

HIT Policy Committee Meeting

Tuesday, June 16, 2009

10:00 am – 2:00 pm EDT

Hubert H. Humphrey Building, Great Hall
200 Independence Avenue, S.W.
Washington, DC 20201

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HIT Policy Committee

June 16, 2009

10:00 a.m. to 2:00 p.m. (EST)
Hubert H. Humphrey Building, Great Hall
200 Independence Avenue, S.W.
Washington, DC 20201

- 10:00 a.m.** **CALL TO ORDER** – *Judy Sparrow, Office of the National Coordinator for Health Information Technology*
- 10:05 a.m.** **Opening Remarks** – *David Blumenthal, MD, National Coordinator for Health Information Technology*
- 10:30 a.m.** **Meaningful Use Workgroup Update**
John Glaser, Office of the National Coordinator
Paul Tang, Co-Chair
Farzad Mostashari, Co-Chair
Members of the Workgroup
Charges for the Workgroup
Presentation on Draft Description of Meaningful Use
- 11:15 a.m.** **Committee Discussion on Draft Description of Meaningful Use**
- 12:00 p.m.** **BREAK**
- 12:30 p.m.** **Certification/Adoption Workgroup Update**
John Glaser, ONC
Paul Egerman, Co-Chair
Marc Probst, Co-Chair
Members of the Workgroup
Charges for the Workgroup
Workplan Timeline
- 1:15 p.m.** **Information Exchange Workgroup Update**
Kelly Cronin, ONC
Deven McGraw, Co-Chair
Micky Tripathy, Co-Chair
Members of the Workgroup
Charges for the Workgroup
Information Exchange/Meaningful Use
- 1:45 p.m.** **Public Comment**
- 2:00 p.m.** **Adjourn**

Next Meeting of the HIT Policy Committee
Thursday, July 16, 2009, 10 a.m. to 2 p.m.

Meeting Report

Health Information Technology Policy Committee

May 11, 2009

Call to Order and Introduction of Committee Members

Dr. Blumenthal welcomed the group to the first meeting of the Health Information Technology Policy Committee and introduced Judy Sparrow of the Office of the National Coordinator for Health Information Technology (ONC). Ms. Sparrow reminded the group that they are operating under the Federal Advisory Committee Act (FACA), meaning that the meeting was being conducted in public. Each FACA meeting provides the opportunity for public comment, and a transcript of the proceedings will be made available on the ONC Web site. Ms. Sparrow acknowledged the large number of stakeholder groups represented at the meeting and asked that any individuals who have a conflict of interest to make full disclosure during roll call. Then Ms. Sparrow conducted the roll call of those present at the table and on the telephone, as follows:

David Blumenthal, M.D., Chair	HHS/ONC
David Bates, M.D.	Brigham and Women's Hospital
Christine Bechtel	National Partnership for Women & Families
Neil Calman, M.D.	The Institute for Family Health
Richard Chapman	Kindred Healthcare
Adam Clark, Ph.D.	Lance Armstrong Foundation
Arthur Davidson, M.D.	Denver Public Health Department
Connie White Delaney, Ph.D, R.N.	University of Minnesota/School of Nursing
Paul Egerman	Businessman/Entrepreneur
Judith Faulkner	Epic Systems Corporation
Gayle Harrell	Former Florida State Legislator
Charles Kennedy, M.D.	WellPoint, Inc.
Michael Klag, M.D.	Johns Hopkins University, Bloomberg School of Public Health
David Lansky, Ph.D.	Pacific Business Group on Health
Deven McGraw	Center for Democracy & Technology
Frank Nemec, M.D.	Gastroenterology Associates, Inc.
Marc Probst	Intermountain Healthcare
Latanya Sweeney, Ph.D.	Carnegie Mellon University
Paul Tang, M.D.	Palo Alto Medical Foundation
Scott White	1199 SEIU Training and Employment Fund

Opening Remarks

Dr. Blumenthal welcomed and thanked everyone present, acknowledging that the group has a lot of work to do in a very short period of time. He noted that later in the week, the first session of the Health Information Technology Standards Committee will convene. Dr. Blumenthal said he felt this group needed to meet ahead of the Standards Committee, in that at least in statute, the Policy Committee is charged with instructing the Standards Committee with regard to where that group should focus its attention moving forward, particularly in terms of which standards to focus on. Additional goals of this first Policy Committee meeting were to have Committee members familiarize themselves with each other

and begin to set priorities for their work. This work will be guided in many ways by the charges that Congress has outlined, and deadlines that Congress has set.

Dr. Blumenthal, newly appointed as National Coordinator for Health Information Technology, explained that he brings a deep and abiding interest in health care reform to the position. He encouraged the group to think of themselves not as people focusing on health information technology, but rather focusing on how to make our health system better. He noted that there are two critical components to the President's overall agenda, and increasingly that of Congress, as well. One focuses on coverage; the other focuses on improving health system performance. These two components are interrelated—the coverage goal cannot be met unless system performance goals are achieved. Dr. Blumenthal added that the President was hosting a meeting at the White House on the same day as this Policy Committee meeting to discuss how to make the nation's system more efficient to uncover resources that can be used to extend coverage. It is expected that the topics being discussed by Committee members at this meeting will be frequently mentioned by those attending the meeting at the White House.

Dr. Blumenthal noted that the health information technology provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) address improving population health, individual health, and health system efficiency. That is why the Policy Committee will be focusing on the meaningful use of health information technology, rather than explicitly on the adoption of health information technology. Dr. Blumenthal also explained that the Health Information Technology Policy and Standards Committees are held in public, have the goal of providing the public with access to important deliberations that are in the public's interest. These committees function according to very specific statutory rules regarding transparency and process. These rules are in keeping with the spirit of the legislation and with the administration's interest in openness and transparency.

Response to Dr. Blumenthal's Remarks

Mr. Chapman asked if there was a third group dealing with the issue of meaningful use. Dr. Blumenthal indicated that there is no formal third group; there are only two FACA committees, and the definition of "meaningful use" will be developed with this group's assistance. Jodi Daniel, ONC, clarified that Ms. Daniel clarified that the National Committee on Vital and Health Statistics (NCVHS) is another committee that has interest in this area. The HIT Policy Committee will need to work closely with NCVHS to clarify the issues to be considered and where they might also have a role to provide advice to the Department of Health and Human Services (HHS) on related activities. She acknowledged that there is some intersection—the statute calls for the HIT Policy Committee to consider any recommendations from NCVHS, which will bring those recommendations to the HIT Policy Committee for discussion.

Mr. Probst asked whether there is an inherent sequence to standards (i.e., if one of the outcomes is to provide guidance, is there some basic sequence that the standards should be in, so that they are in the proper sequence?). Dr. Blumenthal replied that the HIT Policy Committee is supposed to advise the HIT Standards Committee on this matter. In some sense, the standards follow the policies that recommended by the HIT Policy Committee. Dr. Lansky noted that the ONC released a strategic plan approximately 1 year ago and asked about how that plan plays into the architecture that may promote fitting into the guidance related to sequencing. Dr. Blumenthal commented that ONC recognizes the importance of strategic planning, and that in a perfectly rational world, this plan would be rolled out in an orderly fashion. The difficulty is that Congress set a series of deadlines, one of which was the meeting of the HIT Standards Committee later this week. Secondly, statute requires that an extension center program be posted in the *Federal Register* on May 18, 2009. This is a critical component of any strategic plan for working forward to achieve meaningful use. Third, the meaningful use requirement is attached to a 2011

timeframe. That timeframe gives very little pause for the purpose of designing policy to support the implementation of the 2011 meaningful use criteria. Therefore, Dr. Blumenthal explained, that the strategic plan will have to be developed in a parallel process along with getting these initiatives started. He encouraged Committee members to provide any suggestions and advice on these activities and processes.

Review and Discussion of Committee's Scope: Statutory Language/ARRA

Ms. Daniel reminded Committee members that ARRA created the two FACA committees (the HIT Policy and HIT Standards Committees). She also noted that the HIT Standards Committee will advise on standards, implementation, and certification for electronic health records (EHRs).

The recommendations from the HIT Policy Committee will be forwarded to the National Coordinator for Health Information Technology. There will likely be a Vice Chair of this committee who will formally make these recommendations to the National Coordinator. Then, the National Coordinator and HHS leadership will consider the recommendations, which will have a strong bearing on ONC's efforts. Ms. Daniel noted that there is a separate process for accepting the committee's recommendations within HHS and considering them with respect to other priorities and activities. Once endorsed by the National Coordinator, however, the HIT Policy Committee's recommendations will be submitted to the HIT Standards Committee for its consideration.

