HIT Policy Committee Meeting
August 1st, 2012

Overview
The August 1st meeting of the HIT Policy Committee agenda included: a discussion of the Meaningful Use Workgroup's preliminary draft recommendations for Meaningful Use Stage 3, a report from the Privacy & Security Tiger Team on the National Strategy for Trusted Identity in Cyberspace (NSTIC) hearing, and an update from ONC's Office of the Chief Privacy Officer.

Background
The HITECH Act, part of the American Recovery and Reinvestment Act of 2009, was passed to help promote the adoption of health information technology (HIT) and create a better health care system. HITECH established two federal advisory committees to assist the Office of the National Coordinator for Health Information Technology (ONC) in the adoption process, with one of them being the HIT Policy Committee (HITPC). This committee provides recommendations to the ONC on major HIT policy issues for consideration. HITPC is itself comprised of many workgroups covering a variety of topics including Meaningful Use (MU), quality measures (QM), the Nationwide Health Information Network (NwHIN), information exchange, enrollment, privacy & security and several others.

Summary of Meeting:
The August HIT Policy Committee meeting focused on a presentation by the Meaningful Use Workgroup on the first four of the five health policy priority areas of meaningful use and the timetable for future consideration. In some instances, the stage 3 recommendation includes certification criteria to support the new or expanded objective or measure. Additionally, the Workgroup includes some Stage 4 placeholders.

During the discussion, the Committee discussed the need for a hearing on the state of health information exchange. The purpose will be to receive feedback from those on the ground concerning current state, where the market is going and what options are needed to accelerate exchange to support increasing meaningful use requirements.

The Committee members were asked to provide comment to the Meaningful Use workgroup for inclusion in the meaningful use recommendations to be presented at the October 3, 2012 HIT Policy Committee meeting. Following the October 2012 meeting, a Request for Comment (RFC) on the Meaningful Use Stage 3 recommendations will be released in the fall of 2012. Following consideration of public comments, the Meaningful Use Stage 3 recommendations will be sent to HHS in the spring of 2013.

Remarks
Judy Murphy, ONC

Deputy National Coordinator for Programs and Policy Judy Murphy gave a brief synopsis of Meaningful Use attestation discussion from the July HIT Policy Committee meeting. She also mentioned the five permanent certification bodies announced last week, the pledge by data and non-data holders to examine ways to encourage consumers to participate in their health through IT, and ONC's website migration to www.healthit.gov. She also highlighted the recent GAO report on RECs, noting that over 40% of primary care providers in the US are working with RECs and that participation with the RECs greatly increases the likelihood of primary care providers achieving Meaningful Use.

Meaningful Use Workgroup: Preliminary Draft Recommendations for Meaningful Use Stage 3
Paul Tang, Chair, Meaningful Use Workgroup
George Hripcsak, Co-Chair, Meaningful Use Workgroup

The PowerPoint presentation shared by the workgroup discusses the initial recommendations in great detail, and is available here:
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__policy_meetings/1813

The Meaningful Use Workgroup began by sharing the guiding principles of their work, holding that Meaningful Use through Stage 3 recommendations for objectives and measures should:

- Support the **new model of care** (such as the team-based outcomes orientation found in accountable care models)
- Address **national health priorities (**National Quality Strategy, Million Hearts Campaign)
- Have **broad applicability** (since MU is a floor)
  - Applicable to specialists
  - Address patient health needs
  - Applicable in diverse areas of the country
- Promote **advancement** – with a focus on activities not already driven by market forces
- Be **achievable** – build upon mature standards widely adopted or that could by widely adopted by 2016

