

Health Information Technology Policy Committee Final Summary of the February 1, 2012 Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 32nd meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting, with an opportunity for public comments, and that a transcript and summary of the meeting would be available on the ONC Website. She called the roll, and turned the meeting over to National Coordinator for Health Information Technology and Committee Chairperson Farzad Mostashari.

2. Remarks

Mostashari referred to a report recently released by the Bipartisan Policy Center report on progress with HIT. The report recommends focusing on interoperability, consumer engagement, improvement of care, and quality measurement. He said that the recommendation is very much in line with HITPC, Health Information Technology Standards Committee (HITSC), and ONC staff efforts.

3. Review of the Agenda

HITPC Vice Chairperson Paul Tang talked about the agenda items. He asked for a motion and second for approval of the minutes of the January 2012 meeting, which had been distributed in advance of the meeting. Tang said that he had submitted edits to the summary. Members approved the minutes by a voice vote with no objections heard.

Action item #1: The HITPC approved by voice vote the minutes from the January 2012 HITPC meeting.

4. ONC Update on Health Information Exchange (HIE)

Claudia Williams, ONC, reminded the members that at the previous meeting a member had requested a report on HIE. She said that she would report on the status of the HIE grant program and Doug Fridsma (ONC) would report on the development of standards. She told the members that she planned to report again at the March meeting at which time she would go beyond the grant program. Following a slide that summarized the current environment, she noted that the original expectation was for state exchanges to serve most of the exchange needs in their respective states. However, it is now obvious that multiple exchange networks and models will operate in a state. The key role of the state HIE program is to catalyze exchange in a state by reducing costs of exchange, filling gaps, assuring a common baseline of trust and interoperability, building on the market, and focusing on stage 1 meaningful use

The grantees are expected to focus on giving providers viable options to meet meaningful use exchange requirements, e-prescribing, exchanging care summaries and lab results, public health reporting, and engaging patients. They were directed to devise approaches that make rapid progress, build on existing assets and private sector investments, and leverage the full portfolio

of national standards. She reported that although e-prescribing has increased dramatically, provision of care summaries and lab exchange are far behind. Williams described challenges such as white spaces, duplication of effort, information silos, disparities, emerging networks, public health reporting, and lack of shared trust and interoperability standards.

She went on to summarize grant-supported efforts in several states. For instance, Delaware formed a directed exchange and jumpstarted low-cost directed exchange services to support meaningful use requirements. In one month 500 providers had signed up. Wisconsin used a shared services approach and offered open, shared services such as provider directories and identity services that can be reused. One of the key factors for a large scale adoption of a provider directory is for it to be flexible and provide accurate and up-to-date information. In Indiana, the grantee connected the nodes—

infrastructure, standards, policies and services—to link existing exchange networks. There are five operational HIEs in the state. The state HIE program is funding these exchange organizations to begin sharing information across exchange entities, with the goal that patient information can securely follow patients wherever and whenever they seek care in the state. The Kentucky HIE is serving the public health and quality reporting requirements to state agencies. Providers can use the HIE to submit data to the state immunization registry. To date, nine providers have tested immunization messages via the HIE to facilitate their meaningful use attestation to Medicare. The state will use the exchange to transmit electronic results from newborn screening to providers across the state, effective the first quarter of 2012.

Some HIEs are trying to support marketplace exchange, making it difficult for ONC to measure progress. In terms of markers and measurement Williams said that ONC will use national surveys conducted by the American Hospital Association and the National Ambulatory Medical Care Survey to determine, for instance, the number of hospitals sharing lab reports with providers external to their systems. According to Williams, emerging issues in HIE are:

- Provider adoption and workflow for key exchange tasks
- Alignment with care transformation and payment reform efforts
- Scaling directed exchange
- Broader adoption of query-based exchange
- Sustainability focused on adoption and scaling
- Business practices

Doug Fridsma, ONC, began by acknowledging that members had seen many of his slides previously. He talked about achieving interoperability and mentioned vocabulary and code sets, content and structure, transport, security, and services. He spoke about use cases requiring different vocabularies, code sets, transport, and security. He exclaimed that the national agreement on the use of HL7 2.5.1 for lab results was a tremendous accomplishment. Regarding transport, he spoke about the Direct Project, which began as an independent, open government project to specify a standard for secure, directed health information exchange. The S&I Framework was modeled after Direct, and Direct has now become one of the S&I initiatives. More than 35 vendors implemented Direct by the fall of 2011. Direct is part of the core strategy of more than 40 state HIE grantees.

