Health IT Policy Committee
A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

HIT Policy Committee
FINAL
Summary of the December 9, 2014 Virtual Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) meeting. She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with an opportunity for public comment (limited to 3 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.

Remarks

National Coordinator and HITPC Chairperson Karen DeSalvo thanked everyone for the work involved in the Strategic Plan to date. The Plan and the Interoperability Roadmap are important for sharing data.

Review of Agenda

Vice Chairperson Paul Tang noted the agenda items. The agenda was distributed in advance of the meeting. He asked for a motion to approve the summary of the November meeting as circulated. Deven McGraw so moved and the motion was seconded by Troy Seagondollar. The motion was approved unanimously by voice vote.

> **Action item #1: The summary of the November 2014 HITPC meeting was approved unanimously by voice vote.**

Data Updates

Elisabeth Myers, CMS, gave a brief monthly report on registrations and payments. Through October 2014, active registrations in the EHR incentive program totaled 505,641. Medicare payments to date total $16,683,444,117. As of November 1, 43,898 EPs had successfully attested for 2014, of which 15,481 were new participants and 11,478 attested to stage 2. 1903 EHs successfully attested for 2014. There were 221 new participants and 840 attested to stage 2. By December 1, 2014 attestations increased substantially. 60,561 EPs successfully attested for 2014, including 17,046 new participants and 16,455 that attested to stage 2. 3696 EHs successfully attested for 2014, 292 new participants and 1681 to stage 2.

Q & A

Aury Nagy inquired about software for direct submission of data to Medicare. Myers indicated that software may be in development. She offered to inquire and to report back. However, she pointed out that software for direct reporting does not directly relate to attestation under the incentive program.

Seagondollar acknowledged that he was perplexed with the definition of EP. Myers explained that EP is defined in HITECH. There are 22 subcategories of EPs. Staff queries the system to identify potential eligibles and look at total claims submitted. Seagondollar wondered about EPs who have opted out. Myers explained that opt-out is not an option. All providers are required to participate. They elect or do not elect to participate. Non-participants will be more clearly identified in the future because there may be adjustments to their payments. Staff is working on hardship exceptions. The hardship exception was recently reopened. It is not possible to determine the number of stage 1 participants that are not participating in stage 2. Because of the flexibility added this year, some EPs scheduled to attest to stage 2 have been allowed to continue to attest to stage 1. The extent to which stage 1 participants are not moving to stage 2 will not be known until February.

Federal Health IT Strategic Plan 2015 – 2020

Tang stated that issues for consideration are: Does the Plan address the broad goal of health? What are the gaps in execution that government can help with? Which actions belong in the private sector and which in the public sector? He said that the Strategy and Innovation Workgroup, with two members to be appointed from the HITSC, will review the Plan and submit comments to the HITPC for action. The Plan is available on the website. Seth Pazinski, ONC, explained that the National Coordinator has statutory authority for updating the HHS Plan. The Federal Health IT Advisory Council, Health IT Strategy and Innovation Workgroup, and the public will provide input, along with a long list of federal agencies. Strategic direction consists of the following: expand adoption of health IT; advance secure and interoperable health information; strengthen health care delivery; advance the health and well-being of individuals and communities; and advance research, scientific knowledge, and innovation. The Plan contains a mission statement, vision, and principles, all of which were shown on the slides. The Plan will delineate 3-year and 6-year outcomes that mix metrics and milestones and identify the relevant participating federal agencies. The public comment period ends February 6. This is a federal plan for federal activities. ONC released the *Federal Health IT Strategic Plan 2015-2020* for public comment on December 8.

Q & A

Regarding the inclusion of PGHD from devices, Pazinski referred to objective 4.a. David Lansky pointed out that the goals are not quantified and wondered how the Strategy and Innovation Workgroup can be helpful regarding measures. He also inquired about the discrete federal role. Pazinski said that the next step is the development of metrics and milestones. The workgroup can help by recommending outcome priorities and the goals on which to focus. DeSalvo added that the workgroup could identify opportunities for the private sector to be helpful. Tang felt a wonderful job was done, saying that the Plan is very comprehensive, precise and forward looking.