Subgroup 1: Improve Quality Safety, Efficiency and Reducing Health Disparities

- New for MU Stage 3 is to add referral and transition orders into CPOE as a trigger for care condition; with a proposed measure of 20 percent of referrals/transition of care orders created by the EP or EH / CAH.
- Proposing that EHRs be able to consume external lists of drug-drug interactions because current drug-drug interactions available have a very high false positive rate. This has ramifications as people ignore suggestions along with clinical decision support reminders. There is a need for inclusion of some external list that is maintained and peer-reviewed and EHRs must be able to consume this information.
- Electronic prescribing and formulary checking: For EPs, more than 50 percent of permissible prescriptions will be compared to at least one formulary, including generic substitutions, and transmitted electronically using certified ERHs. For EHs, more than 30 percent of discharge medication orders for permissible prescriptions will be compared to at least one formulary and transmitted electronically using certified ERHs.
- Additional categories will be added to collection of demographic information, including occupation, sexual orientation, gender identity and disability status, with more than 80 percent of unique patients seen by EPs or admitted by EH / CAH have demographics recorded as structured data. This assumes that these standards will be developed by 2016.
- Add fields so that EHRs can capture missing data for problem lists, medication lists and code medication allergies. There is substantial value in having accurate and complete problem lists, and there are ways the system can help maintain the accuracy of those lists. In terms of allergies, there is movement towards code standardization with regards to both ingredients and classes of drugs. Currently there is overuse of the allergy field in EHRs as a place to add data that is not specifically captured elsewhere.
- Consideration of retiring the vital sign objective and measure as the 80 percent measure for recordation of vital signs has been achieved.
- Consideration of retiring smoking status objective and measure as the 80 percent measure has been achieved. Alternatively, the objective and measure could be incorporated into the CQMs.
- Advanced directives: Add for EPs if not included in Stage 2 and move it to the core measure set for EH in Stage 3. Ensure that standards support in CDA by 2016.
- Increase use of clinical decision support (CDS) to 15 interventions related to 5 or more CQMs if applicable, at the relevant point in patient care for the entire EHR reporting period. The Workgroup also suggests two certification only criteria – EHR capability to track CDS triggers and provider responses and EHR capability to flag preference-sensitive conditions and provide patients with decision support materials.
- Move the measure for the incorporation of clinical lab-test results into EHRs as structured data to 80 percent of all clinical lab test results ordered by EPs or EHs / CAHs.
- Modify current objective to generate lists of patients for multiple specific conditions to a presentation of real-time dashboards to use for quality improvement, reduction in disparities, research or outreach.
- Increase the measure associated with the objective to provide patient reminders to 20 percent.

- EHRs should have the capability to track mismatches in medication orders using medication administration record (eMAR).
- Incorporate image results and information into certified EHRs as a core objective, pending the Stage 2 Final Rule.
- Record high priority family history data in the patient family health history recorded as structured data, with a measure that such data is recorded for 40 percent of patients seen during the EHR reporting period. The certification criteria will require every CDS intervention to take into account the family history for outreach purposes.
- Increase the measure for hospital labs sending structured electronic clinical lab results to the ordering provider for more than 70 percent of electronic lab orders received.
- New for Stage 3 is the need for transition documents. The details surrounding this are currently in development.

Comments
Overall there was a positive response from the HIT Policy Committee surrounding the recommendations for Stage 3. There were a few clarification questions from the Committee, as well as a discussion of the timing of the Meaningful Use stages and their significance in guiding what's achievable. It was also important to many Committee members to consider what's really important to providers and patients and have a learning process in this work. In terms of the dashboard function, discussion centered on the benefit of a near real-time dashboard, rather than a real-time dashboard, and the ability to report dashboard results longitudinally.

Another point of conversation concerned the thresholds, and whether 100 percent attainment is a goal. There is a sense that it's too difficult and not practical to reach 100% for almost all of these measures. There was a general consensus that 80% is the highest that can be pushed in a policy context.

During the discussion on measures, the readiness of e-measures was raised. Concerning standards, some committee members noted that in some instances the standards are available but are not mature. The question was raised when Stage 3 should be used to drive accelerated industry activity on standards and quality measures and when to follow the industry activity.

The Committee supports more dialogue by ONC and federal partners regarding ways to accelerate some of this work and ensure there isn't duplication. It is also important to mitigate some of the concerns about the fiscal burden of complying with all of these measures.

Timing is also an area of concern. Even though it's important to begin working towards Stage 3, there is data from Stage 1 that should be reflected in Stage 2 and in the thinking for Stage 3.

