



Health IT Policy Committee
Meeting Summary
February 1, 2012

[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.

Opening Remarks – (Farzad Mostashari, National Coordinator)

There was a report from Bipartisan Policy center that took a thoughtful look at the current state of our health IT journey. It acknowledged our successes on adoption and moving the needle on MU. They also pointed to a lot of issues we've discussed here, and it highlights the need for a push on information exchange and interoperability, engagement of consumers, and linking health IT to improved care and quality measurement. These are in line with our committee discussions and I think it serves as a good reminder that, as we celebrate our progress, we must also keep focused on what more needs to be done.

Update on Health Information Exchange – (Claudia Williams, ONC; Doug Fridsma, ONC)

Where are we with data exchange?

- ◆ We are seeing a diversity of models to enable exchange, whereas two years ago, we were focused on regional, local models
- ◆ We now have a portfolio of exchange options to meet different needs

State HIE Grant program

- ◆ The role of the program is catalyzing change through meaningful use and to build infrastructure of trust and governance
- ◆ All grantees have been asked to present a clear strategy to advance participation between providers
- ◆ Asking grantees to make rapid progress, build on existing assets, recognize diversity in approaches, and that they leverage the full set of national standards

Challenges/opportunities

- ◆ White space: portions of a state that do not have exchange capacity
 - Urban spaces generally are developed while rural areas are not
- ◆ Duplication
- ◆ Information silos
- ◆ Disparities
- ◆ Emerging networks: need funding and guidance on how to deploy in a way that reflects national standards
 - Support local networks
- ◆ Public health capacity
- ◆ No shared trust

Exemplar states

- ◆ Wisconsin
- ◆ Indiana
- ◆ Kentucky

Dr. Fridsma: Interoperability

Layers of transport from one system to another

- ◆ Vocabulary/code sets: how should values be coded so they are universally understood?

- ◆ Content structure: how should that message be formatted?
- ◆ Transport/security: how do we move from point a to point b?
- ◆ Services: how do exchange participants find each other?

Direct Project

- ◆ Used early experience with Direct to inform the S&I framework tools
- ◆ 35 vendors have implemented Direct, and more have publicly announced that Direct specifications are part of their product roadmap
- ◆ There is significant uptake in users using Direct

NwHIN

- ◆ Exchange is currently operational and demonstrating value to participants, including:
 - Federal agency benefit determination is expedited (shortened turnaround time by 45%)
 - Expedited benefit payments to disabled
 - Improved benefits in clinical decision making, including avoiding prescribing multiple narcotics based on information shared
- ◆ As of January 2012, 22 organizations are exchanging data in production, representing:
 - 500 hospitals
 - 4,000+ provider organizations
 - 30,000 users
 - 1 million shared patients
 - Population coverage~65 million people
 - 90,000 transaction as of Sept 2011, and growing dramatically each month
- ◆ Exchange CC is developing business and transitional plan to guide the Exchange to a sustainable, scalable and efficient public-private model
- ◆ Exchange can serve as basis for HIE innovation and critical element in nationwide health information infrastructure

DURSA

- ◆ Amended 2011 DURSA: No longer required to have a contractual relationship to participate in NwHIN
 - Removes all references to governance of the NwHIN
 - Clarifies that the Exchange is a voluntary group of exchange partners (i.e., the organizations participating in the Exchange, not “the nationwide health information network.”)
 - Indicates that the Exchange Coordinating Committee only has authority with regard to these exchange partners and that it has no authority with regard to “the nationwide health information network.”
- ◆ Indicates maturation of the program

Discussion

Judy Murphy

- ◆ In November, we exchanged 800,000 documents from all across the country
- ◆ Planning an overseas exchange
- ◆ We are told daily that this exchange capability through Direct is saving lives

Doug Fridsma

- ◆ In every state HIE program, the question is being asked about how HIE will dovetail with new bundle payment programs, ACOs, PCMH models, etc. It’s important to think concretely about syncing these initiatives

HITPC 2012 Workplan – (Paul Tang; Jodi Daniel, ONC)

Update on the policy roadmap – not complete

Quarter 1

- ◆ MU NPRM & preliminary Stage 3



- ◆ Governance ANPRM
- ◆ Quality measures

Quarter 2

- ◆ Quality measures lifecycle hearing
- ◆ Patient-generated data
- ◆ Information exchange
- ◆ Certification/adoption : Long-term and post-acute care

Quarter 3

- ◆ Draft MU Stage 3 recommendations
- ◆ Governance NPRM
- ◆ Certification/ Adoption: safety

Quarter 4

- ◆ MU Stage 3 Recommendations (give to Standards Committee)
- ◆ Consumer eHealth
- ◆ Strategic Plan revision

Regular updates to the Committee

- ◆ Meaningful Use
- ◆ ONC's programs
- ◆ Health information exchange
- ◆ ACOs and other reform activities

