



HIT Standards Committee Meeting
May 18th, 2011

Agenda

Background

The [Health IT Standards Committee](#) is charged with making recommendations to the National Coordinator for Health IT on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information. In developing, harmonizing, or recognizing standards and implementation specifications, the Health IT Standards Committee will also provide for the testing of the same by the National Institute for Standards and Technology (NIST).

Opening Remarks – Farzad Mostashari, MD National Coordinator for Health Information Technology

- This will be the summer of fun with the process and timelines for taking the recommendations of the Policy Committee and creating Certification criteria and appropriate standards.
- The Policy Committee will be making final recommendations for Stage 2 Meaningful Use on June 8th.
- Systems are starting to be put into place to support a nationwide learning system.
- Better payment will be a product of the quality of the measures recommended by the Standards Committee
- ONC and the HITSC Implementation Program is seeking comments on the Temporary Certification Program. “We really want your feedback.”
- HITSC and ONC “Summer Camp” will be seeking early public comment on metadata standards in order to give industry an early start. Tasks will be coordinated by ONC’s Doug Fridsma.
- Welcome to the newest member of the HITSC, Rebecca Kush (CDISC)
- ONC/HITSC “Summer Camp” includes activities in:
 - Metadata Analysis - Stan Huff
 - Lead Patient Matching - Marc Overhage
 - Lead Surveillance Implementation Guide- Chris Chute
 - PHR/EHR Interoperability (ONC Seeking Leadership before June)
 - Lab Simplification, Clinical Coordination S & I Framework
 - Lead ePrescribing of Discharge Meds - Jamie Ferguson
 - NwHIN - Dixie Baker
- We must make sure this work aligns with Meaningful Use Stage 2.

Meaningful Use Stage 2 Update & Discussion Paul Tang, Chair, Meaningful Use Workgroup, HITPC

- Timeline for Meaningful Use Workgroup
 - May 11, 2011: Presented revised set of stage 2 MU recommendations to HITPC
 - May 13: Hearing on specialists and feedback from field
 - June 8: Final stage 2 MU recommendations will be presented for HITPC approval

Draft Meaningful Use Stage 2 Criteria

Stage 1 Final Rule	Stage 2 Recommendations (BLUE) = New Objectives not included in Stage 1 (RED) = Proposed Changes based on Public Comments from the first draft in January 2011
<i>Improving Quality, Safety, Efficiency & Reducing Disparities</i>	
EP: >30% of unique patients with at least one med order have at least one med order entered using CPOE	CPOE for 60% of Rx and lab; radiology CPOE “in use” (≥ 1 order) (unless no radiology orders)
Implement drug-drug and drug-allergy interaction checks (enabled functionality)	Employ drug interaction (drug-drug, drug-allergy) checking; Providers have the ability to refine DDI [In stage 3, goal is to have nationally endorsed lists of DDI with higher positive predictive value and ability to record reason for overriding alert]
EP: Generate and transmit permissible prescriptions electronically for >40% of prescriptions	50% of outpatient medication orders and 20% of hospital discharge medication orders transmitted as eRx
>50% of all unique patients have demographics recorded as structured data. (preferred language, gender race ethnicity, DOB, data and preliminary COD- EH ONLY).	80% of patients have demographics recorded and can use them to produce stratified quality reports using more granular demographic categories per IOM report—additions to value sets for existing fields for stage 2; new demographic fields for stage 3 (HITSC needs to work on standards)
Report CQM as per CMS attestation	Report CQM electronically as per CMS
Maintain an up-to-date problem list for >80% of all unique patients	Maintain problem list (80%)
Maintain active med list for >80% of all unique patients	Maintain active med list (80%)
Maintain active med allergy list for >80% of all unique patients	Maintain active med-allergy list (80%)
Record and chart vital signs for >50% of all unique patients age 2 and over	80% of patients have vital signs recorded during the reporting year; change age for peds BP from 2 yrs to 3 yrs
Record smoking status for >50% of all unique patients 13 years or older	80% of patients have smoking status recorded [stage 3 add new field in certification for secondhand smoke]
Implement 1 clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance	Use CDS; HITSC: Suggest changing certification criteria definition as indicated on comment summary
Menu: Record AD for 50% of all unique patients 65 years and older	Implement drug formulary checks according to local needs (e.g., may use internal or external formularies, which may include generic substitution as a “formulary check”) (move to core)
Menu: Incorporate clinical lab-tests results as	For hospitals, 50% of patients >65 who have recorded the result of