Subgroup 2: Engage Patients and Families
- The Workgroup recommends exploring further in the RFC the method for achieving the view/download/transmit (VDT) measure, including an auto blue button and an on-demand capability, the transmittal of a summary of care document to a specific care team member and the ability of providers to review and accept updates.
- A new objective was recommended to provide 10 percent of patients with the ability to submit information to providers, with two options proposed. Option one permits EPs and EHs to select one or more information types appropriate for their practice. Option two provides a semi-structured questionnaire platform and the capability for the providers to receive uploads from home devices that can accommodate the data included in the questionnaire.
- New for Stage 3 is the certification criteria that will require EHRs give providers the ability to accept pre-visit information such as consent forms or administrative forms.
- New objective recommended for Stage 3 is the ability for patients to update or correct information and the measure is that 10 percent of patients are offered this ability.
- Modify the objective to identify patient-specific education resources and add one of two options to support language preference for patients. Option one will offer 80 percent of materials, where publically available, in the language preferred by the patients for those patients speaking one of

the top 5 nationally prevalent languages. Option two will offer patient education materials in a language for one non-English speaking population, where the materials are publically available.
- Increase the measure for providers to use secure electronic messaging to communicate with more than 15 percent of patients.
- For stage 3, the Workgroup included a recommendation that EHRs query research enrollment systems to identify available clinical trials.

Comments
There was appreciation among the Committee for the certification only recommendations.

The blue button reference will be clarified to indicate whether it refers to the general concept of blue button or specifically the Blue Button.

There is also a request to clarify whether the language requirements and capacities would be applicable to all EPs.

Subgroup 3: Improve Care Coordination
- Reduced reconciliation to 50 percent for all transitions of care, but perform reconciliation for medications, medication allergies and problems.
- Maintained 65 percent threshold for summary of care but increased the electronic requirement to 30 percent. Specify 4 fields that must be included in "site" transitions. Transitions in setting of care do not include from one floor to another in the same setting, but can include transition to the home.
- New in Stage 3 is the certification criteria that will require the EHRs set aside a concise narrative section in the summary of care document that allows providers to prioritize clinically relevant information such as the reason for the transition.
- New objective in Stage 3 requires that the care plan information for each transition of care include 8 elements, as applicable, including 3 as free text. The measure is that EPs, EHs / CAHs provide the electronic care plan for 10 percent of transitions of care to receiving providers.
- New in Stage 3 requires that the EPs, EHs / CAHs who receive referred patients acknowledge receipt of the transmitted care information. The measure is that for 10 percent of patients referred the receiving provider's EHR generates a referral result to the referring provider via scan, fax, CDA or printout.

Comments
There was discussion of whether the incentives are strong enough to promote the exchange of information necessary and noted concern that data exchange is not there for many providers. Members wondered whether there are new alternative ways to look at the environment and see what's really happening in the market and on the ground.

A conversation about the broader exchange environment is necessary. This is a critical time for exchange in support of care coordination. There was a consensus that a public hearing bringing together stakeholders who are on the ground working through the problems would be beneficial in guiding the Committee's recommendations.

ONC brought up an interesting point that perhaps percentages should not be included in the recommendations. After having gone through this MU development process twice now, it's become apparent that the percentages can be distracting and take away from the policy being put forward.

Subgroup 4: Improve Population and Public Health
- New objective for Stage 3 is capacity for EPs and EHs to receive patient immunization history from an immunization registry or immunization information system. The measure is timely and successful electronic receipt by certified EHR of immunization history for 30 percent of patients who received immunizations. The certification criteria is the ability of EHRs to receive and present a standard set of structured, externally-generated, immunization history

