



HimSS
Health IT Policy Committee
Meeting Summary
October 12, 2011

Meeting Agenda

Background

The [Health IT Policy Committee](#) will make [recommendations](#) to the National Coordinator for Health IT on a policy framework for the development and adoption of a nationwide health information infrastructure, including standards for the exchange of patient medical information. The American Recovery and Reinvestment Act of 2009 (ARRA) provides that the Health IT Policy Committee shall at least make recommendations on standards, implementation specifications, and certifications criteria in eight specific areas.

Dr. Mostahari

“Pardon our appearance, transformation underway.” This was on a sign I saw at a construction site on the way over here and it made me think about our transition. Yes, it’s messy and sometimes it doesn’t look very good. But the construction site did something smart – they put a picture of what it’s going to look like. We don’t do enough of begging pardon for the messiness of change and the difficulty of transformation, and we don’t put the picture up of what it’s going to look like and that it’s going to be worth it. And it is going to be worth it.

We look to California for the future. I was there recently and I visited a one-doctor office, which is typical. He was the one provider, his wife is the practice manager, and they had 3 exam rooms. For year his practice has been 10 minute office visits. Like so many other providers in small practices, his livelihood depends on being able to see those patients and charge for the encounter. But there is a transformation underway. Three years ago he started the transition to EHR. He got a lot of help from the REC over the last year to help with customizations, and they are helping them get incentive payments. The REC has served as a point of convening and trust. They brought an IPA together, and the doctors can now see patient records from referrals, even if they didn’t get sent to them. And he saw the transformation - he was being pushed to share his records, and he didn’t like it. He said the main thing was he realized, “it’s not my record; it’s the patient’s record.” What else is happening in that IPA? They are getting 160% of Medicaid payments because they have reduced avoidable hospital admissions. They have applied to be a pilot ACO.

This is part of a bigger picture, of the larger transition. We still have a lot of work to be done; this is still in its infancy. It seems that it is largely unnoticed to the world, even those who are concerned about how health care expenses are breaking our budgets, that there are three trends happening: patient care, payment reform, and patient engagement in their own health. These trends will become apparent in a few years, and if we can work together - if the payment side takes advantage of the IT infrastructure, if IT can better serve patient engagement and performance improvement - then I think we really have a chance to exceed anyone’s expectations about how health care can improve in cost, coordination, and safety. The expectations are low. But I am very hopeful. So, pardon our appearance, transformation underway. But we now have some pictures to show where we’re going.

Key News Items

- ◆ Rule Making: working on Standards and Certification rule, targeting end of December – early January

Review of the Agenda (Paul Tang)

Motion to approve the letter of transmittal (DOUBLE CHECK)

- They are provisionally approved

Privacy & Security Tiger Team Recommendations

- (1) Research ANPRM regarding secondary uses of EHR data for research purposes (Deven McGraw, Chair)
 - This letter focuses on research, not on public health uses of secondary data
 - We were looking at a category of activities that in the gray area between operations and research
 - Not a global look at all secondary uses

*Revised letter to include language that the letter does not address public health data uses.
Revised letter approved.
- (2) Query health (Paul Egerman, Co-Chair)
 - Our recommendations are related to policies ONC is establishing for a pilot project
 - ONC established a set of baseline policies and then asked for our comments

Tiger Team Proposed Policies and Recommendations

- **Disclosing Entity (data holder):** Whether or not to run a particular query, and to release any results, will be under the control of the disclosing entity/data holder.
 1. The Tiger Team recommends the Policy Committee endorse this policy. It is consistent with the core value that patients trust their providers with respect to the privacy and security of health information; it is also consistent with our most recent recommendations on secondary uses of EHR data, which called for provider entities to be accountable for all access, use and disclosure of health information from their EHRs, including for secondary purposes.
- **Data Exchange:** Data being exchanged by a disclosing entity/data holder will be either (1) mock or test data; (2) aggregate de-identified data sets or aggregated limited data sets, each with data use agreements (even in circumstances where they are not required by law), or (3) a public health permitted use under state or federal law (which may be identifiable information where permitted by law).
 2. The Tiger Team agrees that the data being exchanged should either be de-identified or aggregated limited data set, with a data use agreement in place even for de-identified data. The data use agreement should, at a minimum, restrict the use of the data to facilitating Query Health and prohibit the recipient from re-identifying the data.
 3. During the initial pilot phase of Query Health, ONC should implement clear policies restricting the data recipient from using information shared for Query Health for purposes other than to address the query that the disclosing entity/data holder has agreed to address.
 4. This should be part of the data use agreement, but as Query Health scales beyond the pilot phase, ONC should consider the need for a governance structure that can enforce compliance with data use agreements and other policies. ONC should also use the

experience of the pilots to help inform the type of governance that may be needed for oversight of Query Health in the future.

