



Health IT Policy Committee Meeting
Meeting Notes
May 11, 2011

[Meeting Agenda](#)

Opening Remarks

- Dr. Mostashari recognized the importance of transparent and inclusive processes.
 - Discussion of Meaningful Use – Exciting to think about – Dynamic tension between the two principles
 - Eye on the Prize and Feet on the Ground
 - Evidence-based – working backward from the S& I Framework
 - Maintaining the momentum for participation in the Health IT program
 - Groups need to feel invited in to the process.
 - Maintain progress UP the escalator
 - Advancement of the technology, quality measures to keep organizations improving care at a “rate they can manage”.
 - Health IT and the Health IT Incentive programs do not live in a vacuum – they are components of overall healthcare transformation. Health IT needs impact the Payment and delivery systems
 - MU can be a roadmap for what needs to happen on administrative and cost effectiveness sides of healthcare delivery.
 - Usability –
 - Significant transparency is desired
 - Part of the process is identifying the appropriate role for government to stimulate innovation, without hurting the smaller company or endangering patients
 - Patient Interests
 - Key to success will be public trust in government – privacy, security, and confidentiality of personal health information
 - Joy Pritts, ONC Chief Privacy Officer, is leading effort.
 - Welcoming Dr. Josh Sharfstein, – representing one of the public health slots for the HITPC. Formerly at FDA; now Secretary of the Department of Health & Mental Hygiene to the State of Maryland

Meaningful Use Workgroup: Stage 2 and Timing

Presented by Paul Tang and George Hripcsak

- [Presentation](#) and Recommendations
- Timeline – Present Draft recommendations on Stage 2 MU; May 13th – hearing on specialists and experience from the field; final recommendations to HITPC on June 8th
 - June 2011 – HITPC stage 2 MU recommendations to ONC and CMS;
 - End 2011 anticipate HHS MU NPRM;
 - Mid 2012 anticipate HHS MU Final Rule

- Based on feedback from the public and the HITPC the Meaningful Use Workgroup revised their recommendations for Meaningful Use Stage 2 with the new objectives in the five categories.
- **Improving Quality, Safety, Efficiency, and Reducing Disparities**
 - CPOE – shifted to 60% and added lab and radiology. – Radiology – > or = to 1 order sent if an order is sent
 - Drug-drug – DDI –
 - Dvorak -- sooner we g
 - E-Prescribing – EP s increased to 50% and EH hospital discharge
 - Demographics – move to 80% and more granular patient demographic information
 - IOM Report --???
 - Dvorak – if we are going to a nationally standardized list for drug-drug interactions, the sooner industry can get the more likely they’ll be able to incorporate into systems
 - Trenkle – need to make sure we take into account that Medicaid providers will be earlier in their Health IT life cycles.
 - Unique patients who have at least 1 lab result in the database
 - Harrell – concern about lab requirements for CPOE in smaller communities
 - Larry Wolf – Demographics – need to get feedback on standards
 - Egerman – Usability and overriding capabilities for CPOE – fewer the key strokes the better.
 - Tang – reason for override needs to make sure that providing the information takes care of the concern throughout the encounter
- Screen 2
 - Vital signs – made technical corrections
 - Smoking status -- increase from 50 to 80%
 - CDS –
 - Menu becomes CORE
 - Advanced directive –end goal – have information available to clinician at EH or EP.
 - Over time, HITPC would like to push the requirements to the EP.
 - Lab test results – Use LOINC
 - Hospital labs are part of MU, and should included in the process.
 - Making LOINC a requirement where available
 - Dvorak – lab results – intended to be structured or unstructured?
 - Conversation around necessity of having a LOINC code for the test results
 - Harrell – If LOINC, then need to make a strong push that all facilities use, and be cognizant of impact on small and rural facilities
 - Egerman and Trenkle – be aware of Advanced Directive requirements and how they impact specialists
 - Wolf – movement toward standards will take time for implementation because internal mapping to national standards may take time and have an incredible cost for the local facility
 - Tang – Conversion problems are an issue for the MU Workgroup
 - Calman – Don’t be afraid to identify the standard and telling industry to get to the standard