- New objective for Stage 3 is generating recommendations for immunizations that are appropriate based on age, gender and immunization history, as applicable by local or state policy. The measure is implementation of an immunization recommendation system, containing baseline recommendations and allowing for local variation, for 20 percent of patients receiving an immunization. The certification criteria that will require the use of a standard rule set and include age/gender/prior immunization history and the act and date/time of the recommendation review.
- New objective for Stage 3, pending final Stage 2 rule, is capability for EPs and EHs to electronically participate and send standardized commonly formatted reports to a mandated jurisdictional registry from certified EHRs to local or state health departments, except where prohibited or where local or state health departments lack mandated registries or are incapable of receiving the reports. The measure is attestation of submission for at least 20 percent of all patients who meet registry inclusion criteria during the entire EHR reporting period. The certification criteria requires that the EHRs are able to build and send a standard message to an external mandated registry, maintain an audit of the report and track total number of reports sent.
- New objective for Stage 3 is capability of EHs to electronically send standardized healthcare associated infection (HAI) reports from a certified EHR to the National Healthcare Safety Network, except where prohibited. The measure for EHs is documentation of successful electronic submission of standardized reports of at least 20 percent of all reports during the entire EHR reporting period in accordance with applicable state law.

Comments
There was discussion surrounding the differences in states' immunization processes. A question was raised about supporting the movement of immunization reports across state lines if the data is formatted differently in each state. States all accept HL7 but each uses it differently. Committee members agreed that more public comment is needed about the readiness of state public health departments. It is very important not to throw too many requirements at once in order to avoid any unintended adverse consequences. The committee recognizes that they cannot drive capacity increases in the states and providers should not be penalized if the state capacity is a barrier to meeting the MU objective. Also important in accomplishing these goals is financial support at the state level. A question was raised about the ability of state designated entities for health information exchange to assist in addressing these recommendations.

A suggestion was raised that this domain could include a new requirement that patient safety events could be captured by certified EHRs and reports sent to Patient Safety Organizations.

Suggestion was offered that the HITPC can make a statement of what the states should do to support the recommendations.

General Comments about Meaningful Use Stage 3
The committee members discussed the current levels of attestation and whether there is reason for concern based on current participation rates.

Interoperability / data exchange activity and the state readiness for the exchange to support registries and reporting with public health were two ideas for future hearings. State CIOs should be included in the hearing.

The recommendations that support the overall effort at a new healthcare paradigm that drives care coordination should be included. The committee also agreed that streamlining of the recommendations is a good idea so that the overall effort remains focused.

The committee will consider whether to remove some of the standard of care pieces that providers are already doing.

Privacy & Security Tiger Team: Report on Hearing on the National Strategy for Trusted Identity in Cyberspace (NSTIC)

Deven McGraw, Co-Chair

The Privacy & Security Tiger Team walked through a discussion of a recent hearing on the National Strategy for Trusted Identity in Cyberspace. The PowerPoint presentation containing detailed information on the hearing is available here:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1814&parentname=CommunityPage&parentid=18&mode=2&in_hi_userid=11673&cached=true

The Privacy and Security Tiger Team (P&STT) offered recommendations:

1) Move to a higher level of assurance for riskier exchange transactions for Meaningful Use Stage 3, to align with the NSTIC initiative. The term riskier exchange transactions is a term to be defined, but could include remote access to systems or data across a network. Low risk could include onsite or intra-organizational access to systems and data.
2) As an interim step, ONC could require a baseline two-factor authentication with existing organization-driven identity proofing (a level of assurance slightly below the NSTIC Level 3).
3) ONC should consult with NIST about future iterations of the NIST requirements so that any unique needs in the healthcare environment are identified and specifically addressed.

The Committee was generally receptive to the points brought up, and asked several questions about the specific exchange scenarios that would trigger the higher level of assurance. The identify assurance related to information exchange was identified as distinct from credentialing or sharing of credentials. The P&STT recommendations go to information exchange. There was recognition that the prescription of controlled substances will necessitate moving to higher level of assurance (Level 4) than what is recommended by the P&STT. The committee members also inquired about the cost associated with moving to the higher levels of assurance included in the NSTIC.

Update from ONC: Office of the Chief Privacy Officer
Joy Pritts, Chief Privacy Officer

The ONC's privacy office shared a presentation with substantial information about the initiatives underway at ONC regarding privacy and security. This presentation is available here:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1814&parentname=CommunityPage&parentid=18&mode=2&in_hi_userid=11673&cached=true