

HIT Policy Committee
FINAL
Summary of the February 6, 2013 Meeting

ATTENDANCE

The following members were present:

- Christine Bechtel
- Christopher Boone
- Neil Calman
- Terry Cullen for Madhulika Agarwal
- Arthur Davidson
- Connie White Delaney
- Judith Faulkner
- Gayle Harrell
- David Lansky
- Deven McGraw
- Farzad Mostashari
- Marc Probst
- Paul Tang
- Scott White

The following members were absent:

- David Bates
- Richard Chapman
- Patrick Conway
- Paul Egerman
- Thomas Greig
- Charles Kennedy
- Frank Nemec
- Joshua Sharfstein
- Latanya Sweeney
- Robert Tagalicod

KEY TOPICS

Call to Order

MacKenzie Robertson, Office of the National Coordinator (ONC), welcomed participants to the 45th Health Information Technology Policy Committee (HITPC) meeting. She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with two opportunities for public comment, and that a transcript will be posted on the ONC website. She called the roll and reminded members to identify themselves for the transcript before speaking. She turned the meeting over to HITPC Chairperson and National Coordinator Farzad Mostashari.

Remarks

Mostashari stated that he wished to clarify his comments made at the January meeting, which had upset a number of vendors and resulted in calls to him. He recalled that he had talked about the importance of

both government and self-regulation and codes of conduct. He acknowledged that people are trying to do the right thing and meet the needs of customers. Most are professionals with high standards. He said that he did not mean to say vendors as a whole are not doing the right thing. He meant to say that at times competition does not yield the best results for the public. Then, government regulation comes into play. Regulation is not the best way to control behavior, but some vendors are beyond the pale. Some pricing and contracting practices reported by providers may be unfair and unacceptable. He would like to have this controlled via norms of transparency. Patient data lock-in and non-reporting of adverse events are other practices that are unacceptable. The newly released safety plan is built upon expectations for minimum regulation and self-policing. He apologized for his overly broad remarks at the January meeting and concluded by asking vendors and their customers to act as a community.

Review of Agenda

Paul Tang, Vice Chairperson, noted the items on the previously distributed agenda. He asked for approval of the summary of the January meeting. It was moved and seconded to approve the summary and the motion was approved unanimously. Mostashari declared that he would review it in conjunction with his comments above. Tang reminded members of the January HIE hearing, which will be reported on at the March meeting, and the up-coming hearing on clinical documentation.

Action item #1: The summary of the January 2013 HITPC meeting was approved.

Summary of Public Responses to HITPC's Request for Comment

Tang and ONC staff emphasized that the summary was very general. More specific and detailed reports will be used by the workgroups to continue their work on Sstage 3 recommendations, which are scheduled to be presented to the committee in April. Michelle Nelson, ONC, reported that 606 comments were received. Comments indicated preference for a greater focus on clinical outcomes in Stage 3 and for a more limited scope in favor of flexibility to foster innovation. Results from Stage 2 should be reviewed prior to increasing thresholds, accelerating measures, or moving from menu to core. Commenters expressed concerns about the readiness of standards to support Stage 3 goals and wanted to address interoperability limitations. They also emphasized that providers have many other responsibilities in addition to meaningful use. They were in favor of ensuring that patient safety remains a high priority. Nelson observed that the certification items were apparently confusing to responders. She showed slides that summarized comments on specific objectives, first commenting that demographics was the item that received the most comments (337). However, 100 of those comments were essentially the same comment favoring adding occupation and industry codes. The public was apparently confused about measures "topping out," and there was agreement on the benefits of greater specificity regarding standards for sexual orientation and identity as well as race and ethnicity. She read the summaries of the comments on each measure, from SGRP 101 through 408. She noted that for 113, too much had apparently been included in the measure. The CDS interventions were questioned.

