HIT Policy Committee
Final
Summary of the April 8, 2014 Virtual Meeting

ATTENDANCE

Members present:

- Madhulika Agarwal
- Christine Bechtel
- Neil Calman
- Karen DeSalvo
- Paul Egerman
- Judith Faulkner
- Charles Kennedy
- David Kotz
- David Lansky
- Devin Mann
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Joshua Sharfstein
- Alicia Staley
- Robert Tagalicod
- Paul Tang

Members absent:

- David Bates
- Patrick Conway
- Arthur Davidson
- Scott Gottlieb
- Thomas Greig
- Gayle Harrell
- Aury Nagy

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 58th 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 an opportunities for public comment (limited to three minutes per person), and that a transcript will be posted on the ONC website. She called the role and instructed members to identify themselves for the transcript before speaking. Members introduced themselves.

Remarks

National Coordinator and Chairperson Karen DeSalvo thanked the members for their participation in recommendations for Stage 3. Staff is planning an opportunity for a listening session on Stage 3. There are several important items on the agenda.

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. Devin McGraw moved to approve the summary of the March meeting. Charles Kennedy seconded the motion. Tang said that he had submitted his edits to Consolazio. The motion was approved unanimously by voice vote.

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

Jodi Daniel, ONC, interrupted to say that the draft FDASIA report on HIT has been released for public comment on specific questions. She offered to present a complete briefing to the committee in May. Tang accepted the offer. A public meeting to receive comments will be held in May. One of the recommendations is to establish a public-private center to promote health IT safety. A center is included in the President's budget.

Family, Friends and Personal Representative Update by Privacy and Security Tiger Team (PSTT)

Team Chairperson Deven McGraw explained that under the HIPAA Privacy Rule, a person authorized under law to act on behalf of an individual in making health care-related decisions is the individual's personal representative. Subject to certain exceptions, the HIPAA Privacy Rule at §164.502(g) requires covered entities to treat an individual's personal representative as the individual with respect to uses and disclosures of the individual's protected health information (PHI), as well as the individual's rights under the Rule. After showing slides and explaining the current HIPAA requirements, she reviewed their intersection with view/download/transmit (VDT). Patients will have an interest in friends and family having access to their PHI through VDT. By law, patients can expressly authorize the sharing of their PHI with others. A legal personal representative may have legal right to directly access a patient's PHI. Under HIPAA, they stand in the shoes of the patient with respect to accessing PHI. Issues to be resolved before VDT access is granted include: identification and authentication of the individual or entity granted access; education of patients and providers on rights and responsibilities of personal representatives; authorization; and caution about sharing passwords. She emphasized that the recommendations pertain exclusively to adult patients; the team will consider minors at another time. The team recommended and urged that ONC develop and disseminate best practices for assuring that access to adult patient VDT be extended to friends and family authorized by the patient, and, where appropriate, legal personal representatives. Slides stated the best practices. In the easiest case when the patient requests VDT access for a friend or family member, it can be done in person or remotely. The providers should document the request. The capability to store electronically would be helpful and out-of-band notification can be used to notify and confirm. In the harder case in which a friend or family member makes a request, such access must be confirmed with the patient, such as through out-of-band confirmation. If the patient is incapacitated, HIPAA permits sharing of treatment-related information with friends or family, limited to information relevant to treatment. Whether someone qualifies as a personal representative depends on state law. Variations in state laws on personal representative access make it difficult to make uniform national policy and best practice recommendations. Providers should consider how they can adapt the processes they currently use for VDT to grant personal representative access to records. Capability to store documentation of personal representative status (as well as patient authorizations of access by friends or family) would be helpful. The patient can provide credentials or directly authorize the access. She noted that previous best practices for identity proofing and authentication also apply. Process and capability to cut off VDT access by friends, family, and personal representatives due to patient change in preferences or changes in personal representative legal status should be delineated. VDT accounts may offer more than all-or-nothing access for proxies, with both respect to data content and functions that can be performed. It is important to educate patients on whatever options are available, so they can make informed decisions about the scope of proxy access to be granted to friends and family. For personal representatives, ONC should disseminate best practices to providers to enable them to establish (and turn off) proxy access to VDT accounts consistent with law and patient needs. Providers also should educate their patients on the risks and benefits of VDT, consistent with the HITPC's prior recommendations; such education should include risks and benefits of proxy access. Tang called for discussion, saying that the recommendations do not constitute new policy, but only distribution of best practices.

