

Health Information Technology Policy Committee Summary of the July 16, 2009 Meeting

Participants:

David Blumenthal, Chair	HHS/National Coordinator for Health Information Technology
Paul Tang, Co-Chair	Palo Alto Medical Foundation
Roger Baker	Department of Veterans Affairs
Christine Bechtel	National Partnership for Women and Families
James Borland	Social Security Administration
Neil Calman	The Institute for Family Health
Adam Clark	Lance Armstrong Foundation
Arthur Davidson	Denver Public Health Department
Connie White Delaney	University of Minnesota/School of Nursing
Paul Egerman	Businessman/Entrepreneur
Judith Faulkner	Epic Systems Corporation
Gayle Harrell	Former Florida State Legislator
Charles Kennedy	WellPoint, Inc.
David Lansky	Pacific Business Group on Health
Deven McGraw	Center for Democracy & Technology
Frank Nemec	Gastroenterology Associates, Inc.
Marc Probst	Intermountain Healthcare
Tony Trenkle	Centers for Medicare and Medicaid Services
Michael Weiner	Department of Defense
Scott White	1199 SEIU Training and Employment Fund
Larry Wolf (representing Chapman)	Kindred Healthcare
Jodi Daniel	Office of the National Coordinator
Judy Sparrow	Office of the National Coordinator

KEY TOPICS

1. Opening Remarks

Judy Sparrow, Office of the National Coordinator, welcomed everyone to the third meeting of the HIT Policy Committee and informed Committee members that a transcript of the proceedings would be available within 10 days.

David Blumenthal, National Coordinator for Health Information Technology, thanked the Committee members who have worked tirelessly to prepare for this meeting and for past and future meetings. He acknowledged the countless hours of volunteer time devoted to this process, as well as the staff time from the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS), as well as the other federal agencies that have made it possible for a great deal of progress to be made on a wide variety of these complicated issues.

He welcomed two new formally seated Committee members: Tony Trenkle from CMS, and James Borland from the Social Security Administration.

ACTION ITEM #1: The Committee accepted the minutes from last meeting, with the addition of more information on remarks that were made by Gayle Harrell on CPOE, per a discussion Gayle Harrell had with Judy Sparrow.

David Blumenthal discussed his thoughts on the process of accepting HIT Policy Committee recommendations. He explained that in the parent organization to this Committee, the American Health Information Community (AHIC), recommendations were frequently adopted by consensus. He indicated that in some ways, this might be the optimal approach. It may not always be possible, and if a vote is called for, he would entertain a motion for a vote. He noted that he would prefer not to call for a vote unless there is sufficient controversy or disagreement over a given topic.

David Blumenthal then welcomed George Hripcsak, who replaced Farzad Mostashari as Co-Chair of the Meaningful Use Workgroup (Farzad Mostashari has joined the ONC as a senior advisor).

2. Overview of Public Comments on Meaningful Use

David Blumenthal introduced Jodi Daniel to discuss the 792 comments that were received relating to Meaningful Use. The comments were received over a 10-day period after this Committee's last meeting on June 16th. Two first-year medical students helped to process the comments and provide a qualitative sense of their content.

Jodi Daniel acknowledged the input of the Meaningful Use Workgroup and the discussions of HIT Policy Committee members. In terms of process issues, she noted that the Committee, its Workgroups, and the ONC all are working under incredibly tight deadlines; it was hoped that a consensus on Meaningful Use could be reached at this meeting. She reminded the group that recommendations made at this meeting represent those coming from a Federal Advisory Committee and are not recommendations made by the Department of Health and Human Services (HHS). She noted that David Blumenthal is serving in two roles at this meeting, one as Chair of the HIT Policy Committee, and one as National Coordinator of Health Information Technology. Any recommendations generated by the HIT Policy Committee will be transmitted from Committee Co-Chair Paul Tang to David Blumenthal, in his role as National Coordinator. Then, the recommendations will be considered through the regular HHS process.