Devin McGraw cautioned about evaluating comments solely in terms of numbers received. Consumers' and providers' comments should be broken out. Christine Bechtel reported that she personally knew about comments from consumer organizations that were not shown in the summaries. Nelson responded that her summary was very general. She will provide more specific and detailed summaries for the workgroups. She concluded by summarizing comments on several of the general questions. Next, Kory Mertz reported on Information Exchange Workgroup objectives, beginning with MU05, a general question about innovation. Then he read the summary comments for IEWG 01 (for which both support and confusion were noted) through 03. He also acknowledged the confusion of certification criteria with objectives.

Jesse James reported on the quality measures comments, saying that nearly all of the 56 commenters encouraged the HITPC to seek input from a broad variety of stakeholders. Seventy-seven percent of the

comments were in favor of the use of process-outcome measures suites. Both pediatrics and other specialist expertise should be included in suite development. It was also suggested that quality improvement shift from quality measurement to registry reporting. Commenters mentioned several challenges with eCQM suites. They may require the same denominator for each measure. Complexity can hinder reporting. However, suites offer an opportunity for research. Comments indicated considerably more support for de nova than retooled measures as well as support for innovation and population management platforms, including increased standards and possibly certification for population health platforms or features. James called out the support for increased listening to and engaging with specialty societies and patients. Kathryn Marchesini reported on responses to the privacy and security questions on the re-use of third-party credentials, testing authentication, attestation for security risks, audit logs characteristics and patient consent. A number of comments urged waiting for the final rule on HIPAA components and for stronger coordination with HIPAA.

Discussion

Tang referred to human behavior and accountability. Following up on Mostashari's remarks, he said that self-accountability and individual responsibility should be balanced with regulation to create a level playing field. Both HITECH and ACA support health reform. HITECH provides some of the tools. The HITPC chose to work on exemplary factors. The original intent was to move toward measuring and improving outcomes in Stage 3. Accreditation often focuses on processes but also on outcomes (experience). Applying that concept to meaningful use, experience may be an alternative pathway. The Stage 3 monetary incentives are smaller compared to earlier stages. This is an opportunity to re-access. Although the certification criteria are linked with measures, their timelines do not necessarily coincide. Considerable lead time is required. He declared that the members should think about alternative ways to do meaningful use in conjunction with the delivery of care. They should look at the overall framework, but without any intent to rip and replace.

Gayle Harrell opined that laws are written for outliers. Behavior can better be controlled by individual responsibilities and mores rather than laws. The infrastructure and certification for HIE are in place. Now is the time to go to de nova quality measures.

David Lansky said that he wanted to see investment results in outcomes. Required reports focus on the capability to measure rather than improvements in health. Flexibility could be used to continue business as usual. Providers should be given flexibility but be required to demonstrate improvements in health. He suggested that the members think about introducing outcome measures as a pathway to meaningful use and to allow skipping certification and functionalities.

Marc Probst noted the frequency of comments about needed standards. He wondered what the HITPC can do to facilitate standards development. Sustainability is another theme in the comments. What can be done to sustain the infrastructure?

Bechtel requested that staff pull out any really good ideas as well as the overall comments for the workgroups' consideration. She expressed agreement with Tang. Gaps in functionalities, such as dashboards, should be addressed in Stage 3 as well as improvements in health. She declared that transformational ideas always meet opposition. The HITPC needs time to consider all of the comments and ideas.

Connie Delaney asked that in addition to an emphasis on outcomes they look at the role of the research enterprise and its infrastructure. The research enterprise ties back to standards.

Judy Faulkner talked about population health and the reduction of costs. The delivery of care is moving from acute care facilities to ambulatory services. There is a shortage of primary care doctors and more

weight should be given to them. She expressed concern about reliance on focus groups. Internationally, things are being simplified.

Neil Calman observed that the environment has changed since the formation of the HITPC. Similar to the breeding of sled dogs for global warming, providers are already focused on outcomes. What is the role of the HITPC? Providers' IT staffs are consumed with reporting without the opportunity for follow-up on identified high priorities. Ways to reward innovation must be devised.