Next, he talked about NwHIN. Exchange is currently operational and is demonstrating value to participants, including to the Social Security Administration for which benefit determination is expedited (shortened turnaround time by 45%) for disability payments. Another value is improved benefits in clinical decision support (CDS), including avoiding prescribing multiple narcotics based on information shared. As of January 2012, 22 organizations are exchanging data. They represent 500 hospitals, more than 4,000 provider organizations, and 30,000 individual users.

He reported that NwHIN is now open to more organizations. The Office of General Counsel recently ruled that having a federal contract was no longer a requirement for participation. NwHIN is transitioning to a more sustainable model organized as a 501(c) 3.

Fridsma asked Judy Faulkner, Epic Systems Corporation, to talk about her experience with Direct. She talked about Care Everywhere and said that having standards is critical for vendors. The latest releases are required. Standards for authenticity, directories, and governance are essential. Fridsma said that Faulkner's experience should give hope to others that the pieces are coming together.

Q and A

Gayle Harrell said that states are different. Governance issues must be addressed in order to assure the public. Federal standards for governance are necessary. Many organizations are getting involved in HIE. Williams reported that feedback from state grantees indicated that they preferred federal standards for governance.

A representative from Maryland briefly described his state's public utility approach, saying that it was possible because of the strong leadership in the state and the partnership with ONC. All 46 hospitals in the state are connected to the state HIE. Most pharmacies are involved. Nevertheless, there are challenges in finding value for ambulatory practices to be engaged. It is difficult to reach all of these practices.

Christine Bechtel asked about NwHIN: What are participants exchanging? Fridsma replied that Direct is a part of NwHIN. Direct is a mechanism to send information that someone needs and requests. But Exchange asks if a provider has information that can be used for a specific patient. Typically, a provider knows where the information may be found. A directed query may use NwHIN standards. Bechtel asked about the driving force for exchange: Is it meaningful use or payment reform? She wondered what the HITPC can do to drive exchange. Williams responded that meaningful use points to several immediate use cases, which are the right first steps. But for a provider organization to commit many more resources, payment reform may be required. Meaningful use has an important role in setting direction but reform will be the momentum.

David Lansky noted the anxiety in California about support after the end of the federal grant. He said that the committee should address sustainability. States seem to approach sustainability with a local business case. Private exchanges are evolving rapidly. The HITPC should discuss payment change in relation to HIE strategy. The payment interests must be mobilized to support HIE. He pointed out that the metrics described by Williams for measuring progress are not policy metrics that can be used to gain support from the public. He suggested a measure based on the number of records transmitted and the clinical benefits of the transmissions.

Harrell declared that the committee should examine the extent to which the provision of care is changing along with HIE. The HITPC should look at payment reform and how to ensure that HIE is a core element. She suggested a hearing. Fridsma noted that the representatives from the Beacon Communities as well as others are also asking questions about the effects of payment reform.

5. HITPC 2012 Workplan

Tang reported. He began by saying that the workplan had been presented at the January meeting but little feedback from members had been received. He reviewed the committee's previous work on HIT-enabled transformation of the health care system. For stage 1, the emphasis was on adoption and meaningful use of EHRs, privacy and security of electronic data storage and access, safe use, consumer access and download, and the HIT workforce. Work to prepare for 2013 focused on: governance, HIE organizations, privacy and security of data sharing, consumer tools, and decision support. For stage 3, the focus is on next generation quality measures, CDS, and population management.

