HIT Policy Committee
FINAL
Summary of the September 9, 2015, 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 and called the roll. She reminded the group that this was a Federal Advisory Committee Act (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.

Remarks and 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 August meeting as circulated, saying that he was submitting several changes to staff. A motion was made and seconded. The motion was approved unanimously by voice vote.

> **Action item #1: The summary of the August 11, 2015, HITPC meeting was approved unanimously by voice vote.**

ONC Deputy Director Jon White repeated the agenda items.

Data Update

Dustin Charles, ONC, showed slides and reported on provider updating of EHR systems to 2014 CEHRT. By the beginning of the 2014 program year, 90% of EHs and 77% of EPs could obtain 2014 CEHRT from their current vendor, compared to 98% of EHs and 94% of EPs by the end of that year. Charles noted that the EP vendor market is considerably more diverse than is the EH market. Among providers who took the flex rule, 96% of EHs and 89% of EPs could obtain 2014 CEHRT from their current vendors. To attest to 2014 meaningful use, 88% of EHs and 90% of EPs obtained 2014 CEHRT from their current vendors; 12% and 10% respectively attested with new products from new vendors. In 2014, more EPs and EHs changed their EHR vendors than in prior years. For EPs, 16% changed vendors, compared to 4% in 2012. Among EHs, 40% made at least one change in vendors, compared to 2% in 2012. Only 4% changed all vendors in 2014.

Q & A

Chris Lehmann reported that yesterday's *Journal of the American Medical Association* contained an article on vendor certification. It reported that vendors use few clinicians in their product testing. He called for a deeper examination of these issues, including the usability of changes made by vendors.

Charles reported that the vendor certification data are publically available, and further analysis by interested persons is encouraged.

Gayle Harrell referred to the 4% of EHs and 8% of EPs that replaced their systems or a part of a system. Replacement is costly; she wondered about their reasons. Charles repeated that only the publicly available certification records were used in the analysis. Reasons for making changes are not captured. In response to another question, he acknowledged that although the majority of changes were of a module, the type or function of the module is not known.

Paul Egerman referred to the interpretation of the data, inquiring about the number of vendors that were decertified. Charles responded that he did not look at specific vendors. In the future, he will examine attrition. However, ONC will not call out specific vendors for shame. He repeated that more data are publicly available for analysis.

Interoperability Task Force Report

Task Force Chairperson Tang showed slides. The Joint Explanatory Statement in the Congressional Record on 2015 Omnibus Bill directed the HITPC to submit a report to the House and Senate Committees on Appropriations and the appropriate authorizing committees no later than 12 months after enactment of the act regarding the challenges and barriers to interoperability. The report should cover the technical, operational, and financial barriers to interoperability and the role of certification in advancing or hindering interoperability across various providers, as well as any other barriers identified by the HITPC. Tang said that the report will consist of a preamble, a summary of past recommendations on interoperability, a summary of points made during the public hearings, and findings and recommendations on business barriers. He described the questions asked of the task force, the process by which it approached its assignment, goals for interoperability, and themes thought to underlie business and financial barriers. Then he presented and elaborated on the draft recommendations, saying that they were for discussion and feedback with action to be taken at a subsequent meeting. He also provided a few examples of actions and measures.

The primary recommendations were as follows:

- Convene major-stakeholder initiative co-led by federal government (e.g., ONC, CMS) and private sector to act on ONC Roadmap to accelerate pace of change toward interoperability
- Develop and implement meaningful measures of HIE-sensitive outcomes for public reporting and payment
- Define nationwide interoperability services required to facilitate implementation of high priority use cases
- Fund development of ‘measures that matter’ to consumers/patients
- Fund agenda for acceleration
- Align health care payment around value goals that are HIE-sensitive

Finally, Tang summarized as follows:

- Market is moving and is directionally correct
- Pace not fast enough to support delivery system reform – affordable high quality care for all
- Complex, 'synchronous,' multi-stakeholder effort required – not all critical stakeholders currently engaged
- Deliberate multi-stakeholder action required to stimulate sustained collective action
- Clear and aligned, measurable incentives required to convert sporadic activities to meaningful impact

Discussion

Egerman commented that he liked the idea of not paying for duplicate lab tests. If CMS were to establish such a policy, interoperability would accelerate. However, he expressed concern about the example of vendor measures, because they would depend on the specific type of vendors involved with interoperability. Measuring the quantity of data sent could contribute to the increased sending of poor quality and useless data. Tang clarified that the examples were used to start the discussion; they are far from final recommendations. In the example referenced, the numerator is the percentage of data that are viewed, incorporated, and used, which would not include useless data. He said that these kinds of measures would cause people to reflect on what data are useful. People will have to come together in a summit and agree on measures than matters.