It is expected that the HIT Policy Committee will help to set some of the priorities for the HIT Standards Committee to work within. The role of the National Coordinator and the ONC is to support both committees and make sure that the work coming out of the Policy Committee has the appropriate scoping for the Standards Committee. ONC also will serve to provide input to the Policy Committee on other work that might be related to the discussions and considerations so that the work carried out within the Policy Committee is consistent with and connected to ONC activities.

Ms. Daniel explained that the statute called for two specific areas of focus for the Policy Committee: (1) the setting of priorities for standards, which will influence the HIT Standards Committee's work; and (2) to recommend a policy framework for the development and adoption of a nationwide infrastructure that permits information exchange. She noted that there were eight specific areas that ARRA set forth for the HIT Policy Committee to consider, as follows:

- Technology to protect the privacy and security of information (and consider segmentation of information).
- Infrastructure for electronic use and exchange of information.
- Utilization of health records.
- Accounting for disclosure to tie to the new provisions and statutes for accounting for disclosures, which would be considered for regulatory activities.
- Using certified health records to improve the quality of health care.
- Technologies to render information unreadable or unusable (this is tied to the new breach notification in the statute; recently, HHS released guidance in area).

- Collection of demographic data.
- Addressing vulnerable populations.

Additional areas suggested for consideration by the HIT Policy Committee include telemedicine, public health, individuals' access to their information, and technologies to improve home health care.

Dr. Blumenthal acknowledged that the HIT Policy Committee is a work in progress and shared his thoughts about prioritizing the Committee's work. There is an enormous mandate that extends from privacy and security all the way to how to carry out post-marketing surveillance, how to monitor public health threats, how to alert the public and providers about epidemic disease, and how to get doctors and hospitals to adopt qualified EHRs. Because it would be extremely difficult to carry out all of these activities at once, setting priorities is essential. Congress has set certain statutory requirements and has put allocated between \$30 and \$45 billion in payments that are available to physicians, hospitals, and certain other qualified providers who demonstrate starting in 2011 and going through 2018 that they are meaningful users of certified, qualified, EHRs. That amount of money focuses the attention, and creates very important benefits and risks. Dr. Blumenthal added that this is the first time in the history of this set of technologies, and in the history of the health care system, that Congress has set about to correct some of the market failures that have inhibited the adoption of technologies that have been widely viewed as essential to improving the functioning of the health care system. These are technologies that have been widely adopted by most other western countries.

At the same time, the fact that the money is available in such a short period of time creates a challenge if the appropriate preparations—through regulation, policy development, and through on-the-ground support—are not made for providers who in good faith want to take advantage of the technologies and thereby have access to the funds that are promised to them. Dr. Blumenthal explained that if this challenge is not met, there is the possibility that a large amount of money will be wasted and that policymakers will be deeply disappointed with the investment that they made and may not be willing to support this effort in the future. Many doctors and hospitals will be disappointed with the federal government for not fulfilling a major responsibility. Therefore, the meaningful use 2011 deadline has ONC's attention in a very important way—this does not suggest that the other issues that are important to creating a highly functioning health care system are unimportant or should not be dealt with. Rather, Dr. Blumenthal explained, it speaks to the need for the HIT Policy Committee, ONC, and others to carry out significant policy development focused on the meaningful use 2011 deadline first, so that the middle and long-term issues that ultimately may be more important can be addressed.

There are a series of particular tasks that must be accomplished to fulfill responsibilities under the law and make meaningful use a meaningful idea. First, the HIT Policy Committee must define "meaningful use," which in many ways is a revolutionary concept. The Committee needs to pick up where the NCVHS left off. There is a group within ONC that is working with representatives from other agencies on this topic and is awaiting the Committee's advice. A second important issue that must be addressed is certification. Providers can only be compensated if they are using certified records in a meaningful way. Dr. Blumenthal commented that the Policy Committee needs to consider how the certification process fits with the agenda that has been created by Congress. There is a third set of issues relating to infrastructure support. The HIT ARRA provisions allocate \$2 billion to ONC to help the nation's health care providers, public health agencies, and other interested parties prepare for the adoption and meaningful use of HIT. There are a number of suggested uses for these funds, including an extension center project and associated training activities. There are funds specifically appropriated to support health information exchange as well as a number of other suggested uses for these funds (e.g., training workers to help with adoption, use, and exchange). There also are funds available to states both for exchange support and also

to cover groups of providers who may not be eligible for Medicare and Medicaid incentives under the law.

Dr. Blumenthal noted that in the area of privacy and security, statute requires appointing a Chief Privacy Officer. HHS has instructions to place in every regional office a privacy officer, whose responsibility will be to keep track of privacy-related issues. In addition, public health and disease surveillance has risen up on the list of priorities for this Committee and for the federal government as a whole in terms of the role of HIT. Although there is infrastructure support for information exchange, exchange in itself at the national and local level constitutes a separate and important issue to address in the short and long-term. Dr. Blumenthal commented that exchange has its own set of challenges, and draws together and encapsulates all of the other issues in this area.

Mr. Chapman commented that given the ambitious schedule and the 2011 timeframe, it would seem that one of the early activities the Committee should set its sights on is how best to take advantage of work that has already been done by other groups. Dr. Blumenthal noted that the NCVHS hearings represent important initial work for the meaningful use discussion. He asked for any thoughts related to work that has been done and is ongoing related to supporting the adoption and use of HIT. He noted that some of the HIT Policy Committee members have participated, and in many cases have led, efforts to secure adoption and use within health care systems. There is a literature base on that topic, although its applicability and remains to be determined. Much work has been done in the area of privacy and security, and the Committee should take advantage of those efforts. The same can be said for the area of health information exchange, looking at precedent and the history of regional health information organizations (some HIT Policy members play a role in information exchange at the local level).

Mr. Egerman noted that he senses some urgency around the issue of certification. Although 2011 may seem like it is a long way away, it is actually a short cycle for vendors that have to address design and installation issues. He noted that clarification regarding certification requirements is needed (e.g., if a product was certified under the old rule, does that mean it will be certified again?).

Ms. Harrell commented that there is much work to be done to ensure meaningful use is achieved according to the statutory definition, including the exchange of data. She suggested that this topic be pushed to the top of the list of items to be addressed by the HIT Policy Committee. In this regard, much work is needed at the state level—many of the states are not prepared for this.

Mr. Egerman suggested that the group might look towards the goal and work backwards, or work bottom-up. Using certification for EHRs as an example, a top-down approach might be to focus on the measurable outcomes. In HIT use, the Committee could consider the care delivered, or the health status achieved. Then, much of the work on how to get there can be left to the innovative approaches, and the Committee can be less worried about the granular specification. It would also drive attention to the goals, reforming the way HIT outcomes and care are delivered.

Ms. Bechtel agreed with this approach and seconded Mr. Egerman's comments, explaining that if the Committee begins to look at care coordination and better medication reconciliation that would point to the data elements that are needed to achieve the outcomes. The question is, when the HIT Standards Committee receives the HIT Policy Committee's recommendations, what happens next? Dr. Blumenthal indicated that the process is still being refined, but that the Standards Committee is charged with making recommendations to the HHS Secretary about which standards to accept. HHS must post a set of rules by the end of the calendar year. Dr. Blumenthal suggested that the HIT Policy Committee provide the HIT Standards Committee with a list of areas on which it should focus initially. It would be a duplication of effort to indentify to the HIT Standards Committee exactly what standards to develop; rather, the HIT Policy Committee should suggest areas in which standards are needed, and perhaps a general approach or

philosophy to standards. Working groups should be formed that will report back to the HIT Policy Committee—it is possible to add non-committee members to these working groups where necessary.

Dr. Calman said that to push the notion of successful adoption, vendors must be responsible beyond the production of a product, to the successful implementation of the product. The same holds true with the problems associated with successful implementation. Vendors can have good and effective products, but if those that they sell them to are not supported and led through the process, the end result could be many cases of unsuccessful adoption. Mr. Calman suggested that an extension is needed, meaning that certification could include something like post-implementation assessment of the sites where products were implemented to ensure that there is meaningful use.

Mr. Chapman noted that although there is a good amount of consensus that outcomes are eventually meaningful, along the way the Committee should consider timing, because certification will have to deal with both the functional certifications that are present in the systems as well as the implementation process where the functions are actually applied and put to use. Ms. McGraw commented that sometimes, too much weight is given to certification. She thinks of it more in terms of functionality. For example, does the system have the basic functionalities to do what is being asked of it? That should be tied to how meaningful use is defined. For one piece to be the exchange of data, then the systems have to be certified that they can exchange data. It needs to be achievable, and the criteria should not be set so high that they are impossible to satisfy. Ms. McGraw also commented that certification tends to be a “one-shot” approach and may not be the most effective way to measure implementation.