structured data for more than 40% of all lab tests results ordered	an advance directive discussion and the directive itself if it exists; for EPs 10% of patients seen during reporting period (need more data on current use to decide on menu vs. core for EPs)
New	Incorporate lab results as structured data (40%) (move to core); HITSC: Use LOINC where available
Menu: Generate at least one report listing patients by specific conditions	Generate patient lists for multiple patient-specific parameters (move to core)
Send an appropriate reminder for preventive/follow up care to more than 20% of all unique patients 65 years or older or 5 years or younger	EPs: 10% of all active patients receive a clinical reminder (appointment reminder not count)
New	30% of EP visits have at least one electronic EP note and 30% of EH patient days have at least one electronic note by a physician, NP, or PA; non-searchable, scanned notes do not qualify [use broad definition of qualifying note types]
New	EH medication orders automatically tracked via electronic medication administration record; (in-use in at least one hospital ward/unit)
New	Consider adding recording of family health history in stage 3 (due to absence of standards for FH)
<i>Engaging Patients and Families</i>	
EH: Provide >50% of all discharged patients patients with an electronic copy of their discharge instructions	DROPPED; to be covered by other objectives and HIPAA
New	Hospitals: ≥ 25 patients receive electronic discharge instructions at time of discharge
Menu: Provide >10% of all unique patients with timely electronic access to health information (EP)	Hospitals: 10% of patients/families view and download relevant information about a hospital admission; information available for all patients within 36 hours of the encounter
Provide Clinical Summaries to patients for >50% of all office visits within 3 business days	EPs: 10% of patients/families view & download their longitudinal health information; information available to all patients within 24 hours of an encounter
Menu: User certified EHR technology to identify patient-specific educational resources and provide to patient if appropriate for >10% of all unique patients	EPs: patients are provided a clinical summary after 50% of all visits, within 24 hours (pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs)
New	Both EPs and hospitals: 10% of patients receive EHR-enabled patient-specific educational resources; make core; take out “if appropriate” instead of raising threshold
New	EPs: patients are offered secure messaging online and > 25 patients have sent secure messages online
New	EPs: Patient preferences for communication medium recorded for 20% of patients
<i>Improve Care Coordination</i>	
Capability to exchange key clinical information – Perform at least one test capability to exchange key	EH and EP: Submit immunization data (attest to at least one) in accordance with applicable law and practice; move to core for both EH and EP [In Stage 3, view cumulative immunization record and



	recommendations]
Menu: Perform medication reconciliation for >50% of transitions for receiving provider	EH: Submit reportable lab results (attest to submitting to at least one organization) in accordance with applicable law and practice; move to core
Menu: Provide summary of care record for >50% transitions of care for the referring EP or EH	EH: Submit syndromic surveillance data (attest to at least one) in accordance with applicable law and practice; move to core EP: [CMS to consider]
New	EP: [CMS to consider] Submit reportable cancer conditions (attest to at least one) in accordance with applicable law and practice (to HITSC: possible use of IHE cancer reporting implementation guide)
New	For Stage 3: Patient-generated data submitted to public health agencies
Ensure Privacy and Security Protections	
Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process	Perform, or update, security risk assessment and address deficiencies. Address encryption for data at rest and attest to policy (not required for all but need policy).
	FOR HITSC CERTIFICATION: Authentication of providers: certification of EHR needs two-factor authentication for controlled substances and providers to have digital certificates at entity level. Single factor authentication (user and password) for patient online account. Audit trails for access to patient online account. Provisions for data provenance. Portal should have secure download ability (e.g., to transfer to PHR). Instructions to standards committee about demographic fields, etc.
	Signal Stage 3 plans about NWHIN governance.

Timeline Issue

- Three Options being considered by HIT Policy Committee
 1. Maintain current timeline and one-year EHR reporting period; or
 2. Maintain current timeline and permit 90-day EHR reporting period; or
 3. **Delay transition from stage 1 to stage 2 by one year (affects only providers who begin MU program in 2011)**
- Option 3 allows additional time for vendor development and provider implementation while maintaining the Meaningful Use “pace” and not conflicting with ICD-10 synergies, CQM measurement and reporting, and CMS and State Medicaid program operations.
 - *Dr. Tang did not explicitly state that Option 3 would be the HITPC recommendation, but he seemed to be endorsing that path.*



Privacy and Security Report- Dixie Baker

- Recommended Standards for Enterprise-Level Provider Directories (ELPD)