Discussion

Paul Egerman inquired about the role of advance directives in situations of incapacitation. McGraw responded that insofar as HIPAA directs the provider to act in the best interest of the patient, an advance directive would be evidence for what the patient wants. State law probably affects the role of a personal representative regarding access to all, part, or none of the record. Egerman wondered about best practices to restrict certain information from others' access. McGraw talked about different levels of functions used by vendors for VDT. The team decided not to be directive, but rather to recommend education as to what friends and family can and cannot do. Egerman was concerned about turning off access to prescription refills at the patient's death and privacy of family history data. McGraw explained that under HIPAA family history is PHI of the patient. She agreed to add something to the transmittal letter about the need for education in this area.

Troy Seagondollar voiced concern about all-or-nothing access, an issue about which he thought there was insufficient analysis. An administrator of a VDT account could send invites to family and others to access the information. Rather than use of the term "may" in the recommendation, he preferred "shall," which would allow the patient to have a choice about granting levels of access. His family members coordinate different layers of health care for a parent and need to have access to different layers of information. McGraw said that the team did discuss a certification requirement, but agreed not to recommend it. Although granularity of access is desirable, the demand will likely be met by the market. Team Co-chairperson Micky Tripathi reported that input from vendors indicates that they are on the path of providing this granularity, but they are doing it in different ways.

David Kotz, a member of the team, recommended that a comment on revocation be added. McGraw referred him to slide 13. Tang talked about transmission to a third party being all or nothing. McGraw declared it to be an issue for information exchange.

Neil Calman asked who is responsible for all of this education. McGraw replied that the committee previously recommended that the provider offering the portal is responsible for education about its use. The committee also recommended that ONC provide materials to assist with education. Calman wondered who and how providers will be educated. Will all of this information about access to patient data be incorporated into medical education? If that is the expectation, it will not happen. Physicians are not good at education. McGraw agreed, saying that she could include something on educating provider staffs. Much more research is needed about how this education will occur in the workplace. She agreed to incorporate members' comments into the transmittal letter to ONC. Christine Bechtel moved to approve the recommendations for best practices, including the additional mention of topics raised during discussion. Judith Faulkner seconded the motion, which was then approved unanimously by voice vote.

> **Action item #2: The best practices recommended by the Privacy and Security Tiger Team and supplemented by members' comments were approved for transmittal to ONC.**

Update from Listening Sessions Convened by Information Exchange Workgroup

Workgroup Chairperson Micky Tripathi reported on the two listening sessions held with vendors and providers in February to identify readiness issues. Although this is early in the attestation period and the field has limited experience to date, the listening sessions were aimed at gaining insights into the initial experiences of vendors and providers. The vendor and provider panels agreed on two main challenges to meeting the TOC and VDT requirements. Exchanging data requires coordination and trust across a variety of players and the health care ecosystem is at an early stage of implementing ToC and VDT. Implementing the electronic sending and receiving of information will require significant workflow retraining and in some instances development of entirely new workflows for providers. But technology did not come through as a major issue in meeting the requirements for those who have implemented 2014 CEHRT. Nevertheless, the issues described during the listening session could impact the ability of some providers to attest for Stage 2 this reporting period. Many specific comments were reported in support of those conclusions. Providers are worried that they will not have sufficient trading partners ready in time to meet the 10 percent electronic requirement. For some rural providers, their only trading partners in the community are ineligible providers. Health systems with closed environments that are primarily served by a single EHR are relying on transitions to LTPAC providers. Providers are actively working with their referral partners to address this through outreach and education. Some providers and their vendors are actively recruiting referral partners into their HISP to make them Direct-accessible. Some providers are even purchasing Direct end-points for their non-MU eligible trading partners to help meet the measure. Regarding HISP-to-HISP interoperability, several panelists referenced participation in DirectTrust or establishing one-off contracts as their approach to enabling exchange across disparate HISPs. The lack of common widely deployed provider directory standards or common directory infrastructure makes it difficult to find addressing information. Providers who practice at multiple organizations are receiving different Direct addresses at each organization often from different HISPs. Panelists were confused about what counts as a valid ToC. They raised workflow retraining as one of the most significant factors in implementing ToC, requiring from 30 days to six months to rework existing workflows. Provider organizations need to work through how to best integrate the ToC documents into their existing care referral processes to limit the sending of redundant data. Providers have developed new workflows to receive and manage inbound electronic care summaries. Some panelists stated that their organizations are creating central facility inboxes managed by the Health Information Management (HIM) department, which receives the messages and then route to the appropriate provider. Often, a transition of care is to an organization rather than a specific provider within the organization. The organization then will decide to which provider to route the patient or information. In contrast to ToC, view and download seem to be well understood and implemented by providers and vendors. The transmit requirement posed the biggest challenge. Overall, panelists thought the VDT measure would not present a significant challenge for providers because patients are using view and download and there is little demand to transmit to third party applications at present. HISP-to-HISP interoperability is a problem for patients. If trust is not established between two HISPs, a patient is not able to transmit information to the desired endpoint. This is a concern many providers and vendors have, and they anticipate it will be a challenge for patients looking to transmit their data. Use of the C-CDA as a single content standard has helped drive standardization and eased implementation of VDT. Some technical issues still arise with vendor implementations of C-CDA, but they are being worked out through testing and actual use. Provider outreach to patients to inform them about the portal is a key step to meeting the 5 percent measure.

