HIT Policy Committee
FINAL
Summary of the March 10, 2015 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 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. Members introduced themselves.

Remarks

National Coordinator and HITPC Chairperson Karen DeSalvo said that the ONC Interoperability Roadmap comment period is still open. She is looking forward to reviewing comments and working with federal partners to finalize the HHS Strategic Plan. She introduced Tom Mason, chief medical officer.

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 summaries of the January and February meetings as circulated. A motion was made and seconded. The motion was approved unanimously by voice vote.

> **Action item #1: The summaries of the January and February 2015 HITPC meetings were approved unanimously by voice vote.**

Data Updates

Elisabeth Myers, CMS, showed slides and gave her standard monthly report on registrations and payments. Through January 2015, 519,966 active registrations are in place. As of March 1, 209,369 EPs successfully attested for 2014. 36,435 were new participants (program year 1). 153,002 EP attested to stage 1 and – 56,367 to stage 2. 125,262 are scheduled to attest to stage 2 in program year 3 and beyond.

Dawn Heisey-Grove, ONC, reported on characteristics associated with meaningful use performance among eligible hospitals. She reminded them that providers must complete 2 years of stage 1 before progressing to stage 2. On average, stage 2 hospitals are sending electronic summaries of care for 36% of all transitions. Critical access hospitals reported the highest summary of care rates. On average, 44% of transitions from CAHs received an electronic summary of care. Large hospitals (400+ beds) reported the lowest provision rate of electronic summaries of care. On average, 32% of transitions from large hospitals received an electronic summary of care. 15% of stage 2 hospitals' patients viewed, downloaded, or transmitted their electronic health information at least once. Hospitals that have been

meaningful users since 2011 have the highest average rates (18%) of VDT. With an average of 17%, hospitals that attested in November had the highest rates of patients viewing, downloading, or transmitting their electronic health information at least once. On average, 70% of medications administered in stage 2 hospitals had all doses tracked through an electronic medication administration record (eMAR). Medium-size hospitals and hospitals that first attested to meaningful use in 2011 reported the highest average eMAR tracking rates. The e-prescribing measure is an optional measure in stage 2. On average, hospitals that selected this measure used e-prescribing for 56% of all permissible discharge medications. Of the hospitals that selected the measure, CAHs and other small hospitals reported the highest average discharge eRX rates at 64%. Of the hospitals that selected the measure, medium-size hospitals had the lowest average discharge eRx rates at 48%. Three public health measures are required reporting for stage 2; these were optional for stage 1. 72% of stage 2 hospitals reported, without exclusion, on all three public health measures. 5% of stage 1 hospitals reported, without exclusion, on all three public health measures.

Q & A

David Lansky observed that this positive story should be told more widely. In response to his questions about the designation of thresholds and to what extent patients are using VDT, staff reminded him that no patient level data are collected through meaningful use. The relatively high rate of transmissions for CAHs may be due to their size and the number of interfaces required to transfer patients.

Paul Egerman wondered whether providers were just meeting the thresholds for transitions of care: What is the median? Heisey-Grove recalled that the majority fell within the 20 to 60% range. VDT cannot be broken into its three components to determine the prevalence of each.

Chris Lehmann referred to the public health measures and inquired about barriers. Heisey-Grove said that a lot of exchange between hospitals and public health agencies is not captured in meaningful use reporting. Nor is there information on the impact on public health agencies. Myers reported that CMS works with a number of quality measures organizations. She suggested that the committee invite a presentation from these organizations.

Chesley Richards suggested that CMS and ONC staff work with public health officials to describe the impact of meaningful use on public health. Public health agency capacity is increasing. Currently, 70% of lab reports are received electronically. Meaningful use has been transformative for public health.

Big Data Hearing Update

Privacy and Security Workgroup Chairperson Deven McGraw and Co-chairperson Stanley Crosley reported on the deliberations. McGraw went through a number of slides summarizing the big data back story and then told about a hearing convened in December 2014 on privacy and security issues, concerns, and potential barriers to progress and innovation as well as potentially harmful uses of big data related to privacy. At that hearing, a number of concerns were raised about de-identification of data. Crosley described those concerns. Possible solutions were listed:

- Context should drive re-identification risk reduction measures
- Consistent de-identification standards for all personal data
- Define standards and best practices for expert determination, such as OCR-led public-private collaboration and publication of expert statisticians
- Certification or accreditation for de-identification experts
- Automate statistical expertise as an easy and affordable alternative to safe harbor
- Legislation to prohibit and establish penalties for re-identification