Harrell commented again, saying that Stage 4 should link innovation and research with reduction of costs. Providers could be given flexibility to come up with new indicators and to improve outcomes. She called the discussion a productive conversation and declared that she wanted a hearing to bring together researchers and innovators.

Bechtel commented again, reminding the members that from a consumer perspective, fee-for-service is still in effect. Widespread advances in consumer empowerment are not yet observable. In many cases, the medical home is no more than a current term and does not indicate a change in practice.

Another member referred to a huge advance in computer science. She suggested that the path from research to innovation could somehow be embodied in certification. However, she admitted that she had no idea how this might be done.

Faulkner reported on a TED talk about innovation and discovery being killed by rules and incentives. Incentives are often built on a lack of trust.

Mostashari asked Calman for his thoughts on setting a floor to help with innovation without holding back the current innovators. Calman replied that innovation is occurring. The financial incentives to get tools to enable innovation are in place as are the standards to use the tools. Not all innovation can come from the leaders in the industry. And not all of the leaders' innovations apply to everyone.

Bechtel made another comment. Regulatory incentive options, such as partial penalties, can be considered.

Deven McGraw disagreed with members who had expressed excitement about the discussion, saying that they had had the same conversation repeatedly. She pointed out that the RFC comments were specific to the criteria and objectives. Many commented about the burden and few about alternatives. She referred to getting out of this groove, admitting that she did not know how to do it.

Lansky pointed out that payers are creating an environment that may result in drivers. He suggested a gap assessment to determine where technology is not meeting the needs of payers. A closer conversation with CMS and other payers to identify gaps could be useful. Looking at foundational standards is also necessary.

Tang summarized. Stages 1 and 2 established a floor. Now it is time to recognize success and align with other federal initiatives. Standards development must be accelerated. New ways to recognize improvements must be identified so that thresholds can be de-emphasized.

Mostashari declared that incentives may not always be the best way to drive change. Evidence should be examined. Then he spoke of setting a minimum expectation and a star rating system for IT users. Recognition of peers is an important incentive. Currently, only a dichotomy (meaningful user and non-meaningful user) is recognized. One value of the regulatory approach for some measures is the network effect – the assurance that everyone will do something. Individual innovation does not necessarily generate a network effect. Sharing of tools is very important. Patients should have reasonable expectations of certain things regardless of where they go. As the technology advances, requirements can be simplified.

Faulkner asked Mostashari about several special achievement awards as means of recognition. He said that he was referring to a scale that could be applied to all and not to a call out or special recognition for a few.

Someone observed that the less code to write, the better, especially for older systems. It would be a good idea to find certain things that embody interoperability and also affect quality. Simplification is desirable.

Tang talked about floors and network effects and market awards.

Public Comment

Robertson announced a three-minute limit for comments.

Sean Cahill, Fenway Health, repeated his organization's submission to the RFC on behalf of the LGBT community. The capture of information on sexual orientation and sexual identity should be required. These and other demographic data are important in addressing disparities and health equity. He referred to recommendations of IOM and the Joint Commission. He mentioned some disparity questions, such as screenings for breast and cervical cancer for lesbians. He acknowledged that both training of providers and education of consumers will be necessary. But these are not insurmountable barriers. He declared that the LGBT advocacy groups support the proposed requirement. Robertson called three minutes.

Chantal Worzola, American Hospital Association, urged the committee to consider the facts. Two years of meaningful use have passed. Those providers that have not yet attested will not fully benefit. She asked the HITPC to ask HHS to conduct an evaluation of the program and to postpone Stage 3 until the results of an evaluation are available. She delineated several evaluation questions for incorporation into an HHS evaluation. She emphasized the importance of fact-based recommendations. She reported that a member hospital had recently contacted a vendor that requires a 60 percent up-front payment in order to put the hospital in its 12-18-month queue.

