HIT Policy Committee
FINAL
Summary of the November 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 Act 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

In the absence of National Coordinator and HITPC Chairperson Karen DeSalvo, Deputy Coordinator Jon White welcomed the members.

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 October 2015 joint HITPC-HITSC meeting as circulated. A motion was made and seconded. The motion was approved unanimously by voice vote.

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

Meaningful Use Stage 3 and Modification Rule

Robert Anthony, CMS, reported that on October 6, 2015, CMS released a final rule for the Medicare and Medicaid EHR Incentive Programs in 2015 through 2017 and stage 3 in 2018 and beyond. For the final rule, see https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications. There is a 60-day public comment period on certain provisions related to stage 3. Stages 1 and 2 have been modified to be consistent with stage 3. Anthony showed slides that delineated reporting periods and participation timelines and explained the changes. By 2018, everyone will be on the same objectives and the same calendar reporting period. Currently, 49% of stage 2-eligible Medicare EPs have achieved stage 2, and 77% of eligible EHs have moved to stage 2. Providers often choose to stay at stage 1, a lower bar. Approximately 42% of Medicare EPs were subject to a payment adjustment; 4% of EHs were so affected. Anthony showed slides and talked about each of the following stage 3 objectives and corresponding measures, explaining the changes made due to experience and public comments:

- Protect electronic health information
- Electronic prescribing

- Clinical decision support
- Computerized provider order entry
- Patient electronic access to health information
- Coordination of care through patient engagement
- Health information exchange
- Public health reporting

The rule also restructures stages 1 and 2 objectives and measures to align with stage 3 for 2015-2017. There are 10 objectives for EPs, including 1 consolidated public health reporting objective with measure options; and 9 objectives for EHs and CAHs, also with 1 consolidated public health reporting objective with measure options. Starting in 2015, the EHR reporting period aligns with the calendar year for all providers. The rule changes the EHR reporting period in 2015 to 90 days to accommodate modifications to meaningful use. The stage 2 patient engagement objectives that require patient action are changed. Redundant, duplicative, and topped out measures are removed. CQM reporting for both EPs and EHs remains as previously finalized. In conclusion, Anthony said that instead of thinking in terms of stages 1, 2, and 3, one should think of three stages of stage 3.

Q&A

Troy Seagondollar referred to the achievement of objectives over time and a drop-off in 2015. Anthony explained that the attestation system was not open for the entire year. Attestation for 2015 will open in January 2016.

Chris Lehmann declared that he was perplexed by the continued inclusion of drug-drug interaction in CDS when there is ample evidence that these alerts only create noise. Also, he reported hearing from pediatric EHR vendors that Medicaid providers in Ohio and Arizona are being required to report this month in order to qualify for 2015 payments. Anthony acknowledged that the regulations allow for some variation; there is no requirement for an early reporting period. He denied awareness of this concern and asked Lehmann to contact him offline. Regarding drug-drug and drug-allergy interactions, there are continuing instances and hospitalizations due to drug-drug interactions. The regulations allow for customization of alerts. Some clinicians report annoyance with pop-ups. The requirement is that a check is available. Elise Sweeney Anthony, ONC, interjected that alerts are not required to be interruptive. ONC has a guidance on this topic.

Gayle Harrell talked about her concerns with stage 3 patient engagement and the 80% threshold. There are regional, cultural, educational, and digital divide issues to be addressed. CMS and HHS should play a greater role in public awareness. She wondered what is being done to increase public awareness. Anthony said that he was not allowed to comment because the rule is in a public comment period. He acknowledged an awareness of the challenges. He suggested that Harrell submit a written comment.

Anjum Khurshid inquired about registries and interaction with public health agencies. Participation in a clinical registry does not require interaction with public health agencies. He also requested information on behavioral health. Anthony responded that the goal of public reporting is to make more options available. A public health registry is not always available to every provider. Specialists want something relevant to their work flow. Immunization registry reporting is relatively routine. Regarding behavioral health providers, CMS does not have statutory authority to require their participation. CMS supports the idea of capturing behavioral health data but has set no specific time line for doing so. Sweeney Anthony said that certification offers a behavioral health option.