Requirement	Standard	Implementation Specification	Certification Criteria
Schema	DSML	IHE HPD subset	Capability to securely send to an ELPD service a DSML query for entities, and entities' exchange services, and to receive a response, as specified in the IHE HPD profile. Capability to enable a user or software to list and select from ELPD responses. Capability to retrieve the digital certificate for a selected entity.
Vocabulary	LDAP + ISO	IHE HPD subset	
Transport	REST or SOAP¹	IHE HPD	
Query Language	LDAP	IHE HPD + HPD Federation Profile ²	

Clinical Quality Workgroup

- The Clinical Quality Workgroup does not have any new recommendations, as they feel the NQF Quality Data Model continues to meet quality measurement and reporting needs
- The Clinical Quality Workgroup will be hosting a hearing tomorrow in Washington DC (Washington Marriott Hotel, 1221 22nd Street, NW)
- Topics will include:
 - Complexities of implementing Meaningful Use Stage 1
 - How can standards support Stage 2 and Stage 3 Meaningful Use Measures?

Implementation Workgroup

- The Implementation Workgroup is seeking comments on the (EHR) Temporary Certification Program, Stage 1 Meaningful Use.
- Comments are due by Friday, June 17, 2011.
 - Comments should be posted on the HIT Buzz Blog at: [Federal Advisory Committee \(FACA\) Blog](#) OR
 - Download a [copy of the survey \[DOCX – 18 KB\]](#); fill it out and email the completed survey to ONC.request@hhs.gov. Please be sure to include “Implementation WG Comments” in the subject line.

Clinical Operations and Vocabulary Task Force Report



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- The Task Force has reviewed their 2009 Stage 2/3 Recommendations for Vocabularies to determine if the recommendation is still valid, if those vocabularies will be ready on time, and can industry implement them in time for Stage 2 and Stage 3:
 - Medication for e-Rx
 - Medication allergies
 - Lab tests
 - Problem List
- Halamka- Goal is to get one vocabulary per domain
- Rx Norm
 - Four components of Rx Norm (Semantic Clinical Drug (SCD); Semantic Branded Drug (SBD) Generic Package (GPCK); Branded Package (BPCK), are recommended to be included in eRx.
 - Rx Norm is ready for adoption
 - NCPDP, Drug Information Providers, and Surescripts will be ready. Not clear regarding EHR vendors and large providers.
- Medication Allergies
 - RxNorm (SCD, Ingredient, SBD, GPCK, and BPCK should be used)
 - UNII (Inactive ingredients)
- Lab Orders and Results
 - LOINC was previously recommended
 - Vocabulary Taskforce will review Lab Orders and Results next.
- Problem Lists
 - Task force will review after lab results work is completed
 - Stage 1 Recs were SNOMED CT or ICD 9 for Stage 1, SNOMED CT or ICD 10 for stage 2, and only SNOMED CT for Stage 3
 - Key issues:
 - Problem list for Problems vs Problem list as a Catch All.
 - Fridsma: We need to work with NIST to be able to add a new code (example H1N1) without it crashing the system.

ONC “Summer Camp Report”- Doug Fridsma ONC

- ONC instructed working group to select “critical elements” for evaluation and recommendations
- Metadata Analysis
 - Have had 3 calls
- Lead Surveillance Implementation
 - Kicks off later this summer
- PHR/EHR Interoperability (ONC Seeking Leadership before June)
- Lab Simplification, Clinical Coordination S & I Framework
- Lead ePrescribing of Discharge Meds
- NwHIN - Dixie Baker
- X509 Certification is another issue that may arise later in the summer.

Patient Matching Group (Power Team)

- HIT Policy Committee has tasked HIT Standards Committee with recommending standards to:
 - Standardize formats for patient matching demographics



- Internally evaluate matching accuracy
- Accountability
- Developing and disseminating best practices
- HIT Standards Committee has created a Patient Matching Power Team to address these tasks
 - First meeting will take place May 20th, 2011
 - Thanks to MITRE and Joy Keeler for assistance
 - Identifying Metadata Elements for:
 - Patient Identity
 - Provenance
 - Suggested Metadata (use HL7 CDA R2 and X.509 Certificate)
 - Tagged Data Element Identifier (TDE)
 - TimesStamping
 - Affiliation (name of actor who sealed TDE)
 - Signature
 - Privacy
 - Content Metadata
 - Datatype
 - Sensitivity (any need for special handling)
 - Coverage (who paid to acquire information)