The timeframe for the interim final rule is December. Jodi Daniel noted that there will be some limitations on what can be done with regard to further input following this meeting. There may be additional questions and thoughts solicited from the Committee in August, but there will be some period of time required to write the regulations, and it will not be possible to collect any further input. In December, there will be another opportunity to comment.

The general themes of the feedback were as follows:

- The majority of people believe Meaningful Use should focus on the measurable improvement of health outcomes, and not adoption of technology for its own sake.
- More than one-third of the comments expressed support for this work.
- Many of the comments suggested specific changes to measures themselves or to the timeline. Although many felt that the timeline was too aggressive; there were many comments that also indicated the timeline either was not aggressive or should be made more aggressive.
- There were requests for items or terms to be clarified. For example, comments asked about what is meant by terms such as “coded format” and “patient preferences.” There were also many questions about details and terminology. The Meaningful Use Workgroup has considered these questions and comments; many will be fleshed out during the rulemaking process.
- Regarding computerized physician order entry (CPOE), the Meaningful Use Workgroup received feedback indicating that CPOE is critical, but there are questions about workflow and how this process can be carried out in 2011. There also was a question about providers other than physicians having access to CPOE.
- In terms of information exchange, there were questions about timeframe, about the type of information to be exchanged, and about regional health information organizations (RHIOs) being used.
- Some comments indicated that it is extremely important to provide patients with access early on. However, the ways in which this could be done in the early years was put into question by multiple comments. Efficiency measures were also discussed.
- Some comments indicated that additional measures are needed relating to specialty providers and voiced concern about how measures will be applied to particular specialties.
- A number of comments indicated that existing sources for measures should be used. HHS and the Meaningful Use Workgroup are looking at a large list of sources, many of which were suggested in these comments, to assist in making measures-related decisions.
- Many comments related to concern regarding the measure for privacy and security; specifically concern that the manner in which the measure is currently written would make it difficult for large organizations to comply. The volume of patients and transactions means that complaints are almost always being lodged, whether they legitimate or not. An unintended consequence might be that agencies would be reluctant to report breaches or make progress towards making information about complaints public, because their payments would hinge on these types of issues.

- Health Insurance Portability and Accountability Act (HIPAA) already address some of the Meaningful Use measures, so redundancy was a concern noted by some comments.

David Blumenthal also noted that a series of 20 listening sessions were held in collaboration with the CMS. Those comments were not tabulated as the others have been, but they have been shared with the Meaningful Use Workgroup.

3. Meaningful Use Workgroup Recommendations

Paul Tang presented a series of slides describing the evolution of the Meaningful Use definition as well as the Meaningful Use Workgroup's thought process. He noted that the American Recovery and Reinvestment Act (ARRA) sets the timeframe, so even though many people are alarmed at how quickly Meaningful Use criteria will be required, that is the way the statute was written. The fact that funding incentives for Meaningful Use are front-loaded, with 2011 being the first and highest-funded incentive year, is also statutory.

Paul Tang noted that the efforts are being made to encourage participation, even if full adoption is somewhat delayed. The Workgroup developed a concept related to an "adoption year." The Workgroup is referring to the 2011 measures as "adoption year 1 criteria," suggesting that "adoption year 1 criteria" would be applied whenever a provider starts.

The following additional points were made during discussion:

- David Blumenthal said that this activity breaks new ground in policy development, not just in HIT, but in setting criteria for improving practices in such a way that they are possible to implement.
- Tony Trenkle questioned the notion of using 2011 criteria as "year 1 criteria," even if they are not implemented in 2011. His concern was that when disincentives begin in 2015, some providers might have been held to a much lower (2011) standard in 2014 if that was their "year 1," and then penalized a year later for not being completely caught up to 2015 standards. He also noted that with every passing year, the technology landscape changes, and he wondered if the 2013 and 2015 standards should reflect this.
- Neil Calman provided a different perspective on why a delay is important. In considering the actual implementation of an EHR, he said, the day that implementation starts is the first day that patients' information starts being entered into the electronic record, so the reporting out of quality data is almost impossible for the first year or so. The first year of implementation is about extensive training, and it takes 1-2 years until the full use of features is possible. There is a good deal of incentive for early adoption, but it would be a mistake to set such a high bar after 2011 that it becomes prohibitive.
- Paul Tang clarified that the 2011 Meaningful Use criterion for hospital CPOE was to have 10 percent of all orders be entered by a physician. Even though the orders were to be entered into the EHR through CPOE (making it available to clinical decision support

processing), electronic transmission of all orders to the receiving department is not required in 2011.

- Mark Overhage noted that in all likelihood, the Committee has not even heard from those who will find this the most difficult to adopt.
- It was noted that because the majority of states have prescriptive authority for advanced nurse practitioners in place, the discussion of CPOE should particularly reference providers such that the advanced nurse practitioner can be encompassed in these measures.
- Gayle Harrell asked whether all practitioners will have to meet all of the measures in order to receive payment. For example, would an ophthalmologist have to verify whether or not a patient has had a mammogram? She suggested that the Committee must proceed in the consideration of specific measures for specialists.
- Gayle Harrell also explained that she has heard many questions from physicians regarding liability, and whether practitioners will find themselves in greater danger of liability issues once they are responsible for following up on information that may not even be appropriate to their specialty. David Blumenthal remarked that the question of what causes liability is enormous and does not fall within the Committee's scope.
- Paul Tang suggested that there should be two sets of measures, one that would be appropriate for everyone, and then specialty-specific measures.
- Latanya Sweeney noted that she has heard a lot of comments regarding patients having some control over opting out, which is directly contrary to the intention of having all records available for exchange.

ACTION ITEM #2: The Committee adopted the Meaningful Use Workgroup's recommendations matrix by consensus, noting for inclusion in the final version a number of specific suggestions and one member's reservation about its aggressive timeframe.

4. Health Information Exchange Workgroup Recommendations

Deven McGraw and Micky Tripathi presented the progress made by the Health Information Exchange Workgroup. David Blumenthal asked the Committee to consider that there appears to be an important choice about how assertive the federal government should be in setting the "rules of the road" for information exchange. One view might be to let the market create the rules. The opposing view would be to have the federal government create an exchange capability, organize it, and govern it—there also are and variations in between these two extremes. He asked Committee members to consider the pros and cons of these viewpoints.

Deven McGraw said that the big question is, if it was left completely up to the market, would it ever be possible that people could actually exchange information across the country? She noted

that proprietary behaviors by vendors might well represent roadblocks to true information exchange. She commented that this behavior should be unacceptable. The other extreme would be a federally controlled system that would have no flexibility, would stifle innovation and cut off those in the industry who are already doing something useful. Devin McGraw also commented that what the HIE Workgroup is proposing is a middle ground (i.e., to set some standards that would give the market a direction to flow in, but would allow for innovation).

Micky Tripathi pointed out that in HIT, unlike any other part of the economy, the supply side and demand side are fragmented.

This connectivity issue was likened to the credit card industry, in that there must be standards, but the government should not dictate the market architecture, because it is not clear what the right architecture will be. A number of Committee members emphasized that the government should not be the organization to build the system.

LaTanya Sweeney noted that, counter to the credit card market analogy, several Internet companies have been very vocal about the hundreds of millions of transactions that they are enabling. They are not content-driven at all, they just structurally enable communication. The issue is, in order to make a system as robust as the Internet, there must be some type of master name service. Naming for labs, for patients, etc., is necessary, which raises significant privacy issues. If that can be set up, she said, the rest would flow and the market would make decisions about structural methods of efficiency.