5. Although HIPAA allows identifiable data to be disclosed for public health purposes, not all public health activities require identifiable data. Query Health policy should be that disclosures are in the least identifiable form necessary to address the particular secondary data use query (i.e. consistent with the HIPAA minimum necessary standard). In other words, data disclosed in response to queries for public health purposes should also be a limited data set or de-identified unless greater identifiable of data is specifically needed.
- **Small cells:** For other than regulated/permitted use purposes, cells with less than 5 observations in a cell shall be blurred by methods that reduce the accuracy of the information provided. (The CDC-CSTE Intergovernmental Data Release Guidelines Working Group has recommended limiting cell size to three counts presuming a sufficiently large population; this is also reflected in guidelines used by several states.)

Tiger Team Recommendation:

6. The Tiger Team agrees with this policy as a method of reducing the risk of identifiability of the data and recommends that the Policy Committee endorse it.

Action Items:

Three proposed amendments/additions

- ◆ Clarify statutory authority and consideration
- ◆ Different kinds of queries: one dividing classes – summarized vs. line-level de-identified data.
- ◆ Might have different policy guide posts.
Clarification of queries and follow-up queries

Revised Recommendations approved (all Ayes, one Nay)

Update on CMS Meaningful Use Activities (Robert Anthony, CMS)

Total Active Registrations		September-11	YTD
Medicare Meaningful Use (MU)	Eligible Professional	16,877	88,255
	Hospital	23	144
	Total	16,900	88,399

Medicaid Adopt, Implement or Upgrade (AIU)	Eligible Professional	6,812	23,993
	Hospital	0	37
	Total	6,812	24,030

Medicare/Medicaid	Hospital (registered for both Medicare & Medicaid)	282	2,215
TOTAL		23,994	114,644

**Medicare Incentive Payments –
September 2011
Meaningful Use (MU)**

	September 2011 Providers Paid	September 2011 Payments	YTD Providers Paid	YTD Payments
Eligible Professional Medicare Only Hospital	1,406	\$25,308,000	3,722	\$66,996,000
Medicare & Medicaid Hospital (Medicare Payment)	3	\$3,407,329	8	\$8,476,845
	30	\$61,012,517	150	\$281,926,545
TOTAL	1,439	\$89,727,845	3,880	\$357,399,390

**Medicaid Incentive Payments –
September 2011
Adopt, Implement, Upgrade (AIU)**

	September 2011 Providers Paid	September 2011 Payments	YTD Providers Paid	YTD Payments
Eligible Professional Medicaid Only Hospital	1,428	\$29,990,850	6,361	\$133,790,065
Medicare & Medicaid Hospital (Medicaid Payment)	4	\$9,114,728	19	\$42,034,249
	82	\$70,077,233	387	\$338,944,994
TOTAL	1,514	\$109,182,811	6,767	\$514,769,308

Highlights:



- ◆ On average all thresholds were greatly exceeded, but every threshold had some providers on the borderline
- ◆ Little difference between EP and hospitals
- ◆ Relatively few exclusions claimed on average.
- ◆ CPOE, e-Rx, Drug Formularies
- ◆ Public Health Objectives (immunization, syndromic surveillance, reportable lab results)
- ◆ Payment year ended for hospitals on September 30th, but hospitals have until November 30th to attest for 2011

Core menu objectives:

- ◆ Performance on all is relatively high
- ◆ One trend we are watching is the number of folks who take a particular menu objective, but also claim an exclusion to it. There is nothing in the final rule prohibiting this. We were curious to see how many providers were meeting the letter of MU, and how many were meeting the spirit. The exclusion rate is relatively low. It is too early to draw a conclusion from the small sample, but it is an early indication that people are engaged.
- ◆ Care coordination objective: this is where we are seeing the highest number of deferrals. The good news is that those selecting these menu options are scoring very high.
- ◆ For eligible hospitals, performance is consistently high. We are seeing relatively low deferral rate on the Quality, Safety, Efficiency, and Reduce Health Disparities objective. We anticipated this would be difficult to incorporate in their workflow.
- ◆ With care coordination, we are seeing high deferral rates among hospitals as well.
- ◆ Overall: high performance from early-adopters. The trends we identified now will be the trends we continue watching as we go forward.

