



Health IT Policy Committee Meeting

Meeting Notes December 13, 2010

[Meeting Agenda](#)

On December 13th, the [Health IT Policy Committee](#) hosted the final full committee face to face meeting of the year. Dr. Blumenthal arrived late, and spoke later in the agenda. He thanked the Governance workgroup for the “challenging and exciting” recommendations. He announced that ONC will be meeting over the next two days with all HITECH Act grantees, including State HIE Grants, Regional Extension Centers, SHARP Grants, and more to discuss lessons learned. The grantees will hear from HHS Secretary Kathleen Sebelius, CMS Administrator Don Berwick, Dr. Blumenthal, CDC Director Thomas Frieden, White House CTO Aneesh Chopra, and numerous ONC staff. Dr. Blumenthal called the meeting “a watershed moment” for ONC and healthcare modernization efforts.

Chair, Dr. Paul Tang, welcomed the committee, approved the meeting minutes from the November meeting, and reviewed the agenda and goals for the meeting.

Governance Workgroup Recommendations: John Lumpkin and Mary Jo Deering

December 2010: Final recommendations

- Principles
 - Transparency
 - Inclusive participation and adequate representation
 - Effective and efficient
 - Accountability
 - Federated governance and devolution
 - Clarity of mission, consistency of action
 - Fairness (due process)
 - Promote Innovation
 - Evaluation and Continuous Improvement

- NW-HIN as preferred approach
 - The NW-HIN should be an environment of trust and interoperability for exchange based on NW-HIN Conditions of Trust and Interoperability (COTIs):
 - Should be the preferred approach for exchange of health information nationwide.
 - Should be supported by the federal government with strong incentives to vigorously promote adoption.

- Federal leadership and shared responsibilities
 - The Federal government should establish conditions for trust and interoperability and use authority to promote compliance
 - Recognize existing state authorities across all relevant domains and facilitate coordination and harmonization with states and other entities as needed
 - All federal agencies should participate in NW-HIN and it’s governance
 - All federal HIE should be compliant with NW-HIN requirements

- NW-HIN Conditions of Trust and Interoperability

- ONC should issue initial set of ONC COTI's as a baseline and address need for variability
- ONC should establish a process for adding and modifying COTIs to allow for maximum flexibility in order to promote innovation and adaptation.
- NW-HIN Validation
 - ONC should establish a mechanism to verify that NW-HIN COTIs are satisfied.
 - NW-HIN validation is required to exchange information using the NW-HIN and assert compliance
 - EHR Certification is a pathway to validation to COTI. Any validation testing methodology used should include EHR Certification testing to establish COTI when applicable.
- Oversight
 - ONC should oversee NW-HIN governance and assure accountability
 - Coordinate between Federal Agencies, state entities and validation entities
 - Monitor and highlight innovation
 - Address governance barriers
 - Provide ongoing evaluation and continuous improvement

Meaningful Use Workgroup

Stage 2 and Stage 3 Meaningful Use Recommendations for Discussion

Discussion DRAFT Meaningful Use Objectives			
Meaningful Use: Stage 1 Final Rule (<i>italics optional</i> Stage 1) and Proposed Objectives for Stages 2 and 3			
Improving Quality, Safety, Efficiency & Reducing Health Disparities			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
CPOE for Rx orders (30%)	CPOE for 60% of Rx, lab, and radiology orders entered by licensed professionals (not specify transmission mode)	CPOE for 80% of Rx, lab, radiology, and referral orders entered by licensed professional (not specify transmission mode)	Stages 2 and 3, order can be transmitted electronically or on paper, except as noted in other objectives (allows market forces to push electronic transmission)
Drug-drug/drug-allergy interaction checks	Employ drug interaction (drug-drug, drug-allergy) checking on appropriate evidence-based interactions	Employ drug interaction (drug-drug, drug-allergy) checking on appropriate evidence-based interactions	Reporting of events to be covered under quality measures WG; challenge of disincentives to report
E-prescribing (EP) (40%)	60% of orders (outpatient and hospital discharge) transmitted as eRx if fits patient preference	90% of orders (outpatient and hospital discharge) transmitted as eRx if fits patient preference	
Record demographics (50%)	80% of patients have demographics recorded and can use them to produce stratified quality reports	90% of patients have demographics recorded (including IOM categories) and can use them to produce stratified quality reports	

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Improving Quality, Safety, Efficiency & Reducing Health Disparities			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Report CQM electronically	Continue as per QM WG and CMS	Continue as per QM WG and CMS	
Maintain problem list (80%)	Continue Stage 1	80% problem lists are up-to-date	Drive list to be up to date by making it part of patient visit summary and care plans
Maintain active med list (80%)	Continue Stage 1	80% medication lists are up-to-date	Drive list to be up to date via medication reconciliation
Maintain active med-allergy list (80%)	Continue Stage 1	80% medication allergy lists are up-to-date	Drive the list to be up to date by making it part of visit summary
Record vital signs (50%)	80% of patients have vital signs recorded	80% of patients have vital signs recorded	
Record smoking status (50%)	80% of patients have smoking status recorded	90% of patients have smoking status recorded	

