HIT Policy Committee
FINAL
Summary of the May 7, 2013 Meeting

ATTENDANCE

The following members were in attendance:

- Madhulika Agarwal
- David Bates
- Christine Bechtel
- Christopher Boone
- Neil Calman
- Arthur Davidson
- Connie White Delaney
- Judith Faulkner
- Gayle Harrell
- David Lansky
- Deven McGraw
- Farzad Mostashari
- Robert Tagalicod
- Paul Tang

The following members were absent:

- Richard Chapman
- Patrick Conway
- Paul Egerman
- Thomas Greig
- Charles Kennedy
- Frank Nemec
- Marc Probst
- Joshua Sharfstein
- Latanya Sweeney

KEY TOPICS

Call to Order

MacKenzie Robertson, Office of the National Coordinator (ONC), welcomed participants to the 48th meeting of the 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 instructed members to identify themselves for the transcript before speaking.

Remarks

Farzad Mostashari, Chairperson and National Coordinator, remarked that he was reported to have said that digitalization by health care providers is approximately 50 percent complete but only about 5 percent of the redesign of workflow to take advantage of incentives and tools has been accomplished. He referred to a recent Institute of Medicine (IOM) meeting. He participates in weekly conference calls with six Beacon and other clinics to discuss their diabetes control measures. In the United States, only about 40

percent of patients diagnosed with diabetes have their risk factors under control. Representatives of the six clinics talk about the application of outcomes data and focus on improvements of processes. The first gate is to identify the system processes that are failing. He related an example of a clinic that sent letters to patients due for an LDL test. The letter yielded a 5 percent response. Mostashari talked about the need to test and measure the effectiveness of interventions to increase patient engagement. Sometimes patients leave their appointments without their lab orders, which should be automated and incorporated into the workflow. Not every decision must be individualized. Process redesign is needed, and though the tools and, increasingly, payment are there, improvements will not be made without knowhow. The challenge is scaling changes practice by practice. Paul Tang, Vice Chairperson, asked what else can be done to change these systems. Answering his own question, he said that by bringing the patient onto the care team, significant change is possible.

Review of Agenda

Tang asked for approval of the summary of the April meeting, which had been distributed with the meeting materials. He noted that he had submitted a few edits. It was moved and seconded to accept the summary with no amendments. The motion was approved unanimously.

> **Action item #1: The summary of the April 2013 HITPC meeting was approved as distributed.**

Tang noted each of the items on the previously distributed agenda.

Data Update

Robert Anthony, CMS, moved through his updated slides, describing registration and payment through March 2013. There were 390,000 active registrations. Eighty-six percent of EHs have registered and 77 percent have been paid. Approximately 42 percent of Medicare EPs are meaningful users. Approximately 46 percent of Medicare and Medicaid EPs have made a financial commitment to an EHR. More than 245,000 Medicare and Medicaid EPs have received an EHR incentive payment. There have been 192,339 EPs attest, 192,126 successfully. There have been 2,874 hospitals attest, all successfully. As in previous months, on average, all thresholds were greatly exceeded, but