Ms. Harrell suggested that given the short timeframe, the Committee needs to examine incremental steps and set a “ladder” to go step-by-step. As the process moves forward, the levels at which the standards are set should be increased. She voiced concern about the ability of vendors to establish a comprehensive EHR that is ready to be interoperable as well as develop the connectivity by 2011. She also expressed concerns about the ability of physicians and/or hospitals to implement these products under such a tight timeframe. Dr. Lansky added that the Committee should consider functionality as well as quality reporting and measurement. There may be certifiable functions associated with each of those areas, which could mean that single products do not have to have everything built into them.

Dr. Tang offered examples of top-down and bottom-up thinking. He explained that going from the top down with respect to coordination of care would also automatically prescribe the exchange of information. From the bottom up it would help to give people incremental steps and “pave the road.” He then likened this process to the creation of interstate roads, which created a public utility and proscribed the width of vehicles. Over time, guardrails and other specifications were added and had to fit within the constraints of the public utility. Carrying that analogy into this conversation, Dr. Tang suggested that it would not be desirable to have every provider worry about how wide the interstate is and where it goes.

Dr. Davidson noted that the Committee might consider prioritizing the eight specific areas that ARRA set forth for the HIT Policy Committee to consider, as presented earlier by Ms. Daniel. Some of these areas might be easier for the Committee to tackle initially with regard to meaningful use. Ms. McGraw commented that if the Committee is taking the top-down approach, with the “top” being the definition of meaningful use, then the definition could be staged over time. This drives a lot of the incremental decisions that must be made about standards needed to ensure that medication management programs are implemented. Ms. McGraw explained that the question would be: what needs to be in place to drive the outcomes that we have decided are the first set that we want to achieve? Then, it would be possible to take some of the requirements that Congress laid out in ARRA and slot them in.

Dr. Lansky suggested that fairly broad principles that would direct the Committee to the priority areas should be considered. He noted that those eight areas will all happen with or without the Committee, and

they will happen more or less simultaneously—Dr. Lansky noted that the Committee could look for opportunities to leverage various activities against/with one another. In the area of quality measurement, this comes through a variety of processes and creates a strong incentive in support of the other HIT adoption efforts. If the Committee settles on medication management IT standards, Dr. Lansky explained that it would be beneficial to have measures reinforcing those, as well as those that are tied to long-term health outcomes. He added that if these principles can be articulated, it would provide the Committee with a litmus test to judge the individual priorities and look for places to get synergy. Dr. Calman agreed, and asked: if this is part of a health reform agenda and we are looking to use technology as transformational, what are the big things that we believe? He suggested that privacy and security, quality improvement, patient centeredness, and access to care are answers to this question. Dr. Calman did voice concern that if one engages in a process of exchange without considering whether or not a principle is the patient's ownership and control of their information, then one moves into directions that would, in the future, not allow for revisiting that fundamental principle. He asked if there was the opportunity to examine these types of issues before the Committee becomes too involved in its work.

In response to a question about the extent to which the law provides a framework for privacy and security, and the extent to which this Committee is free to develop such a framework, Ms. Daniel explained that her interpretation of the law is that it focuses on the Health Insurance Portability and Accountability Act (HIPAA) framework and provides modifications to the current HIPAA requirements that existed before ARRA. There are clearly a lot of areas that either will be outside of the HIPAA framework, or where the Committee and ONC can have conversations about how to advance what has been adopted in the statute. Ms. Daniel indicated that the Committee could engage in beneficial discussions about how to better protect information through technologies, and about the approaches to taking up privacy for health information exchange

Mr. Egerman asked whether the statute allows an individual patient to opt out of using electronic records altogether. Ms. Daniel replied that it does not have a specific provision for this, and that patient choice may be a topic for HIT Policy Committee discussion. Currently, the HIPAA privacy rules provide a floor of protections; state laws may be more protective or provide additional types of requirements for privacy.

Dr. Calman raised the issue of patient access to information. He pointed to examples of inaccurate information being transferred, noting that this is a significant concern. He also suggested that access to unidentified patient information on the part of public health agencies could be a topic for discussion. In New York State, there is almost open access to aggregated information for the purposes of disease surveillance. Dr. Calman emphasized the importance of having access to information from hospitals and physicians' offices, and for the Committee to consider the principle of whether or not this information should be available for use by public health for disease surveillance (and also whether it is appropriate to try to capture information about the prevalence of various diseases). This issue is of particular concern as it relates and applies to vulnerable populations.

Dr. Blumenthal commented that regardless of what this group chooses as their priorities, many of the issues discussed today will go forward in parallel process. This Committee does not have to take up everything that is part of the statute, or is on the agenda. It may be more beneficial to select a few areas and focus on them. Dr. Blumenthal indicated that he is hearing from the discussion that there is an emphasis on privacy, security, and the role of the patient in HIT policy. He also heard a focus on how to define meaningful use in the most effective way, so as to inform other policy development. Finally, he heard a focus on certification and designing a process that was useful but not obstructive of innovation, and not overly burdensome.

Dr. Clark suggested that the question of how HIT will support 21st century science is critical to the research infrastructure. Dr. Tang pointed out the issue of workforce training has not received enough

attention. He clarified that by workforce training, he means the training of the individuals who will help all of the physician practices and health care organizations to implement HIT in ways that can be used effectively, in addition to the general training of the professional workforce. Both of those issues have been underplayed but are critical to HIT's effective use.

Dr. Lansky turned the discussion back to the timeline issue, commenting that it would be helpful for the Committee to identify opportunities for early success. He added that if the Committee selects the opportunities appropriately, all of the goals that have been articulated can be achieved, and made visible to the public. Ms. Bechtel agreed, and followed up on Ms. Harrell's earlier comments regarding a ladder/step-by-step approach. Ms. Bechtel indicated that in care coordination for example, this would create a road map that the HIT Standards Committee could consider. It would be an approach for experts to discuss the technical nature of the information and standards in a way that gets at how to make significant progress.

Dr. White Delaney affirmed previous comments made related to the research infrastructure, support, and workforce training. She voiced her support for these areas being included in the meaningful use definition.

Mr. Chapman also voiced support for the ladder/step-by-step approach, given the complexity of the goals facing the Committee. He noted that if there is any marked failure of groups in the past it has been that their recommendations are so comprehensive that they are not implementable. These functional areas could all be explored in depth, but the foundational message is that these have to be implementable in the short term. Mr. White commented on the concepts of workforce training, adoption, and meaningful use. He emphasized that if the workforce is not engaged at an early level, all of the macro-conversations will be almost useless. Unless the workforce is trained properly, and there is an understanding of their role in the bigger picture, these efforts will likely fail from the beginning. Ms. Faulkner warned fellow Committee members of the dangers associated with requiring the software companies to do certain things that they may not be able to do. Particularly in the areas of privacy and security, it must be very crisply and clearly laid out what can be done, what cannot be done, and what is required.

Following a brief break, Dr. Blumenthal turned the conversation to the establishment of working groups. Based on previous discussions, he noted that there are at least three areas in which the Committee wants to carry out intensive work: (1) defining meaningful use, (2) defining or improving certification, and (3) the area of patient-centeredness (e.g., assuring patient access to their health information). Other possibilities include areas such as workforce and infrastructure development. Dr. Blumenthal suggested that the issue of quality falls under the auspices of "meaningful use" because the statute defines quality reporting as an aspect of meaningful use. Similarly, the issue of exchange could fall under meaningful use because the statute requires some level of exchange to define meaningful use.

Ms. McGraw commented that she would be somewhat reluctant to have a workgroup set off to the side to work on privacy and security issues. She indicated that she has no problems with creating a workgroup to dive deeper into some discrete, difficult questions relating to privacy and security. However, since the tone of the earlier discussions were about privacy being foundational to each and every one of the aspects under consideration, she expressed concern that all privacy and security issues will be handed over to the workgroup, and thus the issues could be addressed out of the contexts from which they arise. She noted that one area for focus could be the technical issues related to privacy and security, and whether the HIT field takes full advantage of technologies that have been developed to protect privacy and security in other domains, even within the federal government. Although that would be a fairly minimal charge, Ms. McGraw indicated that it is core to the HIT Policy Committee.