Jodi Daniel, ONC, reviewed the 2012 workplan, which she presented by quarters. First quarter plans consist of responding to the meaningful use Notice of Proposed Rule Making (NPRM) and preliminary plans for stage 3. Coordination across several workgroups will be required. Coordination across workgroups will also be required in responding to the governance Advanced Notice of Proposed Rule Making (ANPRM). Quality measures are also on the agenda. Daniel observed that the committee will have to consider these topics more or less simultaneously.

Second quarter activities will focus on a quality measures lifecycle hearing, patient-generated data, information exchange, and certification and adoption. Transitions to long term and post-acute care will be considered. The hearing will be jointly convened with the HITSC. In the third quarter, stage 3 meaningful use objectives will be recommended. The committee will be asked to respond to the governance NPRM. ONC is developing an action plan in response to the Institute of Medicine report on safety and will request feedback from the committee.

During the fourth quarter, stage 3 recommendations will be finalized. Consumer e-health will be considered and the ONC strategic plan revisions will be reviewed. She announced that throughout the year, staff will present updates to the committee on topics such as meaningful use, ONC programs, HIE, Accountable Care Organizations (ACOs), Centers for Medicare and Medicaid (CMS) and other payment policies. She requested suggestions for additional topics. Overall, ONC staff will work toward better integration and coordination of HITPC and HITSC activities.

Discussion

A member spoke in favor of more attention to the life cycle of quality measures and a better data model. A base must be built and vocabularies organized. The ways in which people want to use the information is changing; now the exchange of images is being discussed.

Harrell commented that specialties, long term care, and behavioral health are excluded from meaningful use. They are essential components of health care.

Lansky spoke about the need for the committee to consider the architecture and conceptualization of HIT. The policy-relevant system question is where are data brought together

for common purposes. The HITPC's charge is broader than meaningful use; meaningful use is only one tool. Fridsma said that at one time there was hope for a single architecture, but ONC's current approach is more like city planning than architecture. ONC is developing general rules and building blocks. Some of the pieces may be re-useable.

Faulkner commented that vendors develop systems differently. There are many data elements to be standardized; standardization is a laborious process. The committee should focus on EHRs because they save lives. She talked about the value of adding more features to sophisticated EHRs versus providing the basics that most small providers need. The incentives are not sufficient to motivate the one-to-four-doctor offices to install EHRs. She nominated interoperability and the personal health record (PHR) as the next priorities following EHRs.

Charles Kennedy agreed that data architecture is the fundamental challenge. He informed the members that the literature is mixed regarding the extent to which the use of EHRs actually saves lives. The more important factor is the exchange of essential information. Both discrete data and architecture should receive more attention. Fridsma said that these topics are being discussed in the HITSC.

Another member spoke about the value of unstructured data. He said that the use of text processing tools combined with structured data appears promising. There may be a breakthrough in the use of unstructured data.

Harrell commented again, saying that the value of EHRs in research is not mentioned in the workplan. She requested an update on the topic.

6. Update on the Million Hearts Campaign

Peter Briss, CDC, and Mat Kendall, ONC, showed slides to describe the campaign. Improved cardiovascular care could save 100,000 lives annually in the United States. Adherence to the evidence-based aspirin use, blood pressure and cholesterol control, and smoking cessation interventions (ABCS) is low. The campaign has set objectives for ABCS as well as for the reduction of sodium and artificial trans fat intake. The campaign is using both clinical and community interventions. Clinically, the approach is to improve ABSC compliance through the use of HIT and team-based care. Kendall said that ONC expects to incorporate the campaign into the meaningful use of EHRs. The regional extension centers and the quality improvement organizations are partnering. CDS tools are being developed and quality measures are being aligned. The Beacon Communities are involved. ONC and CMS intend to engage in a memorandum of understanding on a CDS strategy to improve outcomes.

Q and A

Larry Wolf suggested that they look at the things people are doing on their own, such as commercial weight management services. Another member opined that health care providers have much to learn about population management.

The Veterans Affairs representative declared that her organization has made great progress with the ABCS and can share information with others.