Kellan Baker, Center for American Progress, spoke in favor of the collection of data on LGBT patients, emphasizing the importance of recognizing the diversity of the patient population. He went on to say that all of the demographic measures are important. Their capture cannot be taken for granted. They should not be retired for Stage 3. He said that more effort should be exerted on their collection and use by providers.

Referring to being in (or out) of a groove, Mostashari observed that the immediate focus is on the implementation of Stage 2, for which the policies are right. The HITPC's role is to look at Stage 3. He said that the conversation was true to the original purpose of meaningful use.

HITSC Response to HITPC's Request for Comment

Tang asked John Halamka, Vice Chairperson, HITSC, to report on the RFC, including what could be done when the desired standards are not ready. Halamka said that the HITSC's comments focused on the maturity of standards. He referred to a spreadsheet that was included in the meeting materials and explained that comments could be categorized as follows: should be menu, should be certification criteria, several gradations of standards do not exist, and no evidence of electronic workflow. He proceeded through the list, noting in particular those objectives for which standards are lacking.

101 – Drug-drug interaction: There are no standards for representation of knowledge that can be easily incorporated. ONC staff is working on knowledge recognition, but no pilots are underway on the consumption of external rules.

130 – Closing referrals: There is no product currently on the market that provides this function. Tang inquired about the possibility of pilot test results being ready by 2016. Halamka described a project by his

group in Boston. He said that the pace of meaningful use is such that the function cannot be expected to be ready for mandating in Stage 3. He repeatedly noted that the HITSC does not want to be a wet blanket. However, members must be realistic.

103 – Formulary: Although the standards are good enough, the workflow challenges on generic substitutions constitute barriers.

Regarding the retirement of topped-out demographics measures, Halamka reported that the HITSC members believe that these data are essential to the reduction of disparities.

105, 106 and 107 – Problem list: Similar to 101, there is no way to represent rules consumable from an external source. The technology should be developed, but the standards are currently too immature to mandate. 107 is on the HITSC work plan for the next one to two years. Currently, allergies do not have controlled vocabularies.

112 – Advanced directives: Standards could be ready by 2016.

113 – CDS: External repositories do not yet exist.

115 – Dashboards: Halamka pointed out that the measure and questions were not clearly stated. What is real time? What is actionable? Once clearly stated, the HITSC can consider it again.

118 – Images including EKGs: Halamka informed them that EKGs are not images; they are a time series of readings. Otherwise, what would be the workflow? Images are not necessarily contained in EHRs. Mostashari inquired about the intent to share images. What does the HITSC recommend? Halamka acknowledged that image sharing is important. Although the policy intent is right, there are many approaches to sharing images. Innovation should be allowed. EHRs are not the right mechanism for holding DICOM data.

119 – Family history: Standards are evolving so that this can be made a menu item.

121 – Lab results: LOINC should be required.

122 is not clearly stated. For example, how is three days defined?

204 – Patient data access: Technology is evolving and innovation should be allowed. Web content accessibility is mentioned in the report.

204b – Patient generated data: The HITSC members are concerned about data integrity. As yet there are no standards for universal device identifiers. There are no patient-friendly vocabulary standards comparable to provider vocabulary standards.

205 – Summary: It is not clear what would be included in specific to an encounter.

207 – Electronic messaging: New technologies will facilitate communication and allow flexibility.

209 – Clinical trials: Standards are not widely deployed. Linking to clinicaltrials.gov was suggested. Bechtel inquired about skipping the language requirement in 206. Halamka admitted that he had skipped it. He said that only one HITSC member had commented and that he did not understand the comment. He offered to return to the HITSC for additional information. Tang told the members to hold their questions until Halamka had completed his report.

Regarding 302, Halamka declared that the workflow for reconciliation does not yet exist. Med reconciliation in itself is challenging.

303 – Transition of care: Halamka indicated he questioned the increase in the threshold per the state of the market.

304 – Care plan and team: The standards are immature.