- Trying to get providers to adhere to particular specialty requirements may impact their ability to participate
 - Considerable discussion on the requirements around laboratory results sharing. – Will the scope for requirements in an ehrs develop BEYOND the capability for the ehrs?
 - Mostashari – Remember that Information Exchange is a requirement from the HITECH Provisions in ARRA
- Screen 3
 - Menu moved to Core
 - Preventive follow up – reminders -- move to core
 - 3 new items;
 - Dvorak – suggested widening the scope of eMedication Administration beyond “automatically tracked” so you don’t have to define “automatically tracked” in the rule making process
 - Larry Wolf --
- **Engaging Patients and Families**
 - Dropping the requirement for > 50% of patients with an electronic copy of health information
 - EHs – Provide 50% -- moved to 25 patients – idea is that once you are doing 25, you’ll incorporate into
 - Attempted to consolidate and make it easier for EPs and EHs to demonstrate they’ve reached the requirements
 - Dvorak – view vs. download. Have the ability to download.
 - Bechtel – Intent is to develop the capacity for the patient to download into a single location from multiple providers.
 - Fischetti – Timely electronic access – is it a measure of true engagement?
 - Bechtel – having a minimum # of individuals have access to information
 - Harrell concerned that digital divide may create an issue.
 - Trenkle – moving from menu to core – be sure to take into consideration whether moving from menu to core will improve the quality of care for the patient and that the patient is a Medicare or Medicaid patient.
 - Sharfstein – is discharge instruction distribution intended to include text messaging?
 - Intended to be more information than text messaging can handle. However, will need to review verbiage.
 - Dvorak – concerned about making sure the public is aware of the “concerns” of downloading and how their data should reside in a
 - Bechtel – ACO regulations with respect to patient engagement – must have plan for beneficiary access to medical record. Doesn’t indicate that access needs to be electronic. ACO rule leverages MU, but doesn’t consider maturation of MU program.
- **Improve Care Coordination**
 - Wolf – longitudinal care plans need to be broadened and may want to consider making core in Stage 3
 - Bechtel – need clarity around data fields
 - Nervous about longitudinal care plan

- Dvorak – strongly suggest moving care plan to Stage 3.
- Harrell – Care coordination is where we’re going to get the biggest bang for our buck
 - Long term care facilities – outside the ARRA requirements and mission of the HITPC. How can we address without having mission creep?
 - Hripcsak—sending information to LTCs will help provider – not intended to count against who and where a care coordination plan is sent.
- Egerman – Why collecting care coordination team?
 - Hripcsak – setting the stage for vendors to develop changes to ehRs to ensure that care coordination (clinicians involved) is collected
- **Population and Public Health**
 - Privacy and Security
 - Timeline Options
 - Notion is to try to maximize EP and EH involvement without negatively impacting their road to HER adoption
 - Shifting to delaying start of Stage 2 by one year
 - Early entrants will get paid for year 3, while the Stages catch up to the requirements
 - Harrell – Getting EPs and EHs on board for Stage 1 and keeping everyone moving forward toward being MU is ideal. Support Option 3
 - Egerman – Support Option 2 to keep the process moving forward.
 - Dvorak – Technical window is the challenge for preparing solutions to
 - Support Option 3 or a redefining of Option 1 or 2 with decreased metrics
 - Unnecessary Upgrade required for Certification year. Suggest making the certification requirement consistent with the MU Stage
 - Probst – 90% of mature users are feeling undue pressure to meet MU Stage 1 requirements. Most will be waiting to meet MU in 2012. More we can relieve their anxieties, while keeping the process moving forward, the better.
 - Wolf – More field experience needed
 - Bechtel – process for updating recommendations – as we see more changes in the field, we should keep from remaining static.
- **Information Exchange Workgroup**
- [Presented](#) by Micky Tripathi and David Lansky, Workgroup co-chairs.
- Presentation was on Recommendations to address Individual-Level Provider Directories (ILPDs). The ILPDs are intended to be sub-national directories that will provide standardized data on provider information (demographics, location, etc.). The ILPDs will feed into the Entity-Level Provider Directories, and create national coherence to provider directories.
- ILPDs will be developed through local communities, State-level Health Information Exchanges, Beacon Communities, etc., and will be beneficial to information exchange in the community.
- Recommendations are intended as Policy Guidance in four domain areas: Content; Functionality; Security, access, and audit; and Immediate policy levers. Recommendations also provide best practice approaches for each domain area.