Kathleen Blake referred to slide 17, saying that clinicians want to continue to provide the same education materials to patients that they have been distributing in the past. These materials may not

necessarily be EHR-generated: Do PDFs qualify? Anthony offered to obtain an answer to the PDF question. Another question pertained to slide 38 on public health reporting. An EP must meet two of three measures; sometimes not all three measures are relevant to that practice. Not all subspecialties have relevant registries. What about exceptions? Anthony said that exclusions are available in the cases described.

Seagondollar requested more information on the Medicare payment adjustments. Anthony said that no quantitative data are available on non-participants and non-reporters. Claims data, although limited, suggest that these adjustments were applied to (1) very small practices that determined that EHRs were too costly to implement or that the bar was too high or (2) clinicians close to retirement. Some may be late starters. Overall, more than half of the EPs subject to adjustments had Medicare claims less than $2,000, which is about a $40 penalty. Seagondollar pointed out that 250,000 providers and a panel of 2,000-2,500 patients mean that a considerable number of patients are not benefiting from EHRs and meaningful use. There should be a way to re-incentivize these EPs and move them forward. Anthony reminded Seagondollar that the incentives are statutory. However, the Merit-Based Incentive Payment System (MIPS) RFI is relevant. Low-volume claims providers are less likely to participate in CMS programs. Private insurers can also drive progress in this area.

Another member asked about medication reconciliation measures. Anthony emphasized flexibility and explained that upon receipt of the summary of care, reconciliation is expected. This can be additions to the past problem list, at the discretion of the clinician, or a note. There is no requirement to incorporate everything; the idea is to close the loop. In terms of perceived burden, CMS has not received much feedback about med reconciliation. CMS does not want to dictate how to incorporate reconciliations into work flow.

In response to a question from Brent Snyder about bringing the entire summary of care document in transitions of care into the EHRs, Anthony said that the common clinical data set is required. Sweeney Anthony said that the common data set is a part of certification. Referring to a question about Direct and sharing documents in addition to the continuity of care, Anthony said that the rule has expanded beyond the Direct standard, which is a floor, not a ceiling. Providers should innovate beyond minimum requirements.

2015 Certification Rule

Sweeney Anthony and Mike Lipinski, ONC, showed slides and reported on the 2015 final rule. Sweeney Anthony said that the rule is part of the HHS-wide effort to achieve better care, smarter spending, and healthier people. It builds on the foundation established by the 2011 and 2014 editions and addresses stakeholder feedback by reducing burden compared to the 2015 edition proposed rule. It focuses on HIT components necessary to establish an interoperable nationwide health information infrastructure and incorporates changes designed to foster innovation, open new market opportunities, and provide more provider and patient choices in electronic health information access and exchange. In addition, it addresses information blocking and the continued reliability of certified HIT. The 2015 edition supports HIT more broadly and is not limited to EHR technology. There is no “Complete EHR” certification in the 2015 edition or future editions. The rule is intended to support HIT across the care continuum and includes LTPAC settings. The certification program will be agnostic to settings and programs and not limited to meaningful use.

Sweeney Anthony went on to describe specific components of the final rule. Regarding enhancement of transparency, ONC-ACBs must ensure that HIT developers conspicuously disclose in plain language on their website, in all marketing materials, communication statements, and other assertions related to certified HIT, any additional types of costs and limitations on use. Developers will be required to provide

a hyperlink for all disclosures and make a transparency attestation. Another requirement pertains to open data. The CHPL will be converted to an open data file to make the reported product data more accessible for product analysis. The ABCs will be required to report an expanded set of information about HIT products. Regarding privacy and security, a HIT module will have to meet applicable privacy and security certification criteria, which are based on the other capabilities included in the HIT module. The final rule removes the responsibility from the providers to ensure that they possess technology certified to all the necessary privacy and security criteria. The final rule establishes requirements for field surveillance consisting of reactive surveillance (e.g., complaints) and randomized surveillance of at least 2% of annually certified HIT at one or more locations with non-conformity and corrective action reported to the CHPL beginning in 2016.