Dr. Tang asked about the possibility of moving privacy under the umbrella of infrastructure. Another Committee member expressed support for this concept, as long as it does not create the idea that the Committee/workgroup is neglecting privacy by not creating a specific workgroup for it. It was noted that although privacy issues have been vetted and addressed in many electronic medical record packages, direct patient access has not. Historically, doctors have analyzed the data and presented it to the patient. Much of the information is sensitive, nuanced, and in some cases can be catastrophic to the patient. It was suggested that there currently is no plan in place for moving forward on how to address suspicious biopsies or disturbing laboratory reports, for example. One Committee member indicated that direct patient access to medical records must be a part of the workgroup focused on privacy in a patient-centric record.

Mr. Probst expressed hope that health information exchange, whether included in the meaningful use discussion or elsewhere, will receive enough attention from the Committee. He commented that health information exchange will be key to a great deal of the meaningful use discussion. Ms. Bechtel asked how time-limited the group dealing with meaningful use will be. She acknowledged having difficulty distinguishing between the goals of a workgroup on meaningful use and some of the larger goals of the HIT Policy Committee. Dr. Blumenthal said that to some degree, this is the Committee's choice. He agreed that meaningful use is a time-limited exercise, but not exclusively time-limited because associated with the requirement of specifying a set of meaningful use criteria for 2011 is the Committee's option to update the criteria.

Ms. Harrell asked whether health information exchange would be addressed within the context of meaningful use or within the context of infrastructure. Dr. Blumenthal explained that there is an aspect to health information exchange that falls under infrastructure because at least \$300 million will be spent on it. So, apart from whatever theoretical definitions will be created for it, there is money that must be spent. The question is, for what? That is the infrastructure issue. He added that there also is a meaningful use component tied to health information exchange (i.e., what are the requirements that should be put forth for the meaningful use definition for the exchange, and what do the records have to be able to do to be able to be certified as capable for working exchange?).

Dr. Blumenthal suggested that ONC staff develop a set of guiding principles and circulate them to the Committee members for comments and input. This would then serve as the basis for discussions and decisions that will lead the workgroups. Ultimately, HIT Policy Committee members decided to form the following three workgroups:

- Meaningful Use.
- Certification/Adoption (with the focus being on certification first—this group will also be tasked with infrastructure issues).
- Information Exchange.

HIT Standards Committee Recommendations

Dr. Blumenthal then proposed that the HIT Policy Committee relay the following to the HIT Standards Committee: (1) that the three workgroups to be formed represent the three primary areas of work; (2) that the statute requires that they focus on meaningful use; and (3) that this group will inform the HIT Standards Committee, as soon as possible, on recommendations concerning meaningful use. The HIT Standards Committee can begin thinking about the process that would be required to get to standards

regarding meaningful use and then wait for a fairly quick set of more defined criteria for meaningful use from the HIT Policy Committee.

Public Comment

The following was noted during the public comment session:

- Dr. Alan Zuckerman of the American Academy of Pediatrics expressed hope that this Committee will be willing to consider some of the barriers associated with interoperability certification efforts. According to Dr. Zuckerman (who also serves as Co-Chair of the Certification Commission for Health Information Technology's [CCHIT] Interoperability Workgroup), most important will be this Committee's policy affirmation on meaningful use, because many vendors persist in doing things that the customers do not ask for. He also noted that children are vulnerable populations not just in health care, but they are also being left out of HIT in general and in the meaningful use considerations. He suggested that the Committee could select a few targets such as vaccine administration and obesity prevention through checking growth; this is a unique convergence of hospital, ambulatory, public and private sector data for children. His hope is that children will not be neglected in the limited range of targets.
- **Mr. Rick Blake, Senior Health Policy Advisor for Rep. Edolphus Towns (D-NY)** noted that the House health disparity bill is moving through its paces, and it will have an impact on health disparities for vulnerable, minority populations. He expressed hope that the infrastructure workgroup will be mindful of the fact that this area of data collection could have a positive impact on the reduction of health disparities.
- Another speaker congratulated the group, and reminded them that a lot of the activities that have been moving forward these last several years have been volunteer-driven. As the Committee moves forward with ideas about what the industry and health care community need to do, it should be considered that there are thousands of hours of volunteer work behind these efforts. The speaker noted that meaningful use is the common, binding question of concern among all constituencies. The sooner there can be clarification and education on what meaningful use means, the better.
- Brian Wagner of the e-Health Initiative stressed the importance of work on local levels. His group has been surveying HIT across the country, and the need for human/social capital is important. As these issues move forward on the federal level, it is important to think about promoting that social and human capital and participation so that the projects have as much support at the local level as possible to avoid any sort of catastrophic failure.
- Phil Barr from Thomson-Reuters noted that the certification addresses software and vendors but does not necessarily recognize the complexity of the health system and the issue of whether vendors can and will participate in the exchanges. He commented that certification should be carried out in some way to ensure that vendors are covered for a variety of very specific use cases, and can share information in a minimum data set.
- **Mike Dunney (sp?)** noted that the bulk of the Committee's discussions focused on the transfer of medical records. When he read through the bill, there was a section that discussed other technologies related to HIT. He expressed interest in whether the Committee will examine other technologies that are more preventive in nature that produce the records being discussed. He also noted that long-term care will be a major issue facing the health care system in the coming years. He noted that there are

technologies that interface with long-term care records only and asked whether these technologies will be considered in the \$20 billion initiative. Dr. Blumenthal responded that the law itself does not specify or focus on long-term care. Ms. Daniel commented that there likely is flexibility to take on the issue of long-term care if the Committee and HHS chooses to do so.

Adjournment

Dr. Blumenthal asked that Committee members inform Ms. Sparrow regarding which workgroup they would like to join. Before adjourning the meeting, he thanked Committee members and others present for their participation and comments.

Additional Public Comments

In addition to those noted previously, a number of comments were submitted to ONC staff following conclusion of the meeting. These comments are as follows:

- Fred Buhr, President of Metasteward LLC, indicated that “meaningful use” should include patient education/training on how to use HIT. From a patient’s point of view, the definition of “meaningful use” should be crisp, clear, and understandable.
- Dr. Zuckerman submitted a letter to ONC staff expanding on the comments he made during the meeting. He noted that the CCHIT has learned many lessons in terms of developing a certification process derived from standards, and that these lessons learned should be shared with the Committee. The Committee can do a great deal to overcome the problems and resistance the CCHIT faced by setting clear “meaningful use” goals for information exchange so that they can get into certification because EHR vendors do not want to implement features that their customers are not asking for and often are unable to use because of lack of interoperability partners and networks. Dr. Zuckerman explained that information exchange must be a routine part of nearly every patient encounter. An important part of this Committee’s deliberations on meaningful use should focus on the information required to make meaningful decisions such as carrying out electronic prescribing in the context of patient problems, medications, and allergies, as well as formulary information or regularly checking immunization status of children and adults.

Dr. Zuckerman also noted that interoperability is a very difficult task to achieve and simplification and clarification of standards and moving resources and privacy protection into networks will help make meaningful EHR certification possible. One of the expectations for certification that he finds among his pediatric colleagues is that one should be able to move a patient record from one certified EHR to another certified EHR so that patients can move to another practice regardless of the EHR used and so that providers will have less fear of choosing the wrong EHR or having their EHR vendor go out of business. If a phased and incremental approach is accepted, this may be possible by 2011. Dr. Zuckerman also expressed hope that the Committee pays due attention to making recommendations on technologies that address the needs of children and other vulnerable populations. Children are a vulnerable population not just in their health risks but in terms of being left out of HIT because they cannot speak for themselves.

- Ilyse Schuman, Managing Director of the Medical Imaging and Technology Alliance (MITA), submitted a letter on behalf of the organization express its views for incorporation into the public record, to describe MITA’s capabilities in standards development, and to offer its assistance and

expertise on the issues vital to the successful achievement of the Nationwide Health Information Network (NHIN). She noted that MITA is the collective voice of medical imaging manufacturers, innovators and product developers. It represents companies whose sales comprise more than 95 percent of the global market for medical imaging technology and has developed standards for many areas including diagnostic ultrasound, nuclear medicine imaging, magnetic resonance imaging, x-ray imaging and radiation therapy. Based on its knowledge and experience, MITA is able to provide recommendations and advice on these and other areas that are central to the development of the NHIN. She noted that improved access to imaging through the NHIN can reduce errors and delays in care, and has the potential to decrease the number of unnecessary duplicate examination, and thus reduce cost and patient exposure to radiation.