- Regulation to require re-assessment of re-identification risk when datasets are combined
- Regulation to impose security requirements (commensurate with risk) to protect de-identified data
- OCR to re-evaluate Safe Harbor
- Reduced requirements for de-identification in certain validated research circumstances and environments

Concerns about consent were also topics at the hearing. Within the HIPAA context, the workgroup focused on research and whether HIPAA and the Common Rule appropriately advance innovation and learning. External to HIPAA, topics such as scalability of consent, the increasing scope of health-related data, and the difficulties of determining the expected uses of non-HIPAA data were considered. Concerns common to both environments were limited choice of all or nothing, limitations of granular choice, persistent consents, and over-reliance on consent. Possible solutions in the HIPAA environment are to refine the ANPRM recommendation on consent for research, IRB consent waiver for low-risk research, and no consent in situations of transparency and appropriate use. In a non-HIPAA environment, the requirements for consent could be assessed, FIPP could be followed, and/or conditional consents in combination with education of consumers could be considered. McGraw went on to report on another hearing, this one held in February on security. Key themes were:

- Maintain a holistic, flexible approach to security
- Regulatory compliance can be impacted by organizational resources
- Many threats with the greatest impact by focusing internally
- Embrace common security frameworks (e.g. HITRUST)

The workgroup intends to use the identified possible solutions to formulate draft recommendations on de-identification, consent, and security. The workgroup will also discuss: transparency; collection, use, and purpose limitations; preventing, limiting, and redressing harms; and the legal landscape including possible under- and over-regulation. McGraw announced that she is interested in obtaining members' opinions on recommendations that can have the greatest impact.

Q & A

Tang said that there is increasing recognition of the impossibility of ensuring the protection of all data. Perhaps it would be better to focus on harm reduction, the harm being discrimination or stigmatization of both individuals and groups. Discrimination is mostly based on groups, according to Tang. The stakes are high in terms of maximizing performance. Should there be a law against discrimination against groups? McGraw referred to the Fair Credit Reporting Act as a possible model. But how could it be scaled to the population level?

Lehmann pointed out that discrimination based on group membership already exists, for example, in actuary tables. Although the underlying assumption may be that the data belong to the individual, the data are really owned by the big organizations that collect them. Perhaps the laws about ownership should change. McGraw explained the ambiguities of the concept of ownership, saying that perhaps the person to whom the data applies has some rights as well.

Egerman talked about the de-identification of all data being impossible for well-known individuals. He said that physicians can also be harmed by being included in data bases, for example, as being identified as someone who prescribes for or treats stigmatized conditions or patients. McGraw responded that the focus of privacy is on the data subject.

Lansky noted that other workgroups are also concerned with levels of granularity. Regarding the Strategic Plan, he wondered whether the HITPC could take a broader look at the rethinking of HIPAA. He observed that a few broad recommendations are preferred.

Khurshid observed that although consent was traditionally seen as a way to involve the patient, it has not been implemented that way. Perhaps new technology will allow a better and more informed consent. Harm is always present. De-identification seems like a way to bypass patients. He urged the group to think about the end goal, which may be increased patient engagement. Another member observed that data are treated by different sets of rules depending on intended use for purposes of research, treatment, quality improvement, and innovation. There should be a signal to the market on situations such as coverage of data generated from medical devices.

David Kotz hoped that fair data principles will be applied to data not traditionally considered health related. Most device manufacturers will not share data with patients. He called for regulation around handling data and limits to their use and re-identification.

Jody Daniel, ONC, asked that the workgroup identify any low hanging fruit. She wondered about conversations about shifting from harm to trust and fiduciary duty. McGraw replied that testimony had been provided on survey data on trusted environments: People trust the organizations with which they directly deal.

Tang said that there seemed to be agreement that the workgroup should bring back a few recommendations on big issues, consider harm and transparency, look at HIPAA, and take into account individuals' expectations and potential surprises.