Kathy Blake observed that slide 11 is critical. A clear operational definition of a pathway to nationwide interoperability is key. The critical few standard-based services are the foundation. In addition to patient matching, provider directories, and record locators, a clear understanding across the industry of what information can and cannot be shared is foundational. Regarding slide 12 and transparent metrics, a consumer report or a trusted evaluator or system for evaluating products may be necessary. Blake indicated that she was skeptical about financial support from the federal government. Perhaps a public-private ownership model with a small amount of funding that can be sustained by all the many disciplines would work.

Harrell observed that although the recommendations are more or less on target, something more in-depth is in order, given that this discussion has been going on for 6 years without much movement. Much more specific recommendations are needed, particularly with regard to funding. Is the recommendation for the establishment of a public-private entity as the convener? The federal government will have to provide the push. Who is going to establish the measures? CMS? The public-private entity? Who will enforce the measures? Tang responded that there is no recommendation for a new entity, only for a working summit. The summit would have an educational role, in that interoperability is more than a technical process and requires the involvement of many actors. The federal government has a huge convening ability. Foundations may want to contribute. Regarding development of measures, there are endorsing organizations, but they do not create the measures. Probably not enough folks are working on outcome-oriented measures that matter. The recommendations call for funding of measure development. The funding could be from several sources in addition to the federal government. Harrell said that the report should state in-depth recommendations more clearly than was done with the slides. In particular, more detail on payment should be provided.

Neal Patterson commented on the integration of the care plan at the community level. For example, immunization records and problem lists should go with the patients. Although the dynamic care plan is a brilliant concept, a truly nationwide interoperable system is required for its development. The notion of financial barriers is often used as an excuse. However, the scale and cost of these systems for interoperability should be included in the report. Patterson went on to comment on the difference

between regional HIE systems and a national approach. A national approach is needed, but that cannot happen without a system and services for patient identification and record location. Opt-in consent has to be a part of it. Incentives are better than metrics for changing practices. If payment for redundant tests stopped, interoperability would proceed much faster. Although a big summit is probably appropriate, there are always people who refuse to collaborate on the subject. Tang responded that a federally convened summit is a way to pull in everybody. Patterson pointed out that in a very large meeting, there are many ways to disagree.

Anjum Khurshid pointed out that in order to improve health outcomes and status, stakeholders in addition to those in health care delivery must be engaged. Will the recommendations emphasize the need for interoperability with public health and social service organizations? Tang said that the emphasis on the plan for health requires the entire continuum. In a hearing convened by the Advanced Care Models and Meaningful Use Workgroup, the need for standards for social services was described. The Institute of Medicine recommendations for EHR content include data elements for social determinants. He agreed to say more about this in the interoperability recommendations, acknowledging that health care can include jobs, housing, and other social determinants.

Brent Snyder agreed on the importance of slide 10. Clarity on what information can be shared across organizations is needed, particularly regarding behavior health data. For EHs, communication with post-acute and long term care providers is critical. He requested that these points be called out in the report.

Blake commented again, emphasizing the need for resolving problems of consent and privacy across state boundaries. Having clarity on how to handle data that fall under different behavioral requirements and additional consent requirements is important. For EHs, the incentives continue to grow for interoperability with post-acute care providers. There are many of these providers with few or no standards for their interaction with hospitals. The report should acknowledge the variation in state laws on sharing information. Patients cross state boundaries to receive care. The report should also urge collaboration among federal agencies on measure development. Blake expressed concern about socioeconomic or sociodemographic status risk adjustments that measure individual patients' levels of engagement. Unintended consequences may result if patients' reasons for non-engagement are not taken into account. Patients should not be discouraged from receiving care to satisfy measures.