HIT Policy Committee

Meaningful Use Workgroup Presentation

Paul Tang

Palo Alto Medical Foundation

Farzad Mostashari,

New York City Health Department

June 16, 2009

Workgroup Members

Co-Chairs:

- Paul Tang, Palo Alto Medical Foundation
- Farzad Mostashari, New York City Health Department

Members:

- David Bates, Brigham & Women's Hospital
- Christine Bechtel, National Partnership for Women & Families
- Neil Calman, The Institute for Family Health
- Art Davidson, Denver Public Health Department
- David Lansky, Pacific Business Group on Health
- Deven McGraw, Center for Democracy & Technology
- Latanya Sweeney, Carnegie Mellon University
- Charlene Underwood, Siemens

ONC Lead:

- John Glaser

Workgroup Charges

Broad Charge

- Make recommendations to the HIT Policy Committee regarding the process for defining and revising meaningful use and national goals, proposed new meaningful use definitions and national goals and standards and policy priorities to support meaningful use and national goals.

3

Workgroup Charges

Specific Charge

- Make recommendations to the HIT Policy Committee on the definition of meaningful use for 2011 and 2013 within one (1) month of the initial meeting of the workgroup and refine within two (2) months.
- Make recommendations to the HIT Policy Committee on the definition of meaningful use for 2015 within three (3) month of the initial meeting of the workgroup and refine within six (6) months.

4

Workgroup Charges

Specific Charge (continued)

- Make recommendations, by the end of 2009, to the HIT Policy Committee on the process for defining and revising meaningful use and national priorities on a bi-annual basis.
- Make recommendations to the HIT Policy Committee on the policies and standards necessary to support meaningful use and the eight (8) specific national priorities of Section 3002(b)(2)(B) of ARRA.
- Review barriers to broad adoption of meaningful use and provide recommendations, to the HIT Policy Committee, for removing barriers.

5

Process

- Materials disseminated to workgroup
- First conference call May 28th
- Iterative revisions made based on feedback
- Second conference call June 3rd
- Additional refinements made

6

VISION FOR MEANINGFUL USE

Health IT and Transformed Health Care

- Ultimate vision is to enable significant and measurable improvements in population health through a transformed health care delivery system.
- Key goals*:
 - Improve quality, safety, & efficiency
 - Engage patients & their families
 - Improve care coordination
 - Improve population and public health; reduce disparities
 - Ensure privacy and security protections

*Adapted from National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008

8

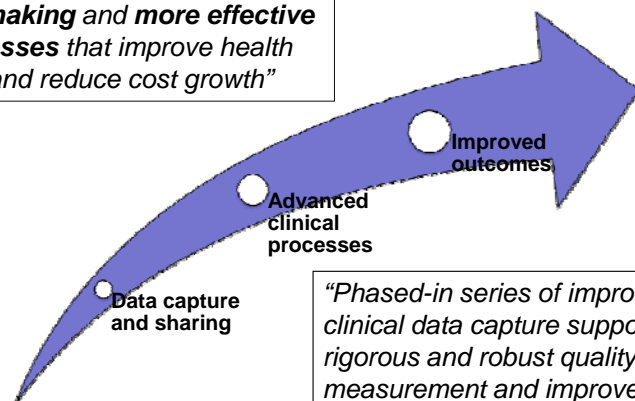
Achievable Vision for 2015

- **Prevention, and management, of chronic diseases**
 - A million heart attacks and strokes prevented
 - Heart disease no longer the leading cause of death in the US
- **Medical errors**
 - 50% fewer preventable medication errors
- **Health disparities**
 - The racial/ ethnic gap in diabetes control halved
- **Care Coordination**
 - Preventable hospitalizations and re-admissions cut by 50%
- **Patients and families**
 - All patients have access to their own health information
 - Patient preferences for end of life care are followed more often
- **Public health**
 - All health departments have real-time situational awareness of outbreaks

9

Bending the Curve Towards Transformed Health Achieving Meaningful Use of Health Data

*“These goals can be achieved only through **the effective use of information** to support **better decision-making** and **more effective care processes** that improve health outcomes and reduce cost growth”*



“Phased-in series of improved clinical data capture supporting more rigorous and robust quality measurement and improvement.”

Connecting for Health, Markle Foundation “Achieving the Health IT Objectives of the American Recovery and Reinvestment Act” April 2009

Example

- Goal
 - 85% of patients with high blood pressure and cholesterol have it well controlled
- Advanced care processes
 - Use of evidence-based order sets
 - Monitoring and addressing medication adherence
 - Clinical decision support at the point of care
 - Patient outreach and reminders
 - Quality benchmarking and reporting
- Clinical data capture (can be queried and trended)
 - Systolic & diastolic blood pressure
 - Medication and Problem list
 - Laboratory tests and procedures
 - Prescription fill histories

11

Relationship to Health Reform and Affordability

- Direct Cost Reduction
 - Reduction in medication errors
 - Formulary adherence
 - Fewer redundant tests due to better information
- Provides information infrastructure for health reform
 - Clinical quality measurement (outcomes)
 - Care coordination (e.g., to reduce readmissions)
 - Reduction in inappropriate care
 - Expanding primary care capacity (e.g., non-visit-based care)
 - Prevention

12

Initial Metrics and Validation

- Provider makes use of, and the patient has access to, clinically relevant electronic information, not just existence of technology
- Achievable whenever possible through automatic reporting from electronic health systems to avoid creating additional unnecessary reporting burden for clinicians
- Verification to be performed by CMS
- Many suitable measures already developed and specified for automated reporting
- Consider use of PQRI EHR/ registry receiving capabilities
- Attestation will be necessary for some criteria (at least initially)
- Can use escalating thresholds

13

Criteria for 2013 and Beyond

- Additional metrics required
 - Additional efficiency, “inappropriate use” measures
 - Patient safety
 - Care coordination
- Transition from “pay for reporting” to “pay for outcomes” as per the CMS EHR demonstrations

14



DISCUSSION OF VISION

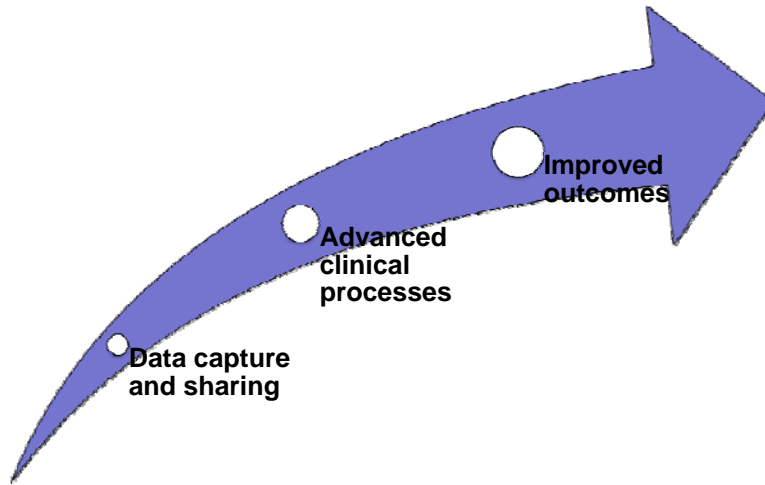
15



ACHIEVING MEANINGFUL USE

16

Bending the Curve Towards Transformed Health
Achieving Meaningful Use of Health Data



17

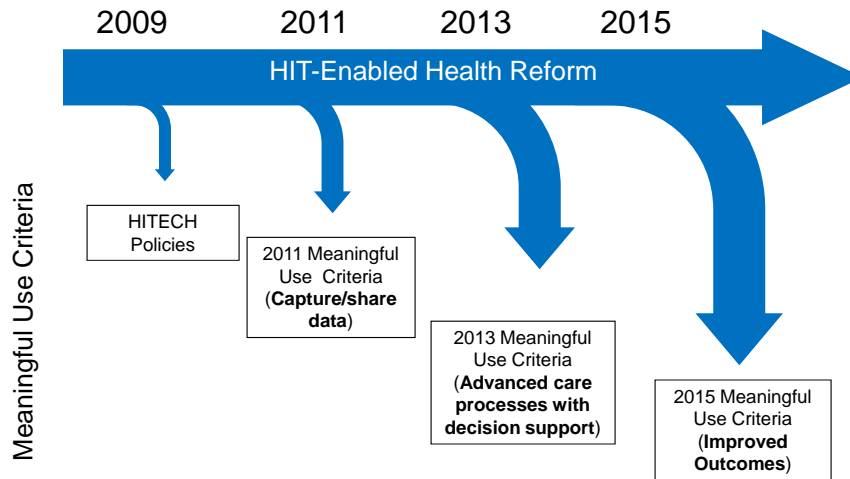
HIT-Enabled Health Reform
Achieving Meaningful Use