Lipinski continued. He explained the base EHR definition and described changes from the 2014 edition. He showed a slide that delineated components of the common clinical data set, previously named the common meaningful use clinical data set. New components are immunizations, unique device identifiers for implantable devices, assessment and plan of treatment, goals, and health concerns. Lipinski went on to describe changes from 2014 to 2015 and changes from the proposed 2015 rule to the final rule. Of the 68 proposed criteria, 14 were not adopted, and 6 were added. Compared to the 2014 criteria, 19 are new, 24 are revised, and 16 are the same. Lipinski reviewed slides that described each criterion in detail. New criteria are patient selection; data category request; all-data request; trusted connection; auditing actions on health information; implantable device list; patient health information capture; case reporting; antimicrobial use and resistance reporting; health care surveys; accessibility-centered design; CCDA creation performance; social, psychological, and behavioral data; creating common clinical data set summary record; receiving common clinical data set summary record; sending data segmentation for privacy; receiving data segmentation for privacy; care plan; and filtering clinical quality measures. Lipinski emphasized that a number of changes are expected to contribute to patient safety. Finally, he showed several slides that described the use of the HIT modules to support stage 3 in 2018 and beyond.

Sweeney Anthony showed a slide and described the use cases. The 2015 edition final rule becomes effective January 14, 2016, except for §170.523(m) (adaptations/updates reporting) and (n) (complaints reporting), which are effective April 1, 2016. There is no comment period for this final rule. The 2015 edition final test procedures are available for a 30-day comment period. The Certification Companion Guides are not undergoing a formal public comment period, but ONC encourages stakeholders to review the Certification Companion Guides during the public comment period of the 2015 edition final test procedures (https://www.healthit.gov/policy-researchers-implementers/2015-edition-test-method).

Q&A

Tang said that the certification rule responds to the HITPC recommendations. Harrell asked about usability. Lipinski said that the safety-enhanced design criterion was applied to demographics because many of the safety related areas begin with the data entry on the patient. The bar is set for testing with heavy reliance on the NIST guidance. Test results are required to be made available. A minimum threshold for summative test participants is set and guidance is given on the types of users to include in the test. The minimum number of 10 testers can reduce medical errors by more than 80%. Usability was not considered for all functionalities. The focus is on patient safety.

Harrell asked about the API requirements for vendors that are building interfaces. Lipinski replied that the APIs focus on data from the data set, functionality, and access and authorization. Sweeney Anthony said that ONC was allowing for innovation by focusing on functionality. An API task force will be formed to deal with some of these issues, including risks.

White interjected that regulations require balance. The AMA and others have initiatives on improving usability. Regarding APIs, there is a lot of activity is the private sector.

A member indicated his disappointment with the focus on safety, saying that bench marks should be included. What is the roadmap to increase safety? He also inquired about discrete elements for behavioral health. Clinicians do not receive this information in usable form. Safety and usability have been established but have yet to be incorporated into products. The private sector is not making the necessary changes. In reality, discrete data elements are generally unusable. Much of the information is tucked away in the EHR and cannot be located in a uniform place. How is the CCDA harmonizing the information? Lipinski said that behavioral information is not currently part of the CCDA. Staff has talked with curators about the creation of template sections to capture types of information. The UDI is to be captured in the procedure section template. ONC staff is trying to provide structure for information so that when it is transferred in a transition of care, it can be found easily.

Public Comment (see below)

HIT Certification Considerations to support Alternative Payment Models Report to Advanced Health Models and Meaningful Use Workgroup

Kelly Cronin, ONC, explained that ONC contracted with two organizations to conduct a literature review and key informant interviews and convene an expert panel to better understand HIT requirements for different provider models. The Medicare Access and CHIP Reauthorization Act (MACRA) and other legislation have implications for providers' HIT needs. Considering different payment models, what HIT ecosystem is necessary for support of providers? What certification standards are needed for products to have consistency?