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Discussion DRAFT Meaningful Use Objectives

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Improving Quality, Safety, Efficiency & Reducing Health Disparities			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Implement 1 CDS rule	Use CDS to improve performance on high priority health conditions. Set CDS attributes (to be used for certification): 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow for use; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action.	Use CDS to improve performance on high priority health conditions. Set CDS attributes (to be used for certification): 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow for use; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action.	
<i>Implement drug formulary checks</i>	Move current measure to core	80% of medication orders are checked against relevant formularies	Issue of availability of formularies on the EP side
<i>Record existence of advance directives (EH) (50%)</i>	For EP and EH: 50% of patients >=65 have recorded the result of an advance directive discussion and the directive itself if it exists	For EP and EH: 90% of patients >=65 have recorded the result of an advance directive discussion and the directive itself if it exists	Consider public hearing; issues include state statutes, ambulatory, age, privacy, specialists; needs to be accessible and certifiable

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
<i>Incorporate lab results as structured data (40%)</i>	Move current measure to core, but only where results are available	90% of lab results are stored as structured data in the EHR and are reconciled with structured lab orders, where results and structured orders available	
<i>Generate patient lists for specific conditions</i>	Generate patient lists for multiple patient-specific parameters (move to core)	Patient lists are used to manage patients for high priority health conditions	Driven by quality measures
<i>Send patient reminders (20%)</i>	Move to core	20% of active patients who prefer to receive reminders electronically receive preventive care or follow up reminders	Need to define what is an active patient
(NEW)	30% of visits have at least one electronic EP note	90% of visits have at least one electronic EP note	Can be scanned, narrative, structured, etc.
(NEW)	30% of EH patient days have at least one electronic note by a physician, NP, or PA	80% of EH patient days have at least one electronic note by a physician, NP, or PA	Can be scanned, narrative, structured, etc.
(NEW)	30% of EH medication orders automatically tracked via electronic medication administration recording	80% of EH inpatient medication orders are automatically tracked via electronic medication administration recording	

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Discussion DRAFT Meaningful Use Objectives

Meaningful Use: Stage 1 Final Rule (<i>italics</i> optional Stage 1) and Proposed Objectives for Stages 2 and 3			
Engage Patients and Families in Their Care			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
<i>Provide electronic copy of health information (50%)</i>	Continue Stage 1	90% of patients have timely access to copy of health information from electronic health record	Only applies to information already stored in the EHR
<i>Provide electronic copy of discharge instructions (EH) at discharge (50%)</i>	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients. (Patients may elect to receive a printed copy of the instructions.)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 90% of patients in the common primary languages. (Patients may elect to receive a printed copy of the instructions.)	Electronic discharge instructions may include items like a statement of the patient's condition, discharge medications, activities and diet, follow-up appointments, pending tests that require follow up, referrals, scheduled tests
<i>EHR-enabled patient-specific educational resources (10%)</i>	Continue Stage 1	20% offered patient-specific educational resources online in the common primary languages	

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Engage Patients and Families in Their Care			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
(NEW)	80% of patients offered the ability to view and download, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in a uniformly human-readable form (HITSC to define; e.g., use of PDF or text).	80% of patients offered the ability to view and download, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in a uniformly structured form (HITSC to define; e.g., use of CCD or CCR).	"Uniformly" implies HITSC should pick a single standard for human readable and a single standard for structured. Inpatient summaries include: hospitalization admit and discharge date and location; reason for hospitalization; providers; problem list; medication lists; medication allergies; procedures; immunizations; vital signs at discharge; diagnostic test results (when available); discharge instructions; care transitions summary and plan; discharge summary (when available); gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. 11

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Engage Patients and Families in Their Care			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Provide timely electronic access (EP)* (10%)	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly human-readable form by 2013 (HITSC to define; e.g., use of PDF or text).	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly structured form by 2015 (HITSC to define; e.g., use of CCD or CCR).	"Uniformly" implies HITSC should pick a single standard for human readable and a single standard for structured. The following data elements are included: encounter dates and locations; reasons for encounters; providers; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders; longitudinal care plan; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. 12

Discussion DRAFT Meaningful Use Objectives

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Engage Patients and Families in Their Care			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Provide clinical summaries each office visit (EP)* (50%)	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly human-readable form by 2013 (HITSC to define; eg, use of PDF or text).	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly structured form by 2015 (HITSC to define; eg, use of CCD or CCR).	<p>"Uniformly" implies HITSC should pick a single standard for human readable and a single standard for structured.</p> <p>The following data elements about the encounter are included (where relevant): encounter date and location; reasons for encounter; provider; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders; future appointment requests, referrals, scheduled tests; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status.</p>

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Discussion DRAFT Meaningful Use Objectives