Dr. Mostashari: There are a few things that we can do, given the resources we have to analyze this data.

- 1) We can perform some of the more simple comparison based on data we already have, such as comparisons by states or other available info about certain parts of population
- 2) We can use REC's as a resource for the "why" behind the trends. There are also surveys that ask questions about intent to apply for MU and other things. We hope we will have the ability to look at survey information for the final rule.

Action Items:

- ◆ There will be a quarterly list of EPs that have successfully attested. Should be published this month.

HIT Standards Committee Update: Report on Summer Camp (John Halamka, HITSC Co-Chair)

Accomplished work and recommendations:

S&I project activities

1. Certificate Interoperability
2. ToC (balloted DSTU in 6 months)
3. Lab (off-cycle ballot to be completed this fall)
4. Provider directories (3 subprojects)
5. Query health (September month)
6. Data segmentation (October launch)

Metadata Analysis Team



- ◆ Identified metadata elements and standards for the following categories:
 1. Patient Identity
 2. Provenance
 3. Privacy
- ◆ Recommended HL7 CDA R2 header elements (with modifications)
- ◆ ANPRM published August 9, 2011
 1. Currently reviewing public comments

Patient Match Power Team

- ◆ Overarching Assumptions
 - a) Specificity – at least 99.9%
 - b) Sensitivity – at least 95%
 - c) Need to align the patient attributes for matching

E-prescribing of Discharge Medications

- ◆ HL7 2.2-2.51
- ◆ Medicare Part D Compliant

Surveillance Implementation Guide Power Team

- ◆ Convergence on the HL7 2.5.1 standard across lab reporting, immunization reporting, and syndromic surveillance
 - a) Electronic Lab Reporting (ELR):
 - b) Recommend: HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm).
- ◆ Immunization Reporting Recommendations:
 - a) The current alternative standard HL7 2.3.1 should be deprecated.
 - b) The corresponding Implementation Specification to be adopted for Meaningful Use Stage 2 should be the 2.5.1 Implementation Guide and Standard Code Sets specified in Stage 1 (unless updated versions of these are established in time for Stage 2 implementation).
- ◆ Syndromic Surveillance Recommendations:
 - a) The current alternative standard HL7 2.3.1 should be deprecated
 - b) Recommend: 2.5.1 Implementation Guide for Hospital Syndromic Surveillance, currently under development
- ◆ Other Recommendations:
 - a) The HIT Standards Committee should carefully follow the maturation of CDA for public health reporting, and encourage its rapid evolution and evaluation.

NwHIN Power Team

- ◆ The NwHIN Power Team was tasked to assist the ONC in defining the set of standards, services, and policies that comprise the Nationwide Health Information Network (NwHIN)
 1. Evaluate the 10 specifications developed for the Exchange pilot and the 2 specifications developed for the Direct pilot with respect to their usability and scalability to support nationwide health information exchange (inputs provided by the NwHIN Exchange Coordinating Committee, NIST, ONC, invited testimony from VA and DOD Exchange implementers, and Power Team members)
 2. Recommend specifications that could be integrated and deployed to support the secure transport and exchange of electronic health information at a national scale, and identify where further work may be needed
- ◆ Evaluation factors