18

HIT-Enabled Health Reform

Achieving Meaningful Use



19

Phasing of MU Criteria

Some Considerations

- Enable health reform (payment reform prerequisite)
 - Create a transformed health care system
 - Support advanced care processes
- Focus on health outcomes, not software
 - Measure health outcomes and key process changes
 - “Pull with quality; push with certification” (per Jon Perlin)
- Feasibility
 - Currently available capabilities in EHRs
 - Balance urgency of health reform with calendar time needed to implement
 - Be sensitive to issues of small practices
- Recovery Act provisions
 - Timelines fixed
 - Funding rules defined



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Phasing of MU Criteria: A Balancing Act

- Urgency of health reform
- Outcomes improvement

- Currently available EHR capabilities
- Time needed to implement
- Small practice realities



Availability of Technical Assistance and Exchange Capabilities

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DRAFT MEANINGFUL USE CRITERIA (FOCUSED ON 2011)

22

Improve Quality, Safety, Efficiency

2011 Objectives

- Capture data in coded format
 - Maintain current problem list
 - Maintain active medication list
 - Maintain active medication allergy list
 - Record vital signs (height, weight, blood pressure)
 - Incorporate lab/test results into EHR
 - Document key patient characteristics (race, ethnicity, gender, insurance type, primary language)
- Document progress note for each encounter (outpatient only)
- Use CPOE for all order types
 - Use electronic prescribing for permissible Rx
 - Implement drug-drug, drug-allergy, drug-formulary checks
- Manage populations
 - Generate list of patients by specific conditions (outpatient only)
 - Send patient reminders per patient preference

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Improve Quality, Safety, Efficiency

2011 Measures

- % Labs incorporated into EHR in coded format
- % CPOE orders entered directly by physician
- Report quality measures using HIT-enabled quality measures (HIT-QM)
 - % Diabetics with A1c under control
 - % Hypertensives with BP under control
 - % LDL under control
 - % Smokers offered smoking cessation counseling
 - % Patients with recorded BMI
 - % Colorectal screening for 50+
 - % Mammograms for women 50+
 - % Current pneumovax status
 - % Annual flu vaccination
 - % Aspirin prophylaxis for patients at risk for cardiac event
 - % Surgical patients receiving VTE prophylaxis
 - Avoidance of high risk medications in elderly
- Quality reports stratified by race, ethnicity, gender, insurance type

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Engage Patients and Families

2011 Objectives

- Provide patients with electronic copy of- or electronic access to- clinical information per patient preference
 - Includes labs, problem list, medication list, allergies
- Provide access to patient-specific educational resources
- Provide clinical summaries for patients for each encounter

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Engage Patients and Families

2011 Measures

- % Patients with electronic access to personal health information
- % Patients with access to patient-specific educational resources
- % Encounters where clinical summary provided

26

Improve Care Coordination

2011 Objectives

- Exchange key clinical information among providers of care
- Perform medication reconciliation at relevant encounters

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Improve Care Coordination

2011 Measures

- Report 30 day readmission rate
- % Encounters where medication reconciliation performed
- Implemented ability to exchange health information with external clinical entities
 - Problems, labs, medication lists, care summaries
- % Transitions in care where summary care record is shared (in 2011, could use any modality)

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Improve Population and Public Health

2011 Objectives

- Submit electronic data to immunization registries where required and can be accepted
- Submit electronic reportable lab results to public health agencies
- Submit electronic syndrome surveillance data to public health agencies according to applicable law and practice

29

Improve Population and Public Health

2011 Measures

- Report up-to-date status of childhood immunizations
- % Reportable lab results submitted electronically

30

Ensure Privacy and Security Protections

2011 Objectives

- Compliance with HIPAA Rules and state laws
- Compliance with fair data sharing practices set forth in the National Privacy and Security Framework

31

Ensure Privacy and Security Protections

2011 Measures

- Full compliance with HIPAA
 - Entity under investigation for HIPAA violation cannot achieve meaningful use until entity is cleared
- Conduct or update a security risk assessment and implement security updates as necessary

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Looking Forward: 2013 Objectives

- Improve quality, safety, efficiency
 - Evidence based order sets
 - Clinical documentation recorded (inpatient)
 - Clinical decision support at point of care
 - Manage chronic conditions using patient lists and decision support
 - Report to external disease registry
- Engage patients and families
 - Offer secure patient-provider messaging
 - Access to patient-specific educational resources
 - Record patient preferences
 - Documentation of family medical history
 - Upload data from home monitoring devices
- Coordinate care
 - Medication reconciliation at each transition of care
 - Produce electronic summary of care at each transition
 - Retrieve and act on electronic prescription fill data

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Looking Forward: 2013 (continued) Objectives

- Improve population and public health
 - Receive immunization histories from registries
 - Receive public health alerts
 - Electronic syndromic surveillance data sent to public health agencies
- Ensure privacy and security protection
 - Use summary or de-identified data when reporting data for population health purposes

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Looking Forward: 2015 Objectives

- **Improve quality, safety, and efficiency**
 - Achieve minimal levels of performance on quality, safety, and efficiency measures
 - Implement clinical decision support for national high priority conditions
 - Achieve medical device interoperability
 - Provide multimedia support (e.g., x-rays)
- **Engage patients and families**
 - Provide access for all patients to PHR populated in real time with data from EHR
 - Provide patients with access to self-management tools
 - Capture electronic reporting on experience of care
- **Coordinate care**
 - Access comprehensive patient data from all available sources

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Looking Forward: 2015 (continued) Objectives

- **Improve population and public health**
 - Use epidemiologic data derived from EHRs
 - Automate real-time surveillance
 - Provide clinical dashboards
 - Generate dynamic and ad hoc quality reports
- **Ensure privacy and security protection**
 - Provide patients with accounting of treatment, payment, and health care operations disclosures
 - Protect sensitive health information

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Summary

- Journey to a transformed health system requires meaningful use of transformation-capable HIT
- Migration of HIT readiness from current situation to fully HIT-enabled ecosystem will evolve:
 - Capture coded data electronically
 - Adopt advanced care processes
 - Measure and improve outcomes
- Proposed MU criteria for 2011 and beyond provides escalating capabilities, balancing urgent need for reform and feasibility of what is achievable
- Meaningful use of HIT is a precursor to effective health reform, and contingent on health care financing reform

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QUESTIONS AND DISCUSSION

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Meaningful Use Matrix

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
<p>Improve quality, safety, efficiency, and reduce health disparities</p>	<ul style="list-style-type: none"> • Provide access to comprehensive patient health data for patient’s health care team • Use evidence-based order sets and CPOE • Apply clinical decision support at the point of care • Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc) • Report to patient registries for quality improvement, public reporting, etc 	<ul style="list-style-type: none"> • Use CPOE for all order types including medications [OP, IP] • Implement drug-drug, drug-allergy, drug-formulary checks [OP, IP] • Maintain an up-to-date problem list [OP, IP] • Generate and transmit permissible prescriptions electronically (eRx) [OP] • Maintain active medication list [OP, IP] • Maintain active medication allergy list [OP, IP] • Record primary language, insurance type, gender, race, ethnicity [OP, IP] • Record vital signs including height, weight, blood pressure [OP, IP] • Incorporate lab-test results into EHR [OP, IP] • Generate lists of patients by specific condition to use for 	<ul style="list-style-type: none"> • Report quality measures, including: <ul style="list-style-type: none"> - % diabetics with A1c under control [OP] - % hypertensive patients with BP under control [OP] - % of patients with LDL under control [OP] - % of smokers offered smoking cessation counseling [OP, IP] • % of patients with recorded BMI [OP] • % eligible surgical patients who received VTE prophylaxis [IP] • % of orders entered directly by physicians through CPOE • Use of high-risk medications in the elderly [OP, IP] • % of patients over 50 with annual 	<ul style="list-style-type: none"> • Use evidence-based order sets [OP, IP] • Record clinical documentation in EHR [IP] • Generate and transmit permissible prescriptions electronically [IP] • Manage chronic conditions using patient lists and decision support [OP, IP] • Provide clinical decision support at the point of care (e.g., reminders, alerts) [OP, IP] • Report to external disease (e.g., cancer) or device registries [OP (esp. specialists) [IP] • Conduct medication administration using bar coding [IP] 	<ul style="list-style-type: none"> • Additional quality reports using HIT-enabled NQF-endorsed quality measures [OP, IP] • % of all orders entered by physicians through CPOE [OP, IP] • Potentially preventable Emergency Department Visits and Hospitalizations [IP] • Inappropriate use of imaging (e.g. MRI for acute low back pain) [OP, IP] • Other efficiency measure (TBD) [OP, IP] 	<ul style="list-style-type: none"> • Achieve minimal levels of performance on quality, safety, and efficiency measures • Implement clinical decision support for national high priority conditions [OP, IP] • Medical device interoperability [OP, IP] • Multimedia support (e.g. x-rays) [OP, IP] 	<ul style="list-style-type: none"> • Clinical outcome measures (TBD) [OP, IP] • Efficiency measures (TBD) [OP, IP] • Safety measures (TBD) [OP, IP]