Discussion

Saying that he had listened to or read the testimonies, Egerman added comments that he said he recalled. At this time, patients are not using VDT to transmit their records. If they did transmit, physicians would probably not know what to do with them. Regarding ToC, a check-off will not change behavior. Egerman went on and referred to the 2015 Edition NPRM and Direct protocols and suggested that standards that are currently not working well are being considered for certification. Tripathi agreed that providers and vendors are unhappy with transmit. At least one panelist was very dissatisfied with the protocol itself.

Data Review—CMS Update

Elisabeth Myers, CMS, gave the monthly report on active registrations and payments. Stage 1 attestation ended March 31. Accumulative attestation data are incomplete and do not take into account such variables as changes in eligibility or EP retirement. Overall, 94 percent of EHs have registered, and more than 90 percent have been paid; 56 percent of EPs have registered. For the 2011 cohort, 63,000 attested in year 1, 114,000 in year 2, and 47,000 in the third year for a total of 224,000. Fourteen thousand Medicare meaningful users from 2011 did not return to attest in 2012, representing 25 percent of Medicare early adopters who did not return to attest after the first reporting year. But in 2013, 57 percent of these providers returned to attest. Eighty-five percent of Medicare early adopters have successfully attested for 2011, 2012, and 2013. Concerning the 2012 cohort, 114,000 providers who successfully attested in 2012 returned to attest in 2013, representing 86 percent of the 2012 cohort and a reduction to 14 percent of new providers who did not return to attest after the first reporting year.

Overall, more that 65 percent of Medicare and Medicaid EPs have made a financial commitment to implementation and 355,000 have received an EHR incentive payment. Myers concluded that the overall trends in participation are very encouraging. Tang agreed.

Egerman asked whether Stage 2 is off to a slow start. Myers declined to speculate in the absence of data. Egerman expressed concern about the low number (20) of EHs that have attested this year. Myers responded that as discussed at a previous meeting, there were problems with software readiness for Stage 2. Faulkner said that providers are reporting they must spend a huge amount of time on implementation.

Data Review—ONC Update

Jennifer King presented information on the results to date of Stage 1. The majority of EPs (56 percent) and EHs (83 percent) have attested to Stage 1. Those EHs account for 90 percent of U.S. beds and 93 percent of Medicare discharges. She referred to her slides that listed core and menu items by percentage of objective score at attestation to show that most attesting providers far exceeded minimum Stage 1 requirements. As with data provided in previous months, attestation rates vary by EH type and EP specialty. Small rural EHs have the highest rate (>90 percent) and small urban EHs the lowest (>70 percent). Interestingly, EPs do not vary by urban-rural. Most attestations occur in the third and fourth quarters, timing which affects the availability of data for analysis. She presented an estimated timeline for the analysis and presentation of program monitoring and evaluation data from AMA surveys, attestation reports, and AHRQ-supported research.

Members had no questions or comments.