Lammot du Pont, Manatt Health Solutions, explained that the study focused on three alternative payment models (APM: ACOs, bundled payments, and PCMH; capabilities that need to be available by January 2019; technology, not staffing; HIT beyond EHRs; and levers consisting of market forces, certification, and comparative tools. Regarding MIPS, MACRA consolidates and expands pay-for-performance incentives into MIPS. Under MIPS, the PQRS, EHR Incentive Program, and Physician Value-Based Modifier become part of a single adjustment to physician payments beginning in 2019 based on quality, resource use, clinical practice improvement activities, and meaningful use of CEHRT. MACRA allows providers participating in APMs to opt out of MIPS. To qualify as an APM participant, providers must meet increasing thresholds for the percentage of revenue received through qualifying APMs. Qualifying APMs are those that require participating providers to take on "more than nominal" financial risk, report quality measures, and use CEHRT. du Pont showed a slide that depicted a framework constructed from the results of the literature review. It consisted of processes, functions, and capabilities.

Scott Afzal, Audacious Inquiry, described the key informant interviews. Select providers, vendors, and CMS program staff were questioned on business and clinical processes, specific HIT capabilities found to be most challenging, the impact of certification programs to date, and what is and is not currently ready for certification. The eight-person technical expert panel was given and built upon the output from the literature review and informant interviews. The panel started with the original CCHIT list of seven processes, 64 functions, and 270 capabilities. After filtering and eliminating many that had previously been addressed, the panelists agreed on 20 candidate capabilities with the stipulation than more could be added later. The technical expert panel rated the 20 candidate capabilities on three dimensions: criticality, gap between ideal and current state, and perceived capacity of the market to close the gap. Slides listed the ratings of each capability on each of the three dimensions. The panel used the ratings to

cluster and rank capabilities by importance. The most important cluster was the care plan, which requires 11 of the 20 capabilities.

The expert panel added usability and patient identification to the capabilities. The panel obtained information on standards readiness and categorized the capabilities based on readiness. The categories are as follows:

- Category A: Capability requires new certification criterion and criterion is mature. There is a viable standard to certify against.
- Category B: Capability requires changes to existing certification criteria. There is a viable standard to certify against, but its use is optional in current certification.
- Category C: Capability requires maturation of potential standard and function. There is a preliminary standard or function to certify against, but additional maturation is needed to be ready for inclusion in a certification program by October 2016.
- Category D: Capability would require development of potential standard and function. No standard or functional expression is currently in pilot. Significant work is required in order to be ready for inclusion in a certification program by October 2016.
- Category E: Standard exists, but policy lever or demand is needed for certification to have impact. The certification criteria exist, but require a lever to get non-EHR products to certify.

Last week, the Advanced Care Models and Meaningful Use Workgroup heard the report, discussed it, and gave feedback. Workgroup Co-Chairperson Joe Kimura, a member of the technical expertise panel, said that the challenges identified in the analysis were generally consistent with the workgroup members' experiences, particularly through the APM provider perspective. The importance of effective closed-loop referral management and the role of the care plan resonated strongly and dovetailed with workgroup discussions of the Interoperability Roadmap. The workgroup members noted that to be successful, APM providers will need to integrate information from a broad and widening array of sources, navigate new relationships and priorities, and define and track shared responsibilities among an expanding scope of care givers.

The workgroup gave the following feedback to the contractors:

- Explore and incorporate additional perspectives (e.g., patient or person, home health providers), as the workgroup envisions the success of these partners will be integral to providers' success. The current analysis strongly reflects the provider perspective.
- Two additional functional domains from the provider perspective are the importance of bringing the output of data analytics (i.e., risk algorithms) into the operational care process work flow through well-designed decision support capabilities and—given the critical role of performance measurement in APM accountability—APM providers will be required to produce system level, provider level, and patient level feedback in order to successfully meet contractual targets. In particular, clinical quality metrics, utilization management metrics, and total cost of care metrics will require robust support.
- Given the conceptual importance of the care plan, the workgroup acknowledges the importance of promoting policies to advance the use and usability of care plans. The workgroup would build upon current thinking on the episodic care plan to meet the future APM needs of a person-centered longitudinal care plan.
- Prioritize integration of patient-generated (and patient device-generated) health data.
- Prioritize bi-directional engagement of patients.