1. Need for specified capability
 2. Maturity of the specification
 3. Maturity of the underlying technology used in the specification
 4. Deployment and Operational Complexity
 5. Industry adoption
 6. Availability of alternatives
- ◆ Conclusions
 1. Architecture is important – whatever standards are chosen must be deployable within an architectural framework and must support the exchange of structured and well as unstructured data.
 2. Neither the Exchange specifications nor the Direct specifications have been proven at large scale, in production environments, across a broad range of healthcare organizations.
 3. The Exchange specifications are highly complex, and designed to support a complex architecture that may not be appropriate for all healthcare organizations, and that may not scale to nationwide deployment.
 4. The Power Team encourages the ONC to consider opportunities to simplify Exchange specifications (specific examples were given)
 5. The standards that Direct uses (SMTP and S/MIME) are well understood, widely deployed, and highly scalable. The Direct specifications do introduce some new approaches that have yet to be fully developed and proven beyond the Direct Project itself, but generally the Power Team supports and encourages broader deployment and use of these specifications.
 6. Some areas were found to be underspecified, including exchange of large images, discovery and retrieval of data elements outside a document context, and more granular query (e.g., “most recent ECG”); these areas may be addressable by PCAST approaches.
 7. Industry is trending toward widespread use of the REST architectural style in designing networked systems; to provide consistency and security in RESTful implementations, a need exists for a specification for “secure RESTful transport for healthcare exchange.”

Vocabularies

- ◆ One vocabulary per domain of medicine
- ◆ Significant use of SNOMED-CT and LOINC
- ◆ Transition plan from current state to future state including all mappings

Action Items:

- ◆ Rule Making: working on Standards and Certification rule, targeting end of December – early January

HIT Policy Committee Enrollment Workgroup Update (Kristin Ratcliffe, ONC)

- ◆ Historical background: convened in response to section 261 of ACA
- ◆ Workgroup made recommendations last September
- ◆ Recently held day-long hearing to reflect on recommendations and implementation challenges
- ◆ Next meeting is week of 10/17/11
 - a) Anticipate that work moving forward will be more technical as we move into the implementation phase

- b) There are 5 areas where we feel the workgroup can continue to provide value to CMS and ONC
 - State and federal hybrid approaches for insurance exchanges
 - Cost allocation for upgrading human services programs
 - Name standards
 - APIs and applications for third parties
 - Interface specification
- c) As we move into the more technical phase, we plan to propose a sister workgroup
 - Early stages of identifying what a charge for what the sister Standards workgroup could look like
- ♦ States are moving forward with RFPs and plans for technical architecture for insurance exchanges, but states are inserting placeholders for 1561 standards of Affordable Care Act
 - a) States waiting for guidance from CMS or HHS
 - b) We will produce product within 6-8 months that could be tested or piloted

Update on ONC's Regional Extension Center Program (Matt Kendall, ONC)

RECs help providers on a whole host of services, including assistance in getting to meaningful use and beyond

- ♦ There are 62 RECs that cover the entire country
 - a) There are three milestones to REC success: recruitment, getting on EHR, and then achieving meaningful use
 - b) The goal is to help 100k primary care providers (approximately 1/3 of all primary care providers) achieve meaningful use by 2014
 - c) There are 96k providers enrolled now
 - Average about 6k per month
 - d) Approximately 800 Critical Access Hospitals enrolled
- ♦ REC success is possible by having a diverse set of stakeholders
 - a) Getting on the ground support is imperative because moving people to meaningful use is a challenge
- ♦ Sharing best practices from RECs on ONC website soon
 - a) We call this the 63rd REC
- ♦ Description of RECs – each REC is unique in its approach
 - a) Ohio Health Information Partnership (OHIP)
 - Strategy: created mini RECs created across state, providing more localized support
 - More than 5k providers enrolled
 - b) South Florida REC
 - Strong local ties; working with local IT companies such as Intel
 - c) Nebraska (Wideriver) REC
 - Focus on rural-providers (90% enrolled)
 - d) Los Angeles REC
 - Tied to Medicaid managed care plan
 - Targeted market segmentation to identify providers that were most at risk
 - Done extensive outreach to recruit those providers
- ♦ Using the HITREC to leverage best practices of REC and other ONC programs

- a) Development of Communities of Practice
- b) Regional meetings, training, etc.
- c) Linking information between programs
- ◆ Community college workforce program
 - a) There are 5 consortiums across country
 - 82 community colleges
 - b) Goal is to get 10,500 people trained in the new field
 - c) Helping to build concrete skill sets in HIT
 - d) Taking people with IT or health background
 - e) Many programs are available online
 - Average graduate age is 45
 - A lot of students are already in jobs and are using the program to move up the ladder
 - We are looking at extending internship opportunities to the students