Federal Health IT Strategic Plan Comments

Strategy and Innovation Workgroup Chairperson David Lansky reminded the committee members that the Strategy and Innovation Workgroup and the Consumer Workgroup were asked to make recommendations on the Federal Health IT Strategic Plan 2015-2020. Co-chairperson Jennifer Covich reported that the workgroup met with Consumer Workgroup Chairperson Christine Bechtel after the February HITPC meeting at which they had been told to align their recommendations. She showed slides and described the joint recommendations. The Strategic Plan should be more of a health improvement plan, rather than emphasizing data in a Collect, Share, Use framework. The end state is not a data-centered health IT infrastructure; it is the widespread, effective use of digitized information to support improved health and health care. The Plan should use language to emphasize the end, not the means. Specifically, while the focus of the framework is data, both groups agree the focus of the Plan should be on improving the health of individuals and communities. The Plan's federal actions and strategies should use unambiguous language to describe how the goals will be achieved and should add definitions to terms used in the Plan to avoid vagueness and misinterpretation. Federal partners need to hold themselves publicly accountable and provide regular, transparent reporting on progress toward health improvement goals in order to ensure that stakeholders can monitor this progress and provide input. The Plan should reframe its focus to:

- Emphasize the importance of person-centered health and wellness
- More clearly align with other national health planning activities
- Leverage health IT so individuals, purchasers, payers, providers, community-based organizations can partner together to identify, align to, and achieve patient goals

The Plan should show how the federal government will help support the nation to build and design a new heath infrastructure that is person-centered by shifting the Plan's focus from data to how

individuals and communities will use information to improve health and working with private sector to identify government data sources that support innovation and improvement in public health goals.

Bechtel said that each workgroup proposed separate potential methods for the Plan to reinforce its focus on improved health, and recommended using existing content in a reorganized way. The Strategy and Innovation Workgroup recommends using goal 4 (Advance the Well-Being of Individuals and Communities) as the organizing principle to revise the final Plan and to provide clear guidance on a broader privacy framework. The Consumer Workgroup recommends the integration of consumers and individuals into each goal area. It also recommends the creation of a new bridge goal to focus on shared partnership among individuals, providers, and communities. She reminded them that they had seemed to like the recommendations that she presented at the February meeting. Those recommendations had not changed. She went on to refer to the many detailed slides and narrative that constitute her workgroup's complete recommendations.

Lansky summarized that despite the many slides and words, the two sets of recommendations are mostly in agreement. The staff has heard and is extremely receptive to the discussions and input. It is up to the HITPC as to what to recommend. He called out several important points. Although there is agreement on the need to refocus or restructure the Plan, two different approaches are suggested. One is to emphasize health improvement with one over-riding goal and the other is to add a bridge goal and objectives. Both approaches agree that the collect share use is perhaps out of date. A second point is that the entire continuum of experience should be considered. A third point is to focus on value. The fourth point is that the role of the federal government is to find pathways not to focus on building out the medical model. Regarding the Strategy and Innovation Workgroup's charge to submit recommendations on a work plan for the HITPC, he said that those recommendations will be presented at the March meeting.

Discussion

In response to a request for clarification from David Bates, Bechtel said that the recommendation is to anchor and reframe the plan around a health goal, along with a separate goal on partnerships. Another member wondered about the possible loss of focus if such a broad goal were translated into actions. Lansky assured him that the workgroup basically agrees with the original action steps. Bechtel said that the Roadmap is more focused on action that may supplement the Plan. Covich indicated that the recommended reframing will make more sense to the public.

Terry Collins asked that the committee be generous of the difficulty of working in the federal environment and federal fatigue. It may be difficult to incorporate many new suggestions. According to DeSalvo, the Plan is designed for better health, beyond health care. She called the framing suggestions excellent ones. There is an increasing need for person-centered data. The market and the entire environment are dynamic and increasingly consumer centric.

Devin Mann observed that the recommendations do not recognize the provider experience as equal to that of consumers. Bechtel referred to the recommendation for a bridge goal on partnerships. The joint recommendations could perhaps highlight something to that effect. Lansky said that the payer environment is also changing very rapidly. He indicated that the suggestion for including improving provider-facing tools could be added. Gretchen Wyatt, ONC, said that the comment period for the Roadmap is open until May 5. Some of the comments could be captured there.

Tang said that there was agreement with the four themes, with some hedging on the bridge concept. In particular, the recommendations call for better packing. Perhaps there could be more added on

providers. He called for a motion. It was moved and seconded to approve the recommendations on the Strategic Plan. The motion was approved unanimously by voice vote.

Action item #2: The HITPC accepted the recommendations from the Strategy and Innovation and the Consumer Workgroups on the HHS Strategic Plan.

Public Comment

None

Interoperability Roadmap – Progress Update

Advanced Health Models and Meaningful Use Workgroup Chairperson Paul Tang reported that staff had asked the workgroup to recommend a repeatable process for use case prioritization as delineated in appendix H. This and the reports of the other three workgroups that were told to comment are preliminary. The HITPC will take action on the comments and recommendations at the April meeting. He showed slides. Workgroup members agreed on a process and to date have selected the top 17 of 56 Roadmap use cases. Next, members will revise and edit the 17 use cases and consolidate them into 5 to 7. They will test each case against impact on the Triple Aim, programmatic need, readiness, and beneficiaries. Finally, they will refine the process based on this experience. He used slides to describe the entire process to be used in prioritization.