305 – Referrals: Workflow and bidirectional communications standards are not ready.

308 – Event notification: Halamka observed that the HITSC needed use cases in order to respond.

309 – Immunization: Although there are no standards for adverse reactions, the HITSC will work on their development.

402 – External rules: There are no standards.

404 and 405 – Mandated registry: What are mandated registries? Specific use cases are required in order to determine the availability of standards.

Standards for 407 are immature. Standards for 408 have not been implemented in EHRs. Furthermore, it is not clear that the EHR is appropriate for adverse event reporting. Mostashari reported that the FDA had asked for the item. He requested that someone explore this and the use of the common format with the FDA. Halamka offered to pursue the item with FDA representatives. Regarding the IE items, Halamka pointed out that 101 is a replication of a paper process and is not representative of how consent is actually handled. In closing, he stated that the HITSC supports the policy manifested in the RFC but recognizes that the policy must be balanced with mature standards. He recommended a focus on a few domains. Staff and the HITSC leaders are developing a workplan to take the need for standards development into account.

Q&A

Lansky inquired about priorities for Stage 3. According to Halamka, Doug Fridsma, ONC, will incorporate priorities into the HITSC's work plan. He said that he intended to vet these priorities with the HITPC.

Bechtel asked what was meant by immature workflow. Halamka responded that it is the clinical workflow, which, he pointed out, is within the purview of the HITSC. The HITSC is charged to consider how products are used and to avoid the introduction of new products without adequate experience. Cross-organizational reconciliation has not been done. Bechtel talked about informational exchange thresholds and changes in the environment and referred to the recent HIE hearing: What will be the environment in Stage 3? Halamka emphasized the lack of clarity as to a transition of care. Does it mean using a different EHR since transition to a different facility within a network may mean that both providers have access to the same EHR? Regarding thresholds, he said that consideration must be given to the infrastructure required to support that threshold. The robust infrastructure across state boundaries to support the threshold may not be available. Bechtel went on to ask about patient-generated data and the use of semi-structured survey data. She stated that the comments indicated skepticism about patient-generated data. Data are collected from patients via paper without evidence of their usefulness. She wondered about examples. Halamka assured her that the HITSC likes patient-generated data. Nevertheless, members were concerned about the incorporation of patient and provider data in the same fields of EHRs without a detailed clinical model. Inside and outside data should have the same integrity. One solution is to enable the viewing of patient-generated data without their incorporation into the record. Halamka indicated approval of the semi-structured questionnaire concept, saying that the incorporation of these data may be acceptable.

Mostashari asked Halamka to prioritize which standards could be ready from the S&I framework's projects. Halamka responded that lab ordering and the transfer of care content are good and elements of query health may be good enough. He promised that he will see that the S&I projects are mapped to the priorities delineated in the workplan. He indicated that he was optimistic about standards for a questionnaire but was not certain of their implementation.

Tang asked about reconciliation of the problems and med lists, using hypertension as the use case. Halamka declared that there is not a universal format for representation of a rule, but advice may be reasonable.

Update from CMS

Robert Anthony presented slides showing the most recent numbers on registrations and payments for the EHR incentive program. The slides and report formats have not changed. More than 100,000 Medicare providers have registered among the 355,000 total providers registered. The Medicaid migration is becoming observable. 190,000 unique providers were paid. 84 percent of all eligible hospitals have registered and 70 percent have been paid. Approximately 28 percent of Medicare EPs are meaningful users of EHRs. Approximately 35 percent of Medicare and Medicaid EPs have made a financial commitment to an EHR. Fifty-eight percent of Medicare EPs receiving incentives are specialists.