Discussion

- ◆ It's important to pay attention to the full lifecycle of quality measures
 - We need to build a better data model: data molecules rather than data atoms
- ◆ One of the holes in our work is that we are not including all of our specialists and long-term care providers. They are not able to qualify for MU, and they feel that they are being left behind. If the end goal is to make sure that every patient has a comprehensive health care record for comprehensive model, we can't leave people out.
 - Also behavioral health and other community health providers
 - Fridsma: Unlikely that there will be a parallel MU program for other providers, but information exchange may help to increase access to patient data
- ◆ Architecture: we have a piece of it in HIE, but that conversation ends up being very transactional. The relevant question is where does data get brought together and processed for multiple purposes. We don't have an answer, and there are governance and consent issues – but we need to take up that question in some way.
 - Paul Tang: we are the tool supplier, but its not MU that creates the whole care system
- ◆ How do we get the biggest bang for our buck? What is the value order?
 - 1) The EHR itself saves the most lives; 2) Interoperability; 3) PHR
 - Point of disagreement: the ability to exchange information in a timely and efficient manner is really what gives providers the tools to take a different course of action than they would have without that information
- ◆ We have not discussed the value of EHR in research
 - There are a whole variety of things going on in research using structured data, and that conversation has yet to be had.
 - We need an update on that as well

Update on Million Hearts Campaign – (Peter Briss, CDC; Mat Kendall, ONC)

- ◆ We have essentially had no progress on combating heart disease since 2000
- ◆ Improved care could save over 100,000 each year

- ◆ Million hearts has an ambitious goal to prevent one million heart attacks and strokes over the next five years
 - We have a public/private campaign to reduce the number of people that need treatment
- ◆ Target of change: Sodium, smoking, aspirin, blood pressure, cholesterol
- ◆ Key components: Community intervention and Clinical intervention
 - Clinical Intervention
 - Focus on ABCS
 - Health information technology
 - Team-based care
 - Community Intervention
 - Strengthen tobacco control and reduce smoking
 - Improve nutrition through decreased sodium and artificial trans fat consumption

Mat Kendall

Partnering with other folks to use health IT for this program

- ◆ ONC is piloting many programs
- ◆ Leveraging the HITRC to connect with health IT initiatives
- ◆ ONC Launched *One in a Million Hearts Challenge*
 - Call to innovators and developers to create an application that activates and empowers patients to improve their heart health
 - Over 20 teams currently signed up
 - Winner will be announced January 20, 2012
- ◆ Leveraging Beacon Communities to accomplish goals
 - Prediction:
 - Archimedes risk stratification based on 5-year risk of heart health (Example: Colorado and Tulsa, OK Beacon Communities)
 - Elevated blood pressure alerts (and other vital readings) transmitted from home-based telemonitoring devices to E.H.Rs in physician offices via HIE.
 - Prevention:
 - Text-based smoking cessation reminders for high risk patients (Example: Bangor, ME Beacon Community)
 - Clinical decision-support for screening and medication alerts (New Orleans, SE Minnesota)
 - Management:
 - Ambulatory care management for high risk patients, and for high risk CHF patients post discharge (Example: RI, Keystone, North Carolina and Bangor, ME Beacon Communities)
 - Acute Intervention:
 - EMS Electrocardiogram sent to area hospital to ensure cath lab/provider team readiness immediately upon arrival (Example: San Diego Beacon Community)

Discussion

- ◆ VA has been working on this issue for quite some time. The focus has been intervention by providers. This is a phenomenal opportunity for further collaboration
- ◆ The patient engagement aspect is key. But how do you operationalize that? We need to make sure we have creative/innovative things such as calorie counters, pedometers, sodium count, etc. Without that encouragement, it's not going to happen.
 - We should be cautioned not to lean too heavily on RECs and the limited resources they have
- ◆ There are a number of public sector efforts (like PQRS) and private sector efforts (NCQA) to highlight high performers, in terms of evolution of measures

Update on Quality Measures – (David Lansky; Doug Fridsma)

Workgroup Agenda

- ◆ Stage 2 Quality Measure Development
- ◆ Stage 2 NPRM Review
- ◆ Alignment with HITSC Clinical Quality Workgroup
 - Quality Measure/ e-Measure “lifecycle” hearing: HITSC, HITPC, CMS, ONC - Q2 2012
 - Identify standards gaps
 - e-Measure HIT “readiness” criteria

Stage 3 Quality Measures Opportunities

- ◆ Enhanced alignment with Clinical Decision Support: technical and policy components
- ◆ Enhanced alignment with clinical outcomes research & comparative effectiveness
- ◆ Considering the needs of Accountable Care Organizations
- ◆ Considering the needs of private payers
- ◆ Review (adequacy/gaps/readiness) measure availability:
 - Patient and Family Engagement.
 - Patient Safety.
 - Care Coordination.
 - Population and Public Health.
 - Efficient Use of Healthcare Resources.
 - Clinical Processes/Effectiveness.

Discussion

- ◆ Contracts for quality measurement development; do they have the expertise to put it in the “e” setting? Most quality measurement developers are specialty oriented.
 - Yes. The contractors and their sub-contractors have been the leaders in developing e-specifications
- ◆ Dr. Mostashari: Quality Measurement is an important deliverable. This is important to help providers “own” their own care quality. Making quality measurement available at the point of care (through EHR) is something we have been working on for some time.