Capturing Social and Behavioral Domains and Measures in Electronic Health Records (EHRs): Institute of Medicine Committee on Social and Behavioral Domains and Measures for EHRs

William Stead and George Hripcsak reported that the committee was asked to: identify domains for consideration by ONC for stage 3 meaningful use; determine criteria for selection; identify domains and measures for inclusion in all EHRs; consider implications of incorporating recommended measures into all EHRs; and identify Issues in linking other data systems. The members selected three frameworks, Ansari et al., Kaplan et al., and MacArthur Research Network on SES Health Model for analysis. The models distinguish characteristics that influence health that reside at five levels: socio-demographic, psychological, behavioral, social relationships and living conditions, and physical and social environment. The five levels with 31 domains were identified for consideration. Two criteria were used to identify candidate domains—strength of the evidence of the association of the domain with health and usefulness of the domain. They showed slides to explain how the committee compared measures along two dimensions to select a parsimonious panel. They identified 31 validated measures for 17 candidate domains and eventually reduced this to 12 measures of 11 domains based on members' ratings of readiness and usefulness. A slide summarized the domains, the number of questions for each measure, and the frequency of screening that the committee suggests. Domains currently routinely collected are alcohol use, race and ethnicity, residential address, and tobacco use. Stead summarized the key findings and corresponding recommendations.

> Four social and behavioral domains of health are already frequently collected in clinical settings. The value of this information would be increased if standard measures were used in capturing these data. ONC and CMS should include in the certification and meaningful use regulations the standard measures recommended by this committee for four social and behavioral domains that are already regularly collected: race/ethnicity, tobacco use, alcohol use, and residential address. The addition of selected social and behavioral domains, together with the four domains that are already routinely collected, constitute a coherent panel that will provide valuable information on which to base problem identification, clinical diagnoses, treatment, outcomes assessment, and population health measurement.
>
> ONC and CMS should include in the certification and meaningful use regulations addition of standard measures recommended by this committee for eight social and behavioral domains: educational attainment, financial resource strain, stress, depression, physical activity, social isolation, intimate partner violence (for women of reproductive age), and neighborhood median-household income.
>
> Standardized data collection and measurement are critical to facilitate use and exchange of information on social and behavioral determinants of health. Most of these data elements are experienced by an individual and are thus collected by self-report. Currently, EHR vendors and product developers lack harmonized standards to capture such domains and measures. ONC's electronic health record certification process should be expanded to include appraisal of a vendor or product's ability to acquire, store, transmit, and download self-reported data germane to the social and behavioral determinants of health.
>
> The addition of social and behavioral data to EHRs will enable novel research. The impact of this research is likely to be greater if guided by federal prioritization activities. Office of the Director of NIH should develop a plan for advancing research using social and behavioral determinants of health collected in electronic health records. The Office of Behavioral and Social Science Research should coordinate this plan, ensuring input across the many NIH institutes and centers.
>
> Advances in research in the coming years will likely provide new evidence of the usefulness and feasibility of collecting social and behavioral data beyond that which is now collected or which is recommended for addition by this committee. In addition, discoveries of interventions and treatments that address the social and behavioral determinants and their impact on health may point to the need for adding new domains and measures. There is no current process for making such judgments. The Secretary of HHS should convene a task force within the next 3 years, and as needed thereafter, to review advances in the measurement of social and behavioral determinants of health and make recommendations for new standards and data elements for inclusion in electronic health records. Task force members should include representatives from

the ONC, CMS, AHRQ, PCORI, NIH, and research experts in social and behavioral science. The full report is at iom.edu/ehrdomains2.

Q & A

Regarding validated measures, Tang wondered about flexibility when scientific evidence changes over time. Referring to a question about talking on the telephone as part of a measure of social isolation, he said that that form of interaction is becoming passé. Stead said that the committee used the concept of common metric, as a part of PROMIS. This is the idea that certain domains have a common metric. And validated measures can be converted to scores. The common metric provides for interoperability as measures themselves change over time. These measures can be converted to SNOMED codes. Hripcsak noted that one recommendation deals with reconvening the group over time to consider new evidence.

Lansky asked about readiness, the value of having uniform national definitions, and accessing these applications in the cloud and drawing on different architectures for the measures. Stead responded that the committee assumed if a measure is available, it would be included. If not available, it should be collected, ideally at the practice with a longitudinal relationship with the patient. Measures in the recommended panel should work together to provide a concise picture. He recognized that depending on the situation and patient, other measures should be collected. Hripcsak noted that readiness is defined in the report and is based on ratings. The report contains other measures worthy of consideration. Their committee is looking into a tool kit for the standard measures.

Christine Bechtel acknowledged that she has not read the Roadmap. The point about a gap in connecting patients and families to community resources, and the possible requirement of two-way consent, is of interest to the Consumer Workgroup. Stead said that there may not necessarily be a gap; but ways to make connections are needed. Public input was obtained through four sessions. Hripcsak said that it was believed that there should be no surprises to patients and families. Bechtel opined that gaps exist.