Q&A

Referring to the public comments from an AHA representative, a member asked about the characteristics of non-engagers. Anthony replied that anecdotal information from the RECs indicates that small, rural hospitals and other hospitals involved in upgrading their systems and those working with legacy systems are in that category. Non-engaged EPs are typically providers that lack the resources for initial investment, have ROI concerns, lack dedicated IT staff, or are experiencing workflow problems in multispecialty practices. In response to a question about the higher participation of Medicare specialists compared to primary care providers, Anthony suggested that financial and workflow challenges may be the cause. He referred to a previous report on RECs, which he indicated he can revisit at a later meeting. Mostashari interjected that the report is only a snapshot. Registration numbers are strong. Compared to other initiatives, the progress is good. A member expressed concern about increasing provider disparities.

Certification and Adoption Workgroup Comments on the Health IT Safety Plan

Marc Probst, Co-Chair, reported that the workgroup was assigned by staff-specific questions on which to respond. He reminded them that staff had presented the Safety Plan at the January meeting. Larry Wolf, Co-Chair, gave the back story. The goal is a learning health system and a culture of safety. Health IT is part of safety and quality. It is both a means and a risk. Although considerable work has been done on quality and safety, the hard data on HIT are limited. He reported that the workgroup attempted to build on efforts related to AHRQ, PSOs, Common Format, and HIPAA risk-assessment requirement. In announcing the plan, ONC officials indicated that they wish to encourage partnerships with providers and vendors without adding to the burden of EHRs users. The co-chairs summarized the RFC comments to the IT safety items. The comments opposed making a safety assessment a meaningful use requirement, many pointing out the prematurity of such a requirement. However, there was some agreement of the need for EHR users to complete a safety assessment. Probst and Wolf presented and explained the workgroup's recommendations:

As a menu option, providers should attest to performing a safety risk assessment and formulate a plan to address key risks. The assessment and plan should address at least one of the high risk areas identified in the SAFER Guides. The guides, scheduled for release in October 2013, will cover these topics: ordering process, including CPOE and e-prescribing; system customization, configuration and upgrades; system to system interfaces (for example: CPOE and pharmacy); patient identification processes; CDS; provider communication during transitions of care; laboratory results review processes; downtime events; and HIT safety-related human skills.

Voluntary reporting of health IT-related patient safety events to Patient Safety Organization (PSO), similar to other event reporting (sic)

Reporting should include additional information, not just that captured by the EHR, typically handed by a performance improvement process inside the provider organization.

Certification should: be based on a convenient mechanism for users to capture safety risks and incidents; automatically capture the EHR context (screen shot, user and patient context); allow for user text; and must be low-overhead to EHR users.

EHR vendor reporting to PSOs should be in partnership with provider customers. The workgroup also recommended the use of the Surveillance Subset of Common Format (expected Q32013) for EHR capture of events/unsafe conditions.

Discussion

Mostashari asked about post-market surveillance. A co-chair indicated that that process was not discussed.

Faulkner brought up the potential conflict of requiring self-reports that may result in penalties. The co-chairs acknowledged the conflict. The requirement to report is established by law. The PSO process provides some protection. Faulkner pointed out that there is no protection from civil suits, media, employees, and federal and state governments. Tang observed that the number of events is greater than the number of reports on the events. These recommendations would provide a way to quantify the risk and then to address it. He asked Robertson what action was required. She instructed him to obtain a motion on the recommendations. Tang asked for a motion to approve the recommendations.

Action item #2: A motion to accept the recommendations on the Health IT Safety Plan and to transmit them to the ONC was made. The motion was seconded and passed unanimously.

ONC Update

Jodi Daniel reminded the members of the June call for nominations for vacancies in the FACAs. More than 100 nominations were received. The appointments (one for the HITPC) will be announced in March. Applications for the consumer empowerment workgroups are being reviewed with Bechtel and Leslie Kelly Hall, consumer representatives on the HITPC and HITSC, respectively. Applications for the new ACO Workgroup are due February 15. A revised HITPC workplan was included in the meeting materials. The e-health equity summit will convene February 21 with a multitude of co-sponsors.