Neil Calman asked about where the patient fits in the various models that were discussed. For example, who is consolidating information into a meaningful view that a provider would look at? Who is creating what would be a different meaningful view that a patient would want to access. It was suggested that the Meaningful Use criteria should be tested against this construct. If, for example, 2013 criteria are sufficiently stringent about pulling data across the network, and every end user has significant financial incentives, that would create the market pull necessary for true HIE.

ACTION ITEM #3: The HIE Workgroup will create three packages of recommendations for consideration by the committee: (1) a minimal, (2) a moderate, and (3) a more robust set of recommendations with pros and cons for each. In this way, the Committee may be better prepared to arrive at recommendations about the federal government's position in HIE.

5. Certification/Adoption Workgroup Recommendations

Marc Probst, Co-Chair of the Certification/Adoption Workgroup, explained that the Workgroup heard testimony from the public regarding the adoption of certified health records that support meaningful use. Paul Egerman walked through the recommendations that came out of the Workgroup's listening sessions and deliberations. David Blumenthal suggested that the Committee focus on the overall recommendations, and not the more detailed sub-recommendations from the Workgroup. He asked whether the Committee felt comfortable

moving in this direction and for Committee members to focus on the short-term transition questions. The discussion that followed included the following points:

- Tony Trenkle voiced his concern about the tremendous need for education and outreach. As the industry moves from today's state to the more evolved state for vendors and providers, there will be a great deal of potential confusion and disincentive, he said.
- Gayle Harrell discussed the gap in certification for existing products that are already purchased. Health care providers have already spent huge resources and are in the process of using new electronic systems. She asked if there would be a time to set the rules for gap certification and then implement. She also stressed the need for an education component for groups looking to buy these products. Paul Egerman indicated that he thought the gap certification roadblock was not as difficult as the others. The gap certification process could be announced and completed by Labor Day, he said, which would mean certifications could begin later this calendar year.
- Neil Calman noted that if there are multiple certifying organizations, they will compete based on "word on the street" about which is the easiest to pass, and this is a concern. Paul Egerman added that efforts will be needed to ensure that the demand for certification can be met. He also noted that pricing will benefit from the competition.
- Marc Probst noted that a "seal of approval" concept is higher level than what this Workgroup was trying to create. They are simply trying to define a system that will achieve Meaningful Use.
- One Committee member asked about how long and how difficult it will be for HHS to establish a process for certifying product evaluators. How long will the Certification Commission for Health Information Technology (CCHIT) continue to be the certifier? David Blumenthal indicated that the ONC is waiting for guidance from the Office of the General Counsel on this issue.
- Neil Calman expressed concern about how this work will be received by the public. He explained that providers are being told to adopt and embrace EHRs, while at the same time, a new set of standards and certification process is being conceived. Sending out those messages simultaneously creates the risk of freezing everyone in place. He stressed the point that education about this information is critical.
- Deven McGraw noted that even with the progress made related to the Certification/Adoption Workgroup's recommendations, there is a need to ensure that certification reflects Meaningful Use.

ACTION ITEM #4: The Committee adopted the high-level recommendations of the Certification/Adoption Workgroup by consensus, and asked the Workgroup to make changes to the sub-recommendations as suggested by the meeting deliberations. The Workgroup was asked to bring those up for consideration at the next meeting of the HIT Policy Committee.

6. HIT Standards Committee – Update on Progress

Jamie Ferguson, Co-Chair of the HIT Standards Committee, explained that by statute the Standards Committee is charged with developing standards to support the decisions made by the HIT Policy Committee. To that end, the Standards Committee has formed three workgroups. Jamie Ferguson then described the Clinical Operations Workgroup process. Janet Corrigan, Chair of the Clinical Quality Workgroup, described their process and discussed the National Quality Forum (NQF). She explained that the Clinical Quality Workgroup identified measures that were appropriate, and then handed the measures off to the Clinical Operations Workgroup, which then identified the appropriate HIT standards. For the majority of 2011 measures, there is an NQF-standardized quality measure. The challenge in moving forward is that the performance measures that are being used were developed by many different measures stewards, and these measures were not developed for use with EHRs so they need to be retooled. As soon as there is agreement on exactly which measures need to be retooled, that process will begin. The goal is to retool by the end of the calendar year.

