incentive payments will be offered. Therefore, certification should be more limited.

Faulkner announced that everything should be directed to the patient. Her company (Epic) consumed 350 person years and at least $50 million to prepare for Stage 2. Wolf observed that a modular approach should be less costly. The workgroup did not obtain unanimity for any to the recommendations. But the hearings indicated that providers really want guidance.

Westley Clark, SAMHSA (not an HITPC member), approved of the organizing principles. His agency is promoting integrated care. In addition to the initial cost, sometimes providers buy software that they cannot use. SAMHSA has developed some open source approaches. SAMHSA does not want providers to buy software. Providers are adopting ICD-10 in order to get paid for Medicaid and Medicare services.

DeSalvo told Faulkner that adoption would lower costs and achieve other goals needed to include all points on the continuum of care.

Lansky said that purchasers are concerned that BH data do not flow well. He pointed out additional provider types that could be included, such as EAP for BH. A quality measure framework could focus on closing the loop with BH referrals and measures of ToC and outcomes. He observed that the recommendations are restricted to a medical model.

Wolf continued with his presentation. He showed slides that described the certification criteria recommended for all BH and LTPAC providers:

- ToC
- Support the ability to receive, display, incorporate, create and transmit summary care records with a common data set in accordance with the CCDA standard and using ONC specified transport specifications. (reference: §170.314(b)(1) , 45 CFR §170.314(b)(2))
- **NEW** In addition, if approved by HHS for meaningful use, support the inclusion of emerging TOC and care planning standards being reconciled as part of August. HL7 CCDA ballot. [MUWG-identified MU 3 criteria].
- Privacy and Security: Support existing ONC-certified Privacy and Security requirements: § 170.314(d)(1) - Authentication, Access Control, and Authorization; § 170.314(d)(2) - Auditable Events and Tamper-Resistance; § 170.314(d)(3) - Audit Report(s); § 170.314(d)(4) – Amendments; § 170.314(d)(5) - Automatic Log-Off; § 170.314(d)(6) - Emergency Access; § 170.314(d)(7) - End-User Device Encryption; § 170.314(d)(8) – Integrity; § 170.314(d)(9) – Optional: Accounting of Disclosures

He went on. HHS should support educational awareness initiatives for LTPAC and BH providers, including how certification supports the technological requirements of HIPAA, however, compliance with HIPAA requires actions that extend beyond the ONC-certified privacy and security criteria.

The workgroup asked the PSTT to advise on the following enhancements to privacy and security:

- Use of the HL7 privacy and security classification system standards to tag records to communicate privacy related obligations with the receiver.
- Standards for controlling re-disclosure of protected data
- ONC should consider supporting equivalent functionality in Stage 3 for standards for communicating privacy policies and controlling re-disclosure of protected data.
- Developing consensus on standards for consent management functionality needed by providers, organizations (e.g. HIEs) to comply with diverse federal and state confidentiality laws , including the Data Segmentation for Privacy Standard

The workgroup also recommended LTPAC setting specific criteria for patient assessments, and survey and certification. For BH, it recommended for patient assessments and consent management. All of these criteria were listed on the presentation slides. Furthermore, the workgroup concluded that not all LTPAC and BH providers need the same certification capabilities. Through a modular approach, certification of other capabilities could support providers and help improve patient care. Those others are: clinical reconciliation, clinical health information, labs and imaging, medication related, CPOE, CDS, patient engagement, advance care planning, data portability, immunization registry reporting. The workgroup asked the QMWG to advise on quality measures. And there is more: The workgroup made the following additional recommendations.

- Past history: Absence of past history (such as surgical history) is an omission in ONC certification generally. Recommend for inclusion in MU, LTPAC, BH certification.
- Track trends: Recommend that ONC track national trends in LTPAC and BH health IT adoption. Such efforts should include tracking use by functionality and by criteria.
- National survey data: Recommend national survey data on LTPAC/BH EHR adoption and utilize definitions, as applicable, that are consistent with those used in ONC/CMS initiatives.

Discussion

DeSalvo asked that prisons and jails be included as settings of care. Cullen emphasized the need for standards and terminology.

Tang said that the presentation was long and detailed and that the recommendations could not be adequately discussed at this meeting. He said that the slides should be color-coded to represent changes from the existing situation. Also, the workgroup should look at the expected impact on developers and providers. The workgroup should focus on a few critical aspects. There is a lot of work remaining, which will probably require several months. When asked about time limits, Posnack responded that staff wants direction for its work on 2017. Tang suggested using the RFC process. Posnack said that the recommendations must be finalized no later than June to inform the next NPRM. NPRMs have very definitively timed steps.

McGraw indicated that the PSTT will need time to make recommendations pertaining to enhanced privacy and security.

Wolf asked for a broad sense of approval of the principles presented. He said that there may be two stages of work. The first is to consider constraints for 2017 and the second is what can be done more broadly, for example, to include jails. DeSalvo said that staff, led by Reider, is looking at the effectiveness and efficiency of the certification program and to expand it beyond a medical model. Wolf offered staggered deliverables, starting with the April HITPC meeting. He asked for a vote to accept the framework (step 1). Several members said that the framework had been approved at a previous meeting.

Public Comment

Tom Bizzaro, First Data Bank, asked for more consideration of the role of pharmacists, who have been using EHRs for more than 30 years.

SUMMARY OF ACTION ITEMS

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

Action item #2: A motion by Bechtel to return the objective on patient reminders to the list of recommendations was defeated by a showing of hands.

Action item #3: The Stage 3 recommendations presented by the MUWG were approved by a show of hands and voice votes of two members who were participating by phone

Meeting Materials

- Agenda
- Summary of February 2014 meeting
- Presentations and reports slides
- Advocacy letters received