Discussion

Blake agreed that closing the referral feedback loop is of the utmost importance. She referred to several findings of a pilot study. Questions asked by the referring clinician, along with responses, should be included. The interpretation of urgent varies greatly; a time limit should be specified. Patients and care givers are the third side of the triangle.

Khurshid inquired about the capture of other data such as images, videos, and unstructured data. Afzal said that the project was constrained by use of the CCHIT framework. du Pont said that some capabilities were filtered out because they had been dealt with previously. They are open to adding capabilities. Kimura interjected that the workgroup members had discussed these types of data but were not sure that there was sufficient information to make a recommendation. According to Tang, who also chairs the Advanced Care Models and Meaningful Use Workgroup, the functions listed by the workgroup may be more important than the functions considered by the panel. Important items, such as the learning health system and quality measures, were apparently filtered out. Front-end providers must have measures so that they can learn at the point of care. Tang asked how the workgroup's feedback will be incorporated into the report. The contractors indicated that they will identify and incorporate additional topics; this is not the end of the dialogue. The focus is on capabilities to be in place by 2019; a learning health system will extend much beyond that time. According to Tang, the usual lead time for inclusion in certification is 18 months. The contractors said that in the interviews, vendors reported needing more time. Tang repeated his concerns.

Harrell inquired about behavioral health and long-term care. The presenters said that although they were not topics for the panel, functionalities in addition to those considered are occurring in the marketplace. The priority is on getting functions in place for 2019. In response to a request from Seagondollar, they promised to distribute a list of the capabilities used in ranking, which was previously presented to the workgroup.

Lehmann asked about potential unintended consequences of new payment models and any functionality to discover unintended consequences. Afzal said that unintended consequences were not in scope. Cronin talked about the formation of ACO silos. Since many encounters occur outside a network, providers need to exchange outside their networks.

Devin Mann referred to the care plan and 11 capabilities, saying that there are many versions of care plans. The contractors acknowledged the extreme variation in care plans but said that there are some common elements. Kimura said that the workgroup discussed the topic; there should probably be agreement on a minimum set of elements. Mann talked about a project in which he is involved. A number of facilities with different care plan formats are attempting to agree on elements for exchange.

Blake requested the list of 270 capabilities on which the filtering was based. She went on to talk about opportunities in APMs and using CCDA as a standard, which may not meet the needs for APMs. She questioned what CCDA is accomplishing, saying that it should not be the only standard for APMs. Cronin said that many other standards, such as the referral note, will support transitions of care for APMs.

Tang asked about follow-up. The contractors responded that the technical expert panel is still working on the project. After the details for certification have been thoroughly defined, the report will be submitted to ONC. Other venues can be used to discuss pathways for APMs. Cronin said that the MACRA RFI and rule making on other initiatives will be used.

Review of Interoperability Report

The 17-page review and the meeting presentation slides had been sent to the members for review on November 9, with revisions sent again after COB EST. Now in his role of chairperson of the Interoperability Task Force, Tang said that the purpose of the report was to summarize the barriers causing slow progress towards interoperability and HITPC recommendations related to interoperability, explore financial and business barriers, and make near-term recommendations to accelerate progress. According to the Joint Explanatory Statement in the Congressional Record on the 2015 Omnibus Bill, the agreement directs 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; the role of certification in advancing or hindering interoperability across various providers; and any other barriers identified by the Policy Committee. Tang listed the past HITPC recommendations under the following categories:

- Lack of universal adoption of standards-based EHR systems
- Changes in operations work flow among providers
- Complex challenges of privacy and security associated with widespread health information exchange
- Difficulty of establishing synchronous collective action among multiple participants
- Weak and, in some cases, misaligned incentives

Tang presented findings on which each of the following recommendations was based:

- Fund development and use of meaningful measures of HIE-sensitive health outcomes and resource use for public reporting and payment that focus on coordinated care and affordable care (example HIE-sensitive measure: no reimbursement for medically unnecessary duplicate orders)
- Fund development and use of HIE-sensitive vendor performance measures for certification and public reporting (example set: # of exchanges of external data (denominator); % of external data elements viewed (numerator); % of external data elements incorporated/reconciled (meaning))
- Set specific HIE-sensitive payment incentives, including specific performance measure criteria, and timeline for implementation that establish clear objectives of what must be accomplished under APMs
- Incorporate mechanisms that identify and discourage information-blocking activities
- Convene major-stakeholder working summit co-led by federal government (e.g., ONC, CMS) and private sector to act on ONC Roadmap to accelerate pace of change toward interoperability with expected outcome to enumerate and define action plan with milestones and accountabilities to achieve widespread interoperability

Tang summarized. Achieving interoperability in health care is substantially more complex than in other homogeneous domains (e.g., ATM and banking) because of the diverse and fragmented delivery system with thousands of data elements that must be understood by systems universally. Interoperability and meaningful health information exchange are critical to delivery system reform (DSR). The current pace of progress on interoperability will not meet the timelines of DSR. The task force members believe that we must convene the multiple stakeholders to define a national work plan and commit to the synchronous, collective actions we have enumerated in this report. To succeed, it must be motivated by clear and specific financial incentives tied to HIE-sensitive measures that matter to consumers, providers, and payers that are defined in the near term.

Discussion

Harrell wondered whether ONC has the authority and resources to implement these recommendations, in particular the summit. What is the next step? Tang reminded her that this is a report to Congress, which has the necessary authority to authorize and appropriate. ONC most likely does have authority to convene a summit, although there may be an issue of resources. CMS may or may not have the funds to develop the recommended measures. Harrell declared that the summit should be ongoing; the HITPC has been talking about interoperability for 6 years, and interoperability has yet to be achieved. She questioned whether a summit could have sufficient power to accomplish much. Tang acknowledged that her concern was legitimate, but he pointed out that the environment has changed over the past 5 years. New payment models are motivating factors.

Sweeney Anthony asked about 3 years for measure development. Tang responded that the recommendations are to start in the near term. Development will take more time.

Although Lehmann approved of the focus on incentives, he said that the recommendations do not go far enough. Regarding information blocking, there are incentives not to share information. Banking works because banks have financial incentives to make information available to their customers. Why not consider paying for sending information? Tang said that incentives are not the only cause of action. The task force did not discuss pay for sending information. The members looked for ways to increase incentives within the existing structure.

David Kotz referred to his work with National Institute of Drug Abuse-funded centers. 42 CFR Part 2 is a barrier to the exchange of information. Restrictions on exchange increase risks to both providers and patients. He wondered about the lack of standards. Tang said that although the report mentions 42 CFR, the task force is not requesting changes in laws. If incentives are sufficient, the technical issues will be resolved.

Blake observed that financial incentives vary across participants. One incentive that is not mentioned is the preservation of time. A study by RAND and the AMA found that the key thing that practitioners want at the end of the day is to know that their work is done. A recent article by Lisa Rosenbaum in the *New England Journal of Medicine* described physicians being inundated with information. The exchange of information that is helpful in treating a patient is a gift or incentive in itself. Referring to slide 21 and funding of measure development, Rosenbaum noted that CMS and others are funding measure development, but often the lead time is insufficient. Disease-specific measures are funded at the expense of cross-cutting measures. Regarding a slide heading of meaningful measures for providers and consumers, Rosenbaum asked that it be changed to measures for everyone, which is more inclusive. Tang seemed to agree to adjust the heading. He emphatically agreed that receipt of information about a patient can be a welcome gift and an intrinsic reward.

Brian Burns wondered about tying incentives to levels of interoperability as well as gradation of standards. Going from one version to another affects the fidelity of the mapping. Looking at the performance measures in terms of interoperability, the end goal is patient care and clinical operational improvement. Is there any correlation or causal relationship between interoperability and the performance measures? Is it an interaction effect to get to more goals? Referring to levels of implementation, Tang said that the task force tried to make the recommendations action oriented. With respect to incentives for achieving various levels of implementation, stages 1, 2, and 3 call for increasing levels of implementation. In stage 3, the emphasis is on outcomes and shared care plans. The examples are outcomes, not process measures.