Harrell talked about operationalizing patient engagement. The use of CDS requires patients' involvement. She referred to her use of Apps—a fast food calorie counter and a pedometer. She

cautioned about burdening the regional education centers with activities beyond their charge of promoting HIT.

Someone reported on his experience in soliciting physicians' participation in registry services. The conversations were more productive when a generic approach was avoided. Physicians and staffs responded better when simple tasks such as making a list were described. Real life cases may be a vehicle to make meaningful use meaningful.

Lansky pointed out that slide 3 listed primarily process measures. He asked Briss and Kendall to propose outcome measures to the Quality Measures Workgroup and to the committee. He inquired about any plans to publicize or reward high performers. Briss said that rewards are being explored but the initial priority is to get providers engaged with the campaign. Some private sector organizations are discussing recognition of performance. Lansky said that consideration is being given to a delta measure in stage 3—the difference between a time 1 and a time 2 blood pressure reading for example. He asked whether Briss could provide advice. Briss said that he was unaware of any technical specifications or plans to use such a measure in the campaign.

7. Update on Quality Measures

Lansky, Chairperson, Quality Measures Workgroup, reviewed work planned on quality measures in 2012. As a continuation of its work on the development of measures for stage 2, the group will review and comment on the stage 2 NPRM. The workgroup will then consider the measurement opportunities for stage 3. Several new models for quality measurement and action will be considered, such as measure platforms, community-wide quality dashboards and decision support, and consumer decision support to allow patients to see and act on quality dashboards. The workgroup must align its work with that of the HITSC Clinical Quality Workgroup.

Fridsma reported that the HITSC Clinical Quality Workgroup will convene an e-measure lifecycle public hearing in the second quarter. The point of lifecycle is who does what in the process of developing, using and maintaining quality measures over time. The members will also identify any gaps in quality measure standards and examine the extent to which EHRs can gather and supply the data for the e-measures. He acknowledged that many technical details were involved. Both emphasized the importance of alignment of the technical and policy components for CDS as well as for research on clinical outcome and comparative effectiveness. The needs of ACOs and private payers must be considered.

Fridsma reported that ONC has let several contracts for work on readiness for and availability of e-measures, some of which may be ready for use in stage 2. Examples include but are not restricted to functional status following orthopedic surgery, adverse drug events, and close of the referral loop.

Q and A

In response to a question about the contractors, Josh Seidman, ONC, assured the member that the selected contractors did indeed have the experience to translate measures to e-measures. They are leaders in their respective fields. Lansky recognized the importance of monitoring their work. Fridsma said that the committees can help determine when the measures are ready. Harrell talked about the importance of assuring that measurement can be done within the EHRs.

Patrick Conway, CMS, reported that his agency is working on alignment of measures, single reporting, and parsimony and for measures to be tested and ready for stage 2. The result may be a smaller number of measures. There may be an opportunity to override exclusions.

Mostashari exclaimed that the quality measures are key to success. In addition to reporting and accountability, they are important for continuous quality improvement within practices. Quality measure cycles are very integrated. A different approach to the definition of measures may be necessary. All stakeholders must be involved. Exclusions are an issue for further consideration. HIT opens many windows. Incredible cooperation within the federal government agencies has been experienced.

8. Public Comment

Jason Dubois, American Clinical Laboratory Association (ACLA), read a prepared statement on behalf of his organization. ACLA represents clinical laboratories, including local, regional and national laboratories. He pointed out that ACLA members are experiencing problems in providing services to providers that are attempting to qualify for stage 2 while at the same time other providers are in the process of qualifying for stage 1. This has created a strain on resources. ACLA requested that HITPC give consideration to a change in requirements so that a provider only needs to qualify with one laboratory not all labs with which they connect. On a broader topic, ACLA recommended greater coordination across regulatory initiatives such as meaningful use and conversion to ICD 10. He suggested that the committee make recommendation on sequential implementation of these and other initiatives.

SUMMARY OF ACTION ITEMS:

Action item #1: The HITPC approved by voice vote the minutes from the January 2012 HITPC meeting.

Meeting Materials

Agenda

Meeting presentation slices

Summary of January 2012meeting