Janet Corrigan explained that there will be some harmonized measures for 2011. They are making a distinction between the modification of existing measures versus making significant changes to measures, which will occur in 2013.

Dixie Baker, Chair of the Privacy and Security Workgroup, explained that for a user to receive reimbursement for adopting an EHR, he or she must show that they have acquired a certified product/service, and they also must demonstrate that it is being used meaningfully. After briefly describing the activities of the Privacy and Security Workgroup, she suggested that this Workgroup and the HIE Workgroup hold a joint meeting; Deven McGraw agreed that the two workgroups should meet together.

7. Public Comments

- Kathleen Connor from Microsoft, with connections to HITSP, HL-7, and IHE, asked that the Committee consider whether the standards being discussed are appropriate for modular components. In some situations they are not, she said, particularly around security standards. IAT standards are more for enterprise systems, and are not helpful for privacy protection.
- Mitro Noyeg, representing himself, suggested that the timeframe being discussed for the work is longer than the presidential term, and that is too long. He also questioned the usage of the term “Meaningful Use.”
- Robert Kapler from the American Blood Center, thanked the committee for allowing them to submit comments and for the transparency of this process. Blood centers were included in the Title 8 Stimulus Act. They are part of national response plan and so are a part of the critical infrastructure of this country, along with Emergency Medical Technicians. He stated that blood centers should be part of this process, and he asked where they can fit in. He said that in the Meaningful Use matrix, his group endorses

most measures and thinks this process is being done correctly. But transfusion should be part of the matrix, he said.

- Rick Blake, Strategic Health Resources, noted that the General Accounting Office released a report this week on harmonizing clinical data. Because veterans use Veterans Administration and non Veterans Administration providers, he asked if there was a plan to harmonize the data.
- Jeanne Sagan, Vice President of Operations for Healthcare Wisconsin, said that her organization has just completed a 3-year process of implementing CPOE in nine hospitals across state. One of their approaches was to stratify the implementation. First they dealt with hospitals, intensivists, and the RN population, to try to apply 80/20 rule, focusing on the inpatient world. She suggested that the Committee could examine this as it looks toward the requirement that 10 percent of all orders be electronically submitted.
- Richard Eaton, with the Medical Imaging and Technology Alliance, emphasized that it is important to include diagnostic images and information into EHRs. Medical imaging is a valuable clinical decisionmaking support tool. The primary purpose of ARRA is to make delivery of medical care more efficient. If a practitioner is unable to access imaging information, this fuels the growth of duplicate imaging. Therefore, both diagnostic images and imaging information must be a part of the EHR.
- Donna Robinson with Caption Colorado indicated that she had not heard much about the patient in all of this. She hopes the Committee will make sure that accessibility for the disabled is included, including those with sight and/or hearing impairments. She emphasized that a patient-centered EHR is important.
- Sarah Nickel Sharp with the American Physical Therapy Association noted that Meaningful Use is severely limited without the inclusion of all health care providers. Physical therapists play a crucial role in care, and they must not be excluded. She urged the Committee to develop a recommendation that insures the inclusion of non-physician providers in the definition of Meaningful Use. She offered her organization's help with the process.

SUMMARY OF DECISIONS AND ACTION ITEMS:

- **ACTION ITEM #1:** The Committee accepted the minutes from last meeting, with the addition of more information on remarks that were made by Gayle Harrell on CPOE, per a discussion Gayle Harrell had with Judy Sparrow.
- **ACTION ITEM #2:** The Committee adopted the Meaningful Use Workgroup's recommendations matrix by consensus, noting for inclusion in the final version a number of specific suggestions and a reservation about its aggressive time frame.

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