HIT Policy Committee Workplan Review

DeSalvo explained that ONC is congressionally mandated to update its HIT strategic plan, and will adjust its organizational structure to align with overall goals and available resources. After reminding them of the committee’s authority and scope, she referred to a slide listing the Federal HIT strategic plan 2011 – 2015 goals:

- Achieve adoption and information exchange through meaningful use of health IT
- Improve care, improve population health, and reduce costs through the use of health IT
- Inspire confidence and trust in health IT
- Empower individuals with health IT to improve their health and the health care system
- Achieve rapid learning and technological advancement

ONC priorities were to:

- Evolve from ARRA structure of the ONC
- Formulate the Federal HIT Strategic Plan
- Develop national consensus agenda
- Health information exchange, use and infrastructure a priority focus
- Meaningful use
- Advance HIT tools in support of the triple aim

She proposed these global policy issues for the committee to consider over the next decade:

- Supporting advanced care models (i.e., health reform)
- Completing EMR adoption across the care spectrum
- Using policy levers to support health information exchange and use
- Supporting consumer engagement and disparities reduction
- Improving certification process
- Moving towards a CQM platform for more agile and efficient incorporation and reporting on CQMs

She proposed a new committee structure to work on the global policy issues consisting of workgroups on: HIT strategic planning; advanced health models and meaningful use; HIT Implementation, usability and safety; and interoperability and health information exchange. The Privacy and Security Tiger Team and the Consumer Empowerment Workgroup will be retained to work across the other groups. She went on to show slides that described the scope of each group and the topics each would consider. Beginning with HIT strategic planning and interoperability and HIE in May, the transition to the new structure is projected for completion in August. She emphasized that there is time for considering scope and membership. Everyone is welcome and needed. Ongoing work will not be disrupted. She welcomed comments at the meeting or by email.

Discussion

In response to several questions from Bechtel, DeSalvo said that the topics listed per group are meant to be included, but not to limit. The area of consumer empowerment affects everything and is rapidly changing. She asked members to let her know about major topics that are missing in the lists. Bechtel asked about membership, saying that more consumers should be included. DeSalvo said that no decisions have been made. In general, she wants technical expertise to be distributed across the workgroups, including consumers. Staffing is moving to a more matrix structure as well. Daniel reminded members about the opportunity and process for nominations for the committee and workgroups, including self-nominations. She is interested in suggestions for increasing consumer participation. Bechtel suggested that members take responsibility for reporting back to other groups, possibly using a monthly summary of activities so that they would not have to attend all meetings. Tang suggested listening to the recordings.

David Lansky asked about public health and improvements in population health. All groups should be focused on the same goals with a mechanism for monitoring national goals. There should be a place to capture customer interests and a way to include outsiders. The current focus on EHRs must be balanced with broader policy. The main question is where the committee fits with broader policy. Tang said that this is an opportunity to look beyond meaningful use to triple aim. DeSalvo said that Lansky's points will be part of the strategic planning process. She acknowledged that incorporation of public health and big data requires additional thought. A draft HIT strategic plan will be released in July. She repeated her willingness to receive feedback.

Accountable Care Workgroup Update

Workgroup Co-chairperson Charles Kennedy said that the group took a broad perspective beyond meaningful use. The workgroup has been meeting since April 2013 to make recommendations on how ONC and HHS can advance priority health IT capabilities in a variety of accountable care arrangements to support improvements in care and health while reducing costs. These are a preview of recommendations and action on this preview is not expected. After showing slides and describing the overall framework, Kennedy asked Co-chairperson Grace Terrell to begin the presentation of recommendations in the six areas.

HIT adoption and infrastructure:

- Strengthen requirements around the adoption of HIT for participants in more robust accountable care models (e.g. two-sided risk model under MSSP)
- Elicit additional detail around HIT infrastructure planning from applicants to accountable care programs
- Expand the Advance Payment Model within the MSSP permanent program
- Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible

Access to administrative and encounter data:

- Encourage the development of state-level all-payer claims databases to support accountable care arrangements (inclusive of Medicare and Medicaid)
- Explore mechanisms for facilitating the flow of behavioral health claims data and other sensitive data that are subject to additional privacy protections to ACOs and other providers
- Make Medicare eligibility and benefit determination data on attributed patients available to accountable care organizations to ensure providers aware of patient health needs
- Develop and disseminate a scalable model for delivering timely electronic patient event notifications to concerned providers supported by admission, discharge, and transfer data
- Drive progress on standardization and capture of social determinants of health data elements that are most critical to accountable care delivery models

Exchanging data across the health care community:

- Set expectations that hospitals and health systems participating in federal accountable care models must participate in health information exchange activities
- Specify within hospital survey and certification standards that institutions must electronically transfer discharge summaries to treating providers in a timely manner
- Increase public transparency around hospitals and health system performance on measures related to health information exchange
- Issue additional guidance around sharing of information protected under 42 CFR Part 2 across participants in an accountable care organization