Mann referred to slide 25 and vendor-sensitive measures, observing that they are volume-based. The denominator is volume, which does not account for the time problem. Mann talked about his user group and reconciling meds from multiple outside encounters. Sometimes the process must be repeated several times, which would affect the numerator. One could drive up the exchange numbers by wasting time. Mann cautioned against volume-based measures. Tang said that the workgroup had talked about another measure, which was not included in the final report. The measure was based on changing an order based upon the receipt of external information.

White asked for a vote of approval for the report and recommendations. Harrell asked whether the members' feedback will be incorporated in the report. Tang replied that the feedback will be incorporated, and the recommendations can be circulated for final approval by email vote. Lehmann said that although he agreed with the report's content, he wanted to add something pertaining to payment for data. Tang said that Lehmann's point could not be included unless the committee agreed to it. White said that the report will be circulated for comment. Staff confirmed that the report will go directly to Congress as approved. Staff confirmed that approval does not require a unanimous vote, only a majority. White said that Lehmann could write a dissenting opinion.

Consolazio thanked Tang for his work, and Tang thanked Consolazio. Consolazio said that a number of joint HITPC and HITSC task forces are being formed as was announced at the October meeting. The Health Information Exchange Workgroup, Consumer Workgroup, Advanced Payment Models and Meaningful Use Workgroup, and Privacy and Security Workgroup will continue but will function as task forces.

Public Comment

The following written comments were submitted during the meeting via the web meeting site chat.

Marq Walker wrote the following:

> *EHR software developers continue to lag behind public health reporting requirements. AR has 3 registries which have declared readiness: immunization, syndromic, and cancer. However, numerous ambulatory EHRs still cannot produce error-free syndromic tests, and we have NO knowledge of ANY ambulatory EHRs which can produce HL7 test files for our oncologists and other specialists who treat cancer. Additionally, NONE of the ambulatory EHRs are proactive in producing HL7 functionality for specialty registries or the CDC national survey registry. In 2015 EPs can claim the alternate exclusion; however, 2016 is looming on the horizon and many Arkansas EPs are considering dropping out of MU because they cannot meet the public health reporting measure due to vendor barriers. What will CMS/ONC do to require EHR vendors to select a clinical data registry or specialty registry so that EPs can meet the public health reporting requirements in 2016?*

Thompson Boyd wrote the following:

> *Regarding the CMS Presentation about Clinical Decision Support (CDS) when appropriately designed and well managed CDS is abruptly turned off, providers swiftly request that CDS be turned back on, as soon as possible, because the value of CDS becomes clear as a patient safety measure. With CDS, the provider also feels more confident that their orders are more accurate, meeting the needs of the patient. Thompson Boyd, MD. Hahnemann University Hospital. Philadelphia, PA*

Boyd also wrote the following:

> *Advanced Care Models: May wish to add the notion of having a Shared Vocabulary. Then, the terms will be known and understood by the stakeholders. A Shared Vocabulary will also aid with*

data integrity, and with the reporting of quality metrics. Thompson Boyd, MD. Hahnemann University Hospital. Philadelphia, PA. Walker wrote the following:

It does not appear that CMS/ONC have given enough consideration to the fact that software developers love the profit that they are able to build into "modules" and how those modules can hijack a provider's ability to afford the technology required to be a meaningful user. For example, software developers hold Arkansas EPs hostage by refusing to provide HL7 test files unless the EP purchases the interface to the registry -- even though the Arkansas registries cannot accept data in "production mode" and are only accepting test data in the form of pdf files. Some of the interfaces are several thousand dollars, plus subsequent "support" fees. I am concerned that the cobbling together of modules for 2015 certification will add complexity to the costs that EPs are expected to incur. This is the reality that our team of Outreach Specialists is seeing in the field across the state of Arkansas.