Khurshid asked about limiting use cases to those currently in use. Tang explained that the first gate to pass is impact on the Triple Aim. Bechtel wondered about beneficiaries being on equal footing versus giving greater consideration to specific subcategories, such as patients with complex needs. Tang said that the beneficiaries are not necessarily equal; the idea is to have a balanced set of use cases.

Consumer Workgroup Chairperson Christine Bechtel did not have slides. She said that the workgroup is just beginning to consider recommendations. Workgroup members see consumers as aggregators of data. It is not reasonable to expect consumers to demand their data. They should be given tools to use data and to go beyond PGHD. Sections c and d are separate and may not reflect true partnership. The Consumer Workgroup will comment on the core data set and dealing with errors and corrections. She is happy to see more emphasis on digital literacy and care planning. The workgroup may also comment on the use cases and will definitely comment on timing.

Lansky observed that consumers' interests vary across place and over time. It is best not to be prescriptive in this dynamic environment. He noted co-ownership of record considerations. He urged Bechtel to think about the topics necessary for governance. Bechtel agreed, saying that parsimony is also necessary. Recommendations should reflect the dynamic nature of roles. Partnerships can be dynamic. The system must be designed for the more challenging cases.

Interoperability and HIE Workgroup Co-chairperson Chris Lehmann reported that the workgroup recognizes the importance of accurate identity matching and reliable resource location as Roadmap categories. But members raised concerns about the aggregate number and complexity of the critical actions and the ability of the industry to accomplish these goals in the 2015-2017 timeline. There are 36 critical actions in these two categories alone, 20 of which are in the 2015-2017 timeframe. The focus of the 2015-2017 timeframe should be on motivating the use of things put in place by stage 1 and stage 2. Anything new should be planned in 2015-2017, but not expected until later. There were a number of comments reinforcing the importance of the Roadmap continuing to articulate an interoperability floor not a ceiling (i.e. should be able to go beyond the minimum data matching elements). Members had questions regarding the definition of coordinated governance process. Half of the 2015-2017 critical

actions are dependent on policy and operational functions driven by coordinated governance yet it was not defined. Members raised concerns about the lack of specificity of which types of levers and incentives would be most appropriate to motivate accomplishment of each critical action. Coordinated governance could include many different types of current and future levers. But unless there is a definition, the workgroup cannot endorse or reject specific planned actions. He shared the workgroup's preliminary thoughts on accurate identity matching, saying that technical standards are necessary but not sufficient to establish accurate and reliable patient matching, which requires a combination of technical standards and aligned business processes. The establishment of a best practice minimum set of data for identify matching would be beneficial. Certification could ensure that EHR technology is capable of capturing and storing this minimum data set. Every transaction should not be required to include the minimum set; such data are often not available at all, or not available with sufficient quality, or not appropriate to the specific exchange use case. The workgroup will make a recommendation on a minimum data set for the next meeting. Chairperson Micky Tripathi explained that patient matching by itself may be setting the bar too low; record location services are also needed.

Egerman asked about accurate identity matching and certification, saying that standards for demographic data are in place. Tripathi said that the workgroup will examine the mapping of a minimum data set to what is defined for certification. Egerman asked about voluntary data elements. Lehmann said that someone might choose to add elements to assist with matching. Tripathi noted a reference to such in the Roadmap. Khurshid inquired whether anyone is providing input about newly emerging innovations, such as those in New Orleans and Chicago. Lehmann acknowledged that to date only the members have provided input; expert advice has yet to be sought. Tripathi reminded Khurshid that the recommendations are to pertain to policy, not technical standards.

Privacy and Security Workgroup Chairperson Deven McGraw did not have slides since the group is at an early stage of its deliberations. The workgroup will respond to questions of sections G and H, beginning with H since the group had commented on authorization previously. Section G is about patient permission to exchange. There is some confusion about basic choice. A probable comment is that ONC needs to be clear: Are we changing policy direction? Another possible recommendation is that consent and control issues are evolving and involve on-going policy issues beyond interoperability. There are questions about role-based access. Attention must be directed to common obstacles beyond identity. She is interested in getting states together to agree on the content of their laws on authorization to collect and share data. Persistence of consent—that consent follows the data—is an issue. Although previously discussed during work on data segmentation, many issues about persistence remain.