Meaningful Use Matrix

		<p>quality improvement, reduction of disparities, and outreach [OP]</p> <ul style="list-style-type: none"> • Send reminders to patients per patient preference for preventive /follow up care [OP, IP] • Document a progress note for each encounter [OP] 	<p>colorectal cancer screenings [OP]</p> <ul style="list-style-type: none"> • % of females over 50 receiving annual mammogram [OP] • % patients at high-risk for cardiac events on aspirin prophylaxis [OP] • % of patients with current pneumovax [OP] • % eligible patients who received flu vaccine [OP] • % lab results incorporated into EHR in coded format [OP,IP] • Stratify reports by gender, insurance type, primary language, race, ethnicity [OP, IP] 				
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Meaningful Use Matrix

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
Engage patients and families	<ul style="list-style-type: none"> Provide patients and families with access to data, knowledge, and tools to make informed decisions and to manage their health 	<ul style="list-style-type: none"> Provide patients with electronic copy of or electronic access to clinical information (including lab results, problem list, medication lists, allergies) per patient preference (e.g., through PHR) [OP, IP] Provide access to patient-specific educational resources [OP, IP] Provide clinical summaries for patients for each encounter [OP, IP] 	<ul style="list-style-type: none"> % of all patients with access to personal health information electronically [OP, IP] % of all patients with access to patient-specific educational resources [OP, IP] % of encounters for which clinical summaries were provided [OP, IP] 	<ul style="list-style-type: none"> Offer secure patient-provider messaging capability [OP] Provide access to patient-specific educational resources in common primary languages [OP, IP] Record patient preferences (e.g., preferred communication media, advance directive, health care proxies, treatment options) [OP, IP] Documentation of family medical history [OP, IP] Upload data from home monitoring devices [OP] 	<ul style="list-style-type: none"> Additional patient access and experience reports using NQF-endorsed HIT-enabled quality measures [OP, IP] % of patients with access to secure patient messaging [OP] % of educational content in common primary languages [OP, IP] % of all patients with preferences recorded [OP] % of transitions were summary care record is shared [OP, IP] Implemented ability to incorporate data uploaded from home monitoring devices [OP] 	<ul style="list-style-type: none"> Access for all patients to PHR populated in real time with data from EHR [OP, IP] Patients have access to self-management tools [OP] Electronic reporting on experience of care [OP, IP] 	<ul style="list-style-type: none"> NPP quality measures related to patient and family engagement [OP, IP] % of patients with full access to PHR populated in real time with EHR data [OP, IP]

Meaningful Use Matrix

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
Improve care coordination	<ul style="list-style-type: none"> Exchange meaningful clinical information among professional health care team 	<ul style="list-style-type: none"> Exchange key clinical information among providers of care (e.g., problems, medications, allergies, test results) [OP, IP] Perform medication reconciliation at relevant encounters [OP, IP] 	<ul style="list-style-type: none"> Report 30-day readmission rate [IP] % of encounters where med reconciliation was performed [OP, IP] Implemented ability to exchange health information with external clinical entity (specifically labs, care summary and medication lists) [OP, IP] % of transitions in care for which summary care record is shared (e.g., electronic, paper, eFax) [OP, IP] 	<ul style="list-style-type: none"> Retrieve and act on electronic prescription fill data [OP, IP] Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge) [OP, IP] Perform medication reconciliation at each transition of care from one health care setting to another [OP, IP] 	<ul style="list-style-type: none"> Additional public reports using NQF-endorsed HIT-enabled quality measures [OP, IP] % of transitions where med reconciliation was performed [OP, IP] % of encounters where fill data accessed [OP] % of encounters where clinical information is shared with external clinical entities [OP, IP] 	<ul style="list-style-type: none"> Access comprehensive patient data from all available sources 	<ul style="list-style-type: none"> Aggregated clinical summaries from multiple sources available to authorized users [OP, IP] NQF-endorsed Care Coordination Measures (TBD)

Meaningful Use Matrix

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
Improve population and public health	<ul style="list-style-type: none"> Communicate with public health agencies 	<ul style="list-style-type: none"> Submit electronic data to immunization registries where required and accepted [OP, IP] Provide electronic submissions of reportable lab results to public health agencies [IP] Provide electronic syndrome surveillance data to public health agencies according to applicable law and practice [IP] 	<ul style="list-style-type: none"> Report up-to-date status for childhood immunizations [OP] % reportable lab results submitted electronically [IP] 	<ul style="list-style-type: none"> Receive immunization histories and recommendations from immunization registries [OP, IP] Receive health alerts from public health agencies [OP, IP] Provide sufficiently anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers [OP,IP] 	<ul style="list-style-type: none"> % of patients for whom an assessment of immunization need and status has been completed during the visit [OP] % of patients for whom a public health alert should have triggered and audit evidence that a trigger appeared during the encounter 	<ul style="list-style-type: none"> Use of epidemiologic data [OP, IP] Automated real-time surveillance (adverse events, near misses, disease outbreaks, bioterrorism) [OP, IP] Clinical dashboards [IP, OP] Dynamic and Ad hoc quality reports [OP, IP] 	<ul style="list-style-type: none"> HIT-enabled population measures TBD [OP] HIT-enabled surveillance measure [OP, IP]

Meaningful Use Matrix

Health Outcomes Policy Priorities	Care Goals	2011 Objectives	2011 Measures	2013 Objectives	2013 Measures	2015 Objectives	2015 Measures
<p>Ensure adequate privacy and security protections for personal health information</p>	<ul style="list-style-type: none"> Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law Provide transparency of data sharing to patient 	<ul style="list-style-type: none"> Compliance with HIPAA Privacy and Security Rules and state laws Compliance with fair data sharing practices set forth in the <u>Nationwide Privacy and Security Framework</u>¹ 	<ul style="list-style-type: none"> Full compliance with HIPAA Privacy and Security Rules <ul style="list-style-type: none"> An entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared by the investigating authority Conduct or update a security risk assessment and implement security updates as necessary 	<ul style="list-style-type: none"> Use summarized or de-identified data when reporting data for population health purposes (e.g. public health, quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk 	<ul style="list-style-type: none"> Provide summarized or de-identified data, when sufficient, to satisfying a data request for pop. health purposes 	<ul style="list-style-type: none"> Provide patients, on request, with an accounting of treatment, payment, and health care operations disclosures <ul style="list-style-type: none"> Protect sensitive health information to minimize reluctance of patient to seek care because of privacy concerns 	<ul style="list-style-type: none"> Provide patients, on request, with a timely accounting of disclosures for treatment, payment, and health care operations, in compliance with applicable law <ul style="list-style-type: none"> Incorporate and utilize technology to segment sensitive data

¹ The Nationwide Privacy and Security Framework was released by The Department of Health and Human Services in December 2008. It is anticipated that further revisions may be made to this document during the calendar year 2010.

“Meaningful Use: A Definition”

Recommendations to the Health IT Policy Committee from the Meaningful Use Workgroup

The American Recovery and Reinvestment Act authorizes the Centers for Medicare & Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers who are successful in becoming “meaningful users” of an electronic health record (EHR). These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the “meaningful use” definition or they will be subject to financial penalties under Medicare.

FRAMEWORK FOR DEFINITION

In 2008, the National Priorities Partnership, convened by the National Quality Forum (NQF), released a report entitled “National Priorities and Goals” which identified a set of national priorities to help focus performance improvement efforts. Among these priorities were patient engagement, reduction of racial disparities, improved safety, increased efficiency, coordination of care, and improved population health. These priorities were used to create the framework for “meaningful use” of an electronic health record. An additional area related to privacy and security has also been included to emphasize the importance of preserving patient protections and ensuring patient trust in the use of electronic health records. The matrix represents a set of objectives and care processes that the workgroup believes should inform the ultimate definition of meaningful use.