Missy Willoughby wrote the following:

It is heartening to hear someone say that 18 months is needed for development of HIT capabilities. But do remember that the discussion related to having the certified functionality for APMs in the marketplace by 1, 1, 2019. The developer/vendor would need the finalized criteria defined and the 18 months to develop and QA the functionality. Then, there is time to have the certification testing done and the deployment to the end-user sites. At the sites, the implementation of training programs, evaluation of new workflows and needed changes, etc. must occur. So, the urgency to have the final criteria/functionality defined is there. It will be much more than 18 months from definition of needs to the implementation and use of the functionality. Thank you.

Michael Banks, MD Owner 4 person orthopaedic group wrote the following:

I'd like to comment on MU Stage 3 presentation. I hope that all of you in ONC positions or influence actually hear from front line providers. MU is devastating the practicing providers, its ruining the EHR vendor - provider relationship. All resources by vendors are used to figure out, implement and program systems to achieve some massive ever changing federal regulatory burden. There is nothing left for usability, efficiency safety or security that providers are so desperately asking for.... MU fits no practice, Ok, may 10% of overachieving data entry provider practices, but not 90% of them. MU it's a complete distraction to patient care and a huge burden. Those of us out here trying to care for patients have had enough of MU and the rest of these programs. Stage 3 reads like a dark comedy, are you actually listening to us out here? So you can have 8 objectives with multiple measures, heck, you could have 800 objectives and measures but we have really given up on MU. Already over half of providers are taking. Already over half of providers are taking penalties and that number is only going up. You can distract people with your figures, but 60,000 providers represents only 10%of the total number of providers. Again we are all leaving the program. Look at the comments currently on the MU stage 3, they are universally 100% negative. If saving money by penalizing hardworking providers what you plan to achieve some savings, you win. But you have also disenfranchised 100's of thousands of providers. How does that help advance Health IT, interoperability? It's a major failure. Anyone penalized is a failure, with over 50% penalized is a ridiculous failure. For anyone that has some influence with ONC or CMS or MU or all this data entry, check boxing, pop up disaster making, attesting, auditing, ….please stop. Quit devaluing physicians and providers and all the work we do. I think the calls for action will get louder and more angry. And that is NOT good. You folks are the leaders, please stop trying to be "yes men" to politics. Our folks are the leaders, please stop trying to be "yes men" to political, complex regulatory action, tell us what is meaningful use of IT and listen to your colleagues that what you are doing is terrible to

both us and for our patients. It's time to end MU and get out of our way. Someone has to say this stuff and you need to hear it. Stage 3 as proposed and MU should be ended and ended immediately.

Boyd then wrote the following:

Interoperability Report: Incentives. Would conform incentives surrounding interoperability to be centered on [quality] information sharing, as opposed to merely sending volumes of data. The shared information needs to be actionable. The paradox is also true: if the information is not shared, the information is missed and slows down patient care by the information receiver. In summary, work on sharing of quality information, as opposed to transmitting volumes of data. Thompson Boyd, MD. Hahnemann University Hospital. Philadelphia, PA.

Upcoming Meetings

The December meeting will be virtual. In January, the HITPC and the HITSC will meet jointly.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the October 2015 joint HITPC-HITSC meeting was approved unanimously by voice vote.

Meeting Materials

- Agenda
- Summary of October 2015 joint meeting
- Presentations and reports slides

Attendance

Name	11/10/15	10/06/15	09/09/15	08/11/15	06/30/15	05/22/15
Alicia Staley	X	X				
Anjum Khurshid	X	X	X	X	X	X
Aury Nagy						
Brent Snyder	X		X	X	X	X
Brian Burns	X	X				
Chesley Richards	X			X		
Christoph U. Lehmann	X	X	X	X		
David Kotz	X	X	X	X	X	
David Lansky		X	X	X	X	X
Devin Mann	X	X	X			
Donna Cryer			X	X	X	X
Gayle B. Harrell	X	X	X	X		X
John Scott	X					

Karen DeSalvo		X	X	X	X	X
Kathleen Blake	X		X	X	X	X
Kim Schofield			X	X	X	X
Neal Patterson		X	X			
Paul Egerman		X	X			X
Paul Tang	X	X	X	X	X	X
Scott Gottlieb	X	X	X			X
Troy Seagondollar	X	X	X	X	X	X