Data portability:

- Pursue greater specificity in federal interoperability standards around transactional data.
- Strengthen data portability elements in certification criteria
- Develop future certification criteria to promote access to EHR data by other types of HIT systems to support population health management, operations, financial management, and other uses
- Increase availability of data from remote monitoring devices to engage patients more deeply in their care

Clinician use of data and information to improve care:

- Create a task force to accelerate the development and adoption of standards-based electronic shared care plans across federal programs
- Develop pilots to test different shared care plan models
- Improve the impact of clinical decision support (CDS) tools by measuring effectiveness
- Increase the sensitivity and specificity of CDS algorithm tools by encouraging standards that will support the incorporation of comprehensive data from multiple sources

The workgroup made recommendations on an additional category not specifically delineated in its charge – streamline administration of value-based programs:

- Align quality measures across all relevant HHS agencies and with private payers

- Articulate HHS’ future strategy around the infrastructure needed to integrate claims and clinical data to support accountable care
- Develop and promote a common standardized methodology and approach to attributing patients in the ACO environment across all payers and providers
- Develop standards for administrative procedures to reduce variation in provision of care for ACOs and other providers
- Conduct a review of current regulatory burden on providers

Discussion

Tang declared that the approach fit well with DeSalvo’s restructuring plan.

Faulkner inquired about a reference to business imperatives. Terrell said that during the public hearing, providers complained that things needed by ACOs are not provided in the market. For example, they need to share information across silos and EHRs are based on episodic care. Kennedy said that he heard from physicians that once vendors have their business, they have no further incentive to do a good job. According to Faulkner, the issue is how to create a business incentive for vendors. She went on to ask about a comment on the use of software by other parties, which can be done in many ways that vary in safety. Kennedy replied that EHRs may be thought of as the source of truth. ACOs may pull data from EHRs for analysis and the results may or may not be accurate. Standards for pulling data from EHRs may be needed to ensure their safety, reliability and actionability.

Seagondollar commented that the care plan verbiage recognized its interdisciplinary nature. But he was concerned about an overall message that the care plan is not standardized. It is very well standardized in the nursing profession. The plan is the mechanism for sharing information within and across health care occupations and care settings. He suggested that representatives from nursing and other occupations be invited to educate committee members. Nurses take information from each member of the team and incorporate it into the plan. Terrell said that the workgroup was primarily concerned with the technology for integration. Seagondollar agreed that the current technology has limitations.

Lansky talked about the importance of quality measurement and accountability requirements from the perspective of the purchaser. It may be necessary to go back into certification and meaningful use to accommodate these needs. Managing cost requires not only claims data but real time cost information. For quality measurement, certification must ensure that the EHRs can capture the necessary data elements. He said that he approves of the overall approach taken by the workgroup. Kennedy agreed that cost data are important, although the workgroup did not consider that topic.

Egerman agreed with Lansky on the need for measuring and reporting on quality. He pointed out that the workgroup membership does not include vendor representatives. Kennedy informed him that vendors were included in invited testimonies in which a variety of opinion was expressed.

Calman declared that he will use the slides in his own presentations. The notification process is critical to PCPs. Standards for social determinants are much needed. He indicated some disagreement with the recommendation on participation requirements. Participants in an ACO should not necessarily have to be meaningful users. He went on to comment on the combining of clinical and claims data, which may raise privacy concerns for both providers and patients. Patients often believe that they should have some control over the sharing of their information. Although such data may be important for managing cost, cost is not the sole concern. The issue merits discussion. Due to their employers’ choices, patients do not always have a lot of choice in their selection of providers. Providers do not want their rates revealed to patients. He suggested that the topic be referred to the Privacy and Security Tiger Team. Terrell described the ways in which such information contributes to good clinical care; it is more than a matter of cost.

David Kotz observed that home monitoring devices raise issues of privacy as well. He asked for a discussion. Tang promised to refer the issue to the PSTT. Terrell said that the workgroup was speaking about data that are pushed, not pulled. This is not behavior monitoring. Tang pointed out that everyone agrees on the benefits. Nevertheless, education is needed.

Public Comment

No public comments were given.

SUMMARY OF ACTION ITEMS

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

Action item #2: The best practices recommended by the Privacy and Security Tiger Team and supplemented by members' comments were approved for transmittal to ONC.

Meeting Materials

- Agenda
- Summary of March 2014 meeting
- Presentations and reports slides