- Micky Tripathi indicated that the first example of a state using the framework outlined by the Information Exchange Workgroup is a May 10, 2011 Request for Proposal from the State of California. RFP includes providers, hospitals, health plans, and medical device manufacturers in their model. Workgroup will monitor activity.
- Tripathy indicated that there are two areas that the Information Exchange Workgroup did not provide solutions and will need further guidance from HITPC and the government include:
 - Sense of urgency from funded state-level activities embarking on directories
 - Varying activities in federal and state policy arenas prevent more specific recommendations.

Privacy & Security Tiger Team

- Deven McGraw and Paul Egerman, co-chairs of the Privacy & Security Tiger Team, briefed the Committee on the Tiger Team's policy recommendations associated with ILPDs
- **Privacy and Security: Content Recommendations**
 - Individuals who can be listed in an ILPD should include all individual health care providers who are licensed or otherwise authorized by federal or state rules to provide health care services or support the health of populations
 - Attributes of those individuals should include:
 - Demographics: Last and first name, provider type, specialty, name and address of practicing locations, practice telephone number, e-mail address and hospital affiliation
 - Identifiers: NPI, DEA, State License #, etc.
 - Entity-affiliations (mapped to ELPD)
- **Privacy and Security: Functionality Recommendations**
 - Discoverability of an individual provider and their practice location(s) in order to support a broad array of HIE functions
 - Tight mapping to nationwide ELPD to allow seamless electronic addressing, synchronization of ILPD listing(s) with their affiliated ELPD listing(s), and in general, interactive access to ELPD information about the entities associated with individual providers listed in the ILPD
- **Privacy and Security: Security Access Audit Recommendations**
 - Access to an ILPDs content should include clinicians and support and administrative staff. Well defined roles and rules-based access policies for users and operators of ILPD services should be put into place.
 - Policies should be set at the local level and consider federal and state law, regulation and accepted practices.
 - Sensitive content (state license and DEA numbers, etc.) needs to be restricted and user access to this information limited.
 - Data integrity policies should ensure that that
 - data contained in the ILPD is appropriately protected from unauthorized changes
 - individuals or their authorized delegates have ability to maintain their own data
 - Audit trail policies and procedures to track data provenance, access and use, and to support investigation of inappropriate use and breaches

Privacy and Security WG: Immediate Policy Levers Recommendations

- Technical interoperability standards (including messaging and content standards) for ILPDs should be recommended to the ONC by the HITSC consistent with the HIT Policy Committee recommendations on ILPDs and ELPDs and with ONC's S&I Framework
- Federal EHR certification standards should include any ELPD/ILPD standards adopted by ONC/CMS as appropriate
- NLR and PECOS content should be made available by CMS for ILPD services funded through the State HIE Cooperative Agreement program.
- State HIE Cooperative Agreement funds to establish state-level ILPDs should be directed to adhere to ONC/CMS adopted ELPD/ILPD standards and policies
- CMS should consider how State Medicaid agencies could be required to incorporate ILPD/ELPD use in their Medicaid Health IT Plans, MITA, and state EHR incentive programs

Certification/Adoption Workgroup – Outcome of EHRs Usability Hearing

- **Presented by Marc Probst, Workgroup co-chair, and Workgroup member, Larry Wolf**
- April 21, 2011 hearing in Washington, DC included opening remarks from Dr. Mostashari (he recapped his comments at start of HITPC meeting – see above), and panels of care providers, consumers, technology developers, and Subject Matter Experts on measuring and improving usability.
- Bottom line for Dr. Mostashari on evaluation is the ability to measure levels of usability, not just “your product is/is not usable”
- All panels were concerned about using technology to enhance collaboration between providers and patients as consumers
- Providers interested in usability that allows them more time interacting with patients than viewing computer screens, as well as taking into account cognitive ability loads and possible provider-level disabilities.
- Consumers are 21st Century thinkers, and expect technology to work as easily as their smart phones. They are also concerned that repurposing of data may not fit as easily as technical community may expect. Consumer understanding of billing data used for clinical updates may be impacted.
- Technology developers had varying views on federal involvement in regulating health IT solutions for usability.
- HITPC members expressed concern that patient safety, the main focus of usability discussion, may be getting lost in the discussion around regulation and technical capability.
- Dr. Calman expressed concern that the usability experience for the provider will have and incredible impact on patient experience from the event. His concerns were echoed by Rep. Harrell.
- As the HITPC moves forward on usability, the workgroup was cautioned to make sure that MU requirements do not negatively impact the provider's comfort level and technology's usability capabilities.