Anjum Khurshid asked about the census tract median income measure and wondered about reimbursement of providers for collecting these data. Stead replied that the committee made no recommendations about compensating providers for the additional time to acquire and record data on these variables. He noted that ACOs compensate for population management. With regard to median income, the recommendation is to geocode patient’s address. Providers need to learn how to bring in geocoded data. Median census tract income is a proxy measure.

Interoperability Roadmap Draft Recommendations

Interoperability and Health Information Exchange Workgroup (IOWG) Chairperson Micky Tripathi presented recommendations for HITPC action. He explained that the recommendations are based on the draft Roadmap. Once another version is available, the IOWG will conduct another review and make recommendations as needed. After repeating some of the information provided in previous meetings, he showed slides that set forth more detailed recommendations in six general areas.

> **The Roadmap should explicitly endorse and map to the JASON Task Force Report recommendations for c**oordinated architecture and Public APIs. Key elements are: loosely coupled architecture connecting disparate data sharing arrangements; Public API which has a technical component (data-level and document-level access) and a policy component (terms for accessing APIs across entities); and FHIR as the current best candidate for the Public API.

The Roadmap should identify specific market motivating implementation actions that the federal government could/should/will take to promote interoperability. The Roadmap should create a framework for describing federal orchestration of the many levers that it has at its disposal. We recommend aligning the Roadmap with the JASON Task Force report, which provides a framework for escalating government actions to motivate the market.

The Roadmap should define meaningful measures of interoperability status and progress. Each milestone should be tied to a measure. The measurement focus should be on outcomes as much as possible with a decreased emphasis on transactional and process measures. This is a highly complex area with much thought to be given about the balance and feasibility of outcomes versus transactional or process measures. The IOWG will provide recommendations on principles for interoperability measurement in our recommendations on v1 of the Roadmap.

The Roadmap should be a prescriptive document although it is yet to be decided whether the level of detail is directional or specific. The road to interoperability will require hard decisions where uniformity or reduced optionality is required and the ecosystem has taken multiple differing approaches. The outcomes of these decisions will necessitate rework by some stakeholders. Careful consideration should be made around these important and necessary decision points. A glide path should be outlined for stakeholders who will need to make changes to align with the selected direction.

Map actions to actors. The Roadmap should explicitly call out the actors who will be expected to implement the various actions and milestones outlined in the Roadmap. This will help coordinate actions across the ecosystem and help reduce duplicate efforts.

During the IOWG deliberations a number of specific items were identified that the group would like to see added to the Roadmap. Orders is a big gap in vocabularies and needs to be addressed. The Roadmap should outline steps to address this need. The Roadmap should make clear that existing approaches will continue to be refined to serve ongoing needs and to fill specific gaps. Registries have a continued important role to play in the ecosystem and should be appropriately represented in the Roadmap. Existing approaches (NCPDP, XCA/XDS, etc.) will continue to serve specific purposes and be refined by users accordingly.

Discussion

Anjum Khurshid asked about the interoperability goals applying to vendors and providers versus patients and small practices. Tripathi recalled that the Roadmap outlines objectives for both patients and providers. Referring to Google Earth and Google Map, Khurshid wondered about macro-level interoperability and whether the final recommendation will help beneficiaries go from point A to point B. Tripathi responded that certain specific elements probably could be accelerated because of the speed of the market. The Roadmap could benefit from more structure on the different levels of interoperability to serve specific uses and users.

Hearing no more questions, Tang asked for motion to approve the recommendations presented by Tripathi. Lansky so moved and Gayle Harrell seconded the motion. The motion was approved unanimously by voice vote.

Action item #2: The IOWG recommendations for the Interoperability Roadmap were accepted unanimously.

Public Comment

None

SUMMARY OF ACTION ITEMS

> **Action item #1: The summary of the November 2014 HITPC meeting was approved unanimously by voice vote.**
>
> **Action item #2: The IOWG recommendations for the Interoperability Roadmap were accepted unanimously.**

Meeting Materials

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

Meeting Attendance	
Name	**12/09/14**
Alicia Staley	X
Anjum Khurshid	X
Aury Nagy	X
Charles Kennedy	
Chesley Richards	
Christine Bechtel	X
Christoph U. Lehmann	
David Kotz	
David Lansky	X
David W Bates	
Deven McGraw	X
Devin Mann	X
Gayle B. Harrell	X
Karen Desalvo	X
Kim Schofield	X
Madhulika Agarwal	
Marc Probst	X
Neal Patterson	X
Patrick Conway	
Paul Egerman	
Paul Tang	X
Scott Gottlieb	
Thomas W. Greig	
Troy Seagondollar	X
Total Attendees	**14**