David Lansky requested that the business model and financial barriers sections of the report be strengthened, which may require gathering more input. He talked about a new bundled payment model for orthopedic surgery that uses 30 risk adjustment measures. A longitudinal personal health record is becoming indispensable for managing people across time and the continuum of care. It is also indispensable for measuring of and paying for use of appropriate protocols and achievement of expected outcomes. Use cases for interoperability should be expanded beyond bedside care delivery and tied to the business care for building the data set for measurement and evaluation in payment. The agenda for any summit should include specifically laying out the data requirements to support the new payment models.

David Kotz talked about the challenge of patient identity and matching when patients are transferred. Although matching algorithms work for the past majority, they do not match everyone correctly. Kotz wondered whether the report described this issue. Tang assured him that it did, as mentioned in previous comments.

Harrell asked that the report specifically call out the need for exchange of information with behavioral health providers and for representatives of behavioral health to be invited to the summit.

Tang observed that there is consensus on the primary areas of recommendations. When he inquired about being on the right track, no one expressed opposition to the draft recommendations.

Strategic Plan

National Coordinator and HITPC Chairperson Karen DeSalvo thanked everyone. The Strategic Plan will soon be released. The Interoperability Roadmap will be released this fall. Gretchen Wyatt, ONC, previewed the Federal Health IT Strategic Plan 2015–2020. The plan involves 35 federal partner agencies. It sets the broad direction that government actions will take over the next 5 years. She thanked the several workgroups and members who had previously commented on the plan. She reported that as a result of comments, the following substantive changes were made:

- More comprehensive narrative; "story" focuses on how health IT and information use can achieve important health goals
- Goal 2 combines health care delivery and public health
- New objective in Goal 1 focuses on partnerships among individuals and their providers
- Goal 4 groups infrastructure objectives (interoperability, privacy and security, safety and safe use, technical standards, and broadband) to showcase their foundational importance and relationship to plan and other goals' success

The plan is aligned with dozens of federal initiatives and agency plans, and all partners are committed to the seven principles outlined in the plan. The plan is directed toward four broad goals. The fourth goal on infrastructure development relates to the Roadmap. Although the Strategic Plan pertains to the federal government, the Roadmap is a shared undertaking recognizing that the efforts of state, territorial, local, and tribal governments and private stakeholders are vital to ensure that health information is available when and where it matters most.

Q&A

Tang said that the changes were responsive to the comments. Lansky agreed, saying that he looks forward to seeing the details. Tang said that his recommendation for a summit on interoperability fits well with the plan.

The meeting adjourned at 11:00 a.m., all agenda items having been covered earlier than scheduled.

Public Comment

None

SUMMARY OF ACTION ITEMS

> **Action item #1: The summary of the August 11, 2015, HITPC meeting was approved unanimously by voice vote.**

Meeting Materials

- Agenda
- Summary of August 11, 2015, meeting
- Presentations and reports slides

Meeting Attendance								
Name	09/09/15	08/11/15	06/30/15	05/22/15	05/12/15	04/07/15	03/10/15	02/10/15
Alicia Staley							X	
Anjum Khurshid	X	X	X	X	X	X	X	X
Aury Nagy								
Brent Snyder	X	X	X	X	X			
Chesley Richards		X				X	X	
Christoph U. Lehmann	X	X			X	X	X	
David Kotz	X	X	X			X	X	X
David Lansky	X	X	X	X	X	X	X	X
Devin Mann	X						X	X
Donna Cryer	X	X	X	X	X			
Gayle B. Harrell	X	X		X	X	X	X	X
Karen DeSalvo	X	X	X	X	X		X	X
Kathleen Blake	X	X	X	X	X			
Kim Schofield	X	X	X	X		X		X
Madhulika Agarwal			X			X		
Neal Patterson	X				X	X		X
Paul Egerman	X			X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Scott Gottlieb	X			X		X		X
Thomas W. Greig			X			X	X	

Troy Seagondollar	X	X	X	X	X	X	X	X
Total Attendees	**16**	**13**	**12**	**12**	**12**	**14**	**13**	**12**