Meaningful Use: Stage 1 Final Rule (<i>italics optional Stage 1</i>) and Proposed Objectives for Stages 2 and 3			
Engage Patients and Families in Their Care			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
(NEW)	EPs: 20% of patients use a personal health record (includes patient portal) to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet.	EPs: 30% of patients use a personal health record (includes patient portal) to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet.	
(NEW)	EPs:30% offered secure patient messaging online	EPs:90% offered secure patient messaging online	
(NEW)	Patient preferences for communication medium recorded for 20% of patients	Patient preferences for communication medium recorded for 80% of patients	
		Offer electronic self-management tools to patients with high priority health conditions	
		EHRs have capability to exchange data with PHRs using standards-based health data exchange	
		Patients offered capability to report experience of care measures online	
		Offer capability to upload and incorporate patient-generated data into EHRs and clinician workflow	

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Improve Care Coordination			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Perform test of HIE	Connect to at least one external provider in "primary referral network" or establish an ongoing bidirectional connection to at least one health information exchange	Connect to at least 30% of external providers in "primary referral network" or establish an ongoing bidirectional connection to at least one health information exchange	Successful HIE will require development and use of infrastructure like ELPD
<i>Perform medication reconciliation (50%)</i>	Medication reconciliation conducted at 80% of transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	Medication reconciliation conducted at 90% of transitions by receiving provider	
<i>Provide summary of care record (50%)</i>	Move to Core	Summary care record provided electronically for 80% of transitions and referrals	
(NEW)	List of care team members available for 10% of patients in EHR	List of care team members (including the PCP) available for 50% of patients via electronic exchange	
(NEW)	Record a longitudinal care plan for 20% of patients with high priority health conditions	Longitudinal care plan available for electronic exchange for 50% of patients with high priority health conditions	Such as: care team members, diagnoses, meds, allergies, goals 15

Discussion DRAFT Meaningful Use Objectives

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Improve Population and Public Health			
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
<i>Submit immunization data</i>	EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law	EH and EP: Mandatory test. Immunizations are submitted to IIS, if accepted and as required by law. During well child/adult visits, providers review IIS records via their EHR.	Stage 2 implies at least some data, not necessarily all (e.g., to another state); goal to eventually review IIS-generated recommendations
<i>Submit reportable lab data</i>	For EH make Stage 1 core. For EP make lab reporting menu.	Mandatory test. For EHs, submit if accepted and as required by law. For EPs, ensure that reportable lab results are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law). Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports.	

Meaningful Use Stage 2 Timeline

- Dec, 2010: refine draft MU criteria, prepare for request for comment (RFC)
- Jan, 2011: HIT Policy Committee will release a draft MU criteria RFC
- Feb, 2011: collect RFC submissions
- Mar, 2011: analyze RFC submissions and revise MU draft criteria
- April, 2011: present revised draft MU criteria to HITPC
- 2Q11: CMS report on initial Meaningful Use RFC comments
- 3Q11: Final HITPC recommendations on stage 2 MU
- 4Q11: CMS MU NPRM

Information Exchange Workgroup Recommendations

Information Exchange Committee Chair Micky Tripanthi noted that the Workgroup would present on Entry Level Provider Directories (ELPDs) at the December meeting, and will present recommendations on Individual Level Provider Directories (ILPDs) at the February 2nd, 2011 meeting

- Recommendation 1: **The HITSC should be directed to identify technology, vocabulary, and content standards that will create an ELPD with multiple registrars and a single, nationwide, registry**
 - [The single, nationwide registry must be accessible by EHR systems](#)
 - Acquisition of a security credential (certificate) and discoverability of this credential using the ELPD must be included in the technical approach
 - The technical approach must also include a process for certification of ELPD functionality in EHRs and accreditation of registrars
- Recommendation 2: The federal government should use the strongest available levers to require registration in, and encourage use of, the nationwide ELPD
 - ELPD registration and use should be incorporated in Meaningful Use Stage 2/3 and in NW-HIN participation requirements
 - The MU Working Group should work jointly with the Information Exchange Workgroup to determine the best approach for incorporating ELPD registration and use into Meaningful Use Stage 2/3 criteria
 - ELPD governance and participation should be included as part of NHIN “Conditions of Trust and Interoperability” and used as a lever to establish NHIN Governance
 - Require ELPD registration for participation in NHIN Exchange and Direct
 - Create an accreditation process for registrars within the context of other similar processes
- Recommendation 3: State-level HIE and Beacon programs should be required to incorporate the national registry in addressing their provider directory needs
 - ONC should require conformance with ELPD standards and technical guidelines
 - ONC should encourage state-level HIE program grantees to become accredited registrars and to promote the establishment of accredited registrars in their states and regions

HIT Policy Committee Privacy and Security Team Update:

- Chair Deven McGraw summarized the December 9th hearing on Patient Matching.
- HIMSS Patient Identity Integrity Workgroup Chair Barbara Demster testified at the hearing. Read her [testimony here](#).
- Common themes emerged from the testimony
 - Accurate patient linking has a number of benefits, including potential for improved patient outcomes and patient safety, greater efficiency, improved fraud detection, and reduced inappropriate data exposure.
 - Achieving greater accuracy in data linking is a challenge due to poor data quality