Kevin Larsen and Kate Goodrich reported on the quality measures work with CMS. Mindy Hangsleben reported on her innovation fellowship with ONC. A project to remove waste from processes is underway. Goodrich reported on a five-day event with stakeholders to work on putting the e-measure life cycle from contracts to measure implementation into a rule. National Quality Forum endorsement was not included in the life cycle. The cycle was divided into smaller scopes and processes were mapped. A typical e-measure may require a development period of from four-to-five years, a process that has now been reduced to one year in a plan. Staff described their excitement with the new relationships formed. Larsen declared that now measures that matter can be developed in reasonable time due to this new agile development framework, which builds on early testing, testing in clinical sites and incorporates a consumer perspective. Members were invited to check out Mindy's blog, HHS Innovates.

Larsen confirmed that NQF endorsement would add approximately one year to the development process. Tang asked about combining testing and endorsement. Someone reported that VAH has formed a LEAN team and is interested in collaboration.

Bechtel inquired about the results of the agile development. Larsen indicated that results are expected this year in time for Stage 3. As standards mature, more useful measure development tools are possible. Measures for value-based purchasing may require different approaches.

Lauren Thompson reported on the Federal Health Architecture (FHA). A new project on structured data capture features the development of four new standards that will enable EHRs to capture and store structured data. Standards for the CDEs will be used to fill the specified forms or templates. The new standards will also include standards for the structure or design of the form or template (container) standards for how EHRs interact with the form or template and standards to auto-populate a form or template. These standards will support structured data requirements needed in patient safety event reporting. She reviewed the FHA story since its establishment in 2003. In 2012 a new governance structure was put in place to encourage: more strategic alignment within and across federal partner agencies; greater transparency and enhanced communications; and commitment to fulfilling the original intent of FHA as E-Gov Line of Business (LoB). The FHA Strategic Plan is nearing completion and the LoB Service Plan was delivered to OMB. In terms of interoperability architecture, staff identified current and planned data exchanges among federal agencies and partners, developed a FHA public-facing portal, aligned with standards harmonization efforts, and demonstrated exchange methods beyond Direct and SOA. She went on to describe RESTful Health Exchange (RHEX) and CONNECT, both open source projects sponsored by FHA.

Q&A

A VA representative noted a struggle with acceleration. Thompson agreed on the struggle and said that she would discuss it with colleagues. Mary Jo Deering, ONC, asked about mapping patient questionnaires into structured data. Thompson said that she would consult with Fridsma.

Faulkner asked who would tackle standards for allergies. Thompson responded that she is working with Fridsma on the HITSC workplan and workgroup assignments. Faulkner asked that she coordinate with vendors in addition to federal agencies.

Robertson asked that the record show that Christopher Boone and Madhulika Agarwal's alternate had joined the meeting after the roll call.

Public Comment

Robin Raiford reported on the progress of her illness since December 12 and the many medical errors that contributed to it. She said that she had experienced even more problems since her report at the last meeting. She had three hospital admissions and multiple rescue events. Pertaining to innovation, she wants to include something on patient satisfaction. Robertson called the three-minute time limit.

Susan Wentz, a physician from an academic medical center, talked about her mother, a sole practitioner in Virginia, who attested successfully in 2011. In 2012, she switched to another, cloud based system. Her broadband was not fast enough for data entry. Her practice consists of an underserved population. She is the IT staff. She is 84 years old and in August she was diagnosed with cancer. Her attestation was rejected because of the timing of two measures although her remaining measures were very good. There should be an appeals process for remedy. Robertson called time and announced that any additional information can be e-mailed to ONC.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the January 2013 HITPC meeting was approved.

Action item #2: A motion to accept the recommendations on the Health IT Safety Plan and to transmit them to the ONC was made. The motion was seconded and passed unanimously.

Meeting Materials

- Agenda
- Summary of January 2013 meeting
- Presentations slides
- January 28, 2013 workplan
- HITSC workplan
- Stage 3 comments summaries