PROGRESSION TOWARDS ULTIMATE GOAL

We recommend that the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities. This “north star” must guide our key policy objectives, the advanced care processes needed to achieve them, and lastly, the specific use of information technology that will enable the desired outcomes, and our ability to monitor them. For example, demonstrating improved performance and reduced disparities in blood pressure control among patients with diabetes will require a host of new care processes for many outpatient providers (e.g., monitoring medication adherence, use of evidence-based order sets, clinical decision support tools at the point of care, patient outreach and reminders). In order to

effectively use the tools that undergird these processes, and to monitor progress towards the outcomes of interest, key information generated in the delivery of care (vital signs, problem lists, medications, procedures, lab tests) must be digitized and queryable. We recognize that changing products and changing workflows will be an evolving process, but providing a clear roadmap of the future (as we have attempted to do in this proposed definition of meaningful use) will help give purpose and meaning to these activities. We recommend a progression similar to the Electronic Health Record demonstration initiated by the Centers for Medicare and Medicaid (CMS) in 2008, wherein “meaningful use” is ultimately linked to achieving measurable outcomes in patient engagement, care coordination, and population health.

In developing the recommended criteria and prioritizing the progression towards a fully interoperable health information system, we have found it necessary to balance the competing goals of encouraging provider participation while promoting progress towards reform of our current health care system. We seek specific stakeholder feedback on whether the recommended timeline of requirements is overly aggressive based on the current state of technology and the demands on new provider workflows, or not challenging enough to result in significant transformation, in light of the declining level of Medicare incentives in future years.

TRANSFORMED HEALTHCARE

As a result of increased effective use of health information technology, considerable improvements will be realized in the prevention and management of chronic diseases including diabetes and heart disease, preventing hundreds of thousands of unnecessary amputations and premature deaths. Medication errors will be averted. Patients will be able to promptly access their own health information, and their end of life preferences will be heard. The nation will be better prepared for the next pandemic. Health care disparities will be systematically identified and addressed. This transformed healthcare delivery system will also enable and amplify the effectiveness of a host of new reimbursement models that will reward more organized, more coordinated, and more efficient care.

PROVIDER TYPE

The recommended definition of “meaningful use” will depend on the healthcare setting in which it is employed. Thus, some features and capabilities will be recommended as required in an ambulatory setting before similar functions are expected to be widely used in the hospital. This reflects both the availability of the technology in these different settings as well as the potential impact of these features on the health of the population served. Although some recommended measures used to assess meaningful use in 2011 may apply to specific chronic diseases, the recommended 2011 objectives are meant to establish a foundation for affecting a more comprehensive set of health outcomes in the future. Many of the current proposed EHR-

generated quality measures apply to primary care providers and are derived from NQF-endorsed measures. New measures under development, by NQF, and other recognized organizations will also address the work of specialists. The Workgroup anticipates that future recommended meaningful use objectives and measures will reflect emerging national priorities.

MEASURES

In identifying potential criteria for “meaningful use” of an electronic health record, it became apparent that there are considerable gaps in EHR-generated measures available to monitor key desired policy outcomes, (e.g., efficiency, patient safety, care coordination). While these measures will not be required for Medicare and Medicaid incentive payments until 2013, the Workgroup is seeking feedback on how to best frame these measures including measurement of key public health conditions, measuring health care efficiency, and measuring the avoidance of certain adverse events. These comments will be used to help revise the recommended measurement strategy to include more extensive and refined outcome measures for “meaningful use” in 2013 and beyond.



HIT Policy Committee

Certification/Adoption Workgroup

Paul Eggerman, Co-Chair

Marc Probst, Co-Chair

John Glaser, ONC

June 16, 2009

Workgroup Members

Co-Chairs:

- Paul Eggerman
- Marc Probst, Intermountain Healthcare

Members:

- Rick Chapman, Kindred Healthcare
- Adam Clark, Lance Armstrong Foundation
- Charles Kennedy, Wellpoint, Inc.
- Scott White, SEIU Training & Employment Fund
- Latanya Sweeney, Carnegie Mellon University
- Steve Downs, Robert Wood Johnson Foundation
- Joseph Heyman, American Medical Association
- Teri Takai, State Chief Information Officer, CA

ONC Lead:

- John Glaser

Workgroup Charges

Broad Charge

- Make recommendations to the HIT Policy Committee on issues related to the adoption of certified electronic health records, that support meaningful use, including issues related to certification, health information extension centers and workforce training.

3

Workgroup Charges

Specific Charges

- Review the existing certification and standards setting processes and make recommendations, to the HIT Policy Committee, within four (4) months of the initial meeting of the workgroup, about how these processes should be structured in the future.
- Provide the HIT Policy Committee with an annual assessment of the performance of the revised certification and standards setting processes.

4

Workgroup Charges

Specific Charges (Continued)

- Make recommendations to the HIT Policy Committee every six (6) months regarding steps to improve the performance of health information extension centers.
- Make recommendations to the HIT Policy Committee every six (6) months regarding steps to improve the development of the HIT workforce.
- Make recommendations to the HIT Policy Committee every six (6) months regarding steps to increase the adoption of certified electronic health records that support meaningful use.

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Certification and Adoption



6



HIT Policy Committee

Health Information Exchange Workgroup

Deven McGraw, Center for Democracy & Technology
Micky Tripathi, Massachusetts eHealth Collaborative
Kelly Cronin, Office of the National Coordinator

June 16, 2009



Workgroup Members

Co-Chairs:

- Deven McGraw, Center for Democracy & Technology
- Micky Tripathi, Massachusetts eHealth Collaborative

Members:

- Judith Faulkner, Epic Systems Corp.
- Connie Delaney, University of Minnesota, School of Nursing
- Gayle Harrell, Former Florida State Legislator
- Charles Kennedy, WellPoint, Inc.
- Frank Nemecek, Gastroenterology Associates, Inc.
- Michael Klag, Johns Hopkins University, Bloomberg School of Public Health
- Latanya Sweeney, Carnegie-Mellon University
- Martin Laventure, Minnesota Public Health
- Dave Goetz, Tennessee Department of Finance and Administration
- Jonah Frolich, California Health & Human Services Agency
- Steve Stack, American Medical Association

ONC Lead:

- Kelly Cronin

HIE Workgroup Goals and Objectives

- **Broad Charge for the Information Exchange Workgroup:**
 - Make recommendations to the HIT Policy Committee on policies, guidance governance, sustainability, and architectural, and implementation approaches to enable the exchange of health information and increase capacity for health information exchange over time.
- **Specific Charges for the Information Exchange Workgroup:**
 - Make recommendations to the HIT Policy Committee within six (6) months regarding priority policy areas and other issues that are necessary in the short term to advance the exchange of health information through implementation of HITECH.
 - Make recommendations to the HIT Policy Committee to inform and provide guidance on the implementation of the Nationwide Health Information Network (NHIN).

3

Federal funding can significantly affect data mobilization

- **Enablement Strategies**
 - Capacity Building with a Clear Long-term Goal in Mind
 - State/sub-national levels
 - Leverage existing capacity
 - Support further capacity development
 - Interoperability
 - Scalability
 - Privacy and Security
- **Key Issues to address along the way**
 - Tailoring to regional/state/local needs
 - Governance
 - Accountability
 - Sustainability

4

Ongoing Considerations Identified by Workgroup (I)

- **The Workgroup recognized that HIE and Meaningful Use, while they may not be programmatically connected, are nevertheless connected**
 - Need meaningful use definition to clearly set high-level expectations for HIE over time.
 - Allows states, state designated entities, providers, and vendors to prepare adequately to meet the criteria each year.
 - At the same time, governance, policies and technical approaches need to proceed in parallel with the evolution of the definition of MU and the criteria for HIE.

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Ongoing Considerations Identified by Workgroup (II)

- **The Workgroup also discussed possible HIE enablers that might significantly facilitate achievement of MU**
 - Need to identify ways to share medication and lab data in the short term that does not rely on proprietary interfaces.
 - Statutory requirement for meaningful use to share information for care coordination – this means information exchange across providers (inter-organizational) in a community.
 - Medicaid programs could define meaningful use in a way that requires hospitals and other providers of lab services to adopt nationally recognized standards to send lab data.
 - Business and economic barriers need to be addressed to get access to medication history and to get independent pharmacies connected to enable e-prescribing.

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Next Steps

- Set priority areas
- Identify and align inter-dependencies with other workgroups
- Agreement on timelines, milestones, and deliverables