DeSalvo told McGraw to think about what can be done in the current environment in the next 3 years to unlock data. ONC is also interested in harmonization of state laws.

Discussion

Lehmann talked about treatment relationships and role-based access. He wondered about letting patients see their audit trails and using crowd sourcing. Troy Seagondollar said that the medical record number is always the first source of matching. He asked DeSalvo why discussion of a national identifier is reportedly prohibited. Daniel responded that HIPAA requires HHS to establish a national identifier system, but every year congress acts to specifically prohibit it. The prohibition is tied to funding. The extent to which debate is limited is open to question. She offered to seek clarification from legal counsel. McGraw reminded the members that the Privacy and Security Tiger Team had held hearings and drafted recommendations on patient matching several years ago. She will circulate that material in order to avoid redundant discussions.

According to DeSalvo, the Roadmap is a national roadmap and is not restricted to ONC. Bechtel requested guidance on the level of detail for recommendations. Daniel offered to work with staff to guide the workgroups. DeSalvo suggested that the workgroups comment on areas that would make the most difference.

Delivery System Reform

Karen DeSalvo, National Coordinator, showed slides and described reform efforts undertaken at the federal level. The Transforming Clinical Practice Initiative (TCPI) was launched in October 2014. It is designed to support 150,000 clinicians to achieve large-scale health transformation. The government will invest up to $800 million in providing hands-on support to practices to develop the skills and tools needed to improve care delivery and transition to alternative payment models. The two network systems under this initiative are the Practice Transformation Networks and the Support and Alignment Networks. In January 2015, HHS announced goals for value-based payments within the Medicare FFS system. A goal is to tie 30% of Medicare payments to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018. A second goal is that 85% of all Medicare FFS payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018. The testing of new models and expansion of existing models will be critical to reaching the incentive goals. Another network, called the Health Care Payment Learning and Action Network, is being formed to align incentives. DeSalvo urged everyone to support these reform efforts.

Q and A

Bates asked about achievability. DeSalvo replied that learnings have occurred from the CMS innovation program. Pathways to the goals have been established. Announcements are forthcoming. Khurshid talked about HIE sustainability barriers and asked about restrictions on funding. DeSalvo said that public utility models may be more sustainable than other models. Conversations are being held with private payers.

Lansky said that this is an opportunity to pay more attention to purchaser use cases and purchaser requirements. These efforts require boldness in designating functional outcome measures. The HITPC may want to revisit quality measures. DeSalvo observed that many issues must be worked out within organizations. Safety net services must be considered.

Bechtel expressed surprise about the percentage of FFS payments tied to value. DeSalvo said that meaningful use is technically tied to performance outcomes. There is a need to move to measurement of outcomes and e-measures in ambulatory care. Many organizations are giving input on appropriate outcome measures.

Tang said that providers support these new efforts. The more consistent and prevalent the message, the more support.

Public Comment

None

SUMMARY OF ACTION ITEMS

Action item #1: The summaries of the January and February 2015 HITPC meetings were approved unanimously by voice vote.

Action item #2: The HITPC accepted the recommendations from the Strategy and Innovation and the Consumer Workgroups on the HHS Strategic Plan.

Meeting Materials

- Agenda
- Summaries of January and February 2015 meetings
- Presentations and reports slides

Meeting Attendance						
Name	03/10/15	02/10/15	02/10/15	01/13/15	12/09/14	11/04/14
Alicia Staley	X				X	
Anjum Khurshid	X	X	X	X	X	
Aury Nagy					X	
Charles Kennedy		X	X	X		
Chesley Richards	X			X		
Christine Bechtel	X	X	X	X	X	
Christoph U. Lehmann	X			X		
David Kotz	X	X	X	X		
David Lansky	X	X	X	X	X	
David W Bates	X	X	X			
Deven McGraw	X	X	X	X	X	
Devin Mann	X	X	X	X	X	
Gayle B. Harrell	X	X	X	X	X	
Karen DeSalvo	X	X	X	X	X	
Kim Schofield		X	X	X	X	
Madhulika Agarwal						
Marc Probst	X	X	X	X	X	
Neal Patterson		X	X		X	
Patrick Conway						
Paul Egerman	X	X	X	X		
Paul Tang	X	X	X	X	X	
Scott Gottlieb		X	X			

Thomas W. Greig	X			X		
Troy Seagondollar	X	X	X	X	X	
Total Attendees	**17**	**17**	**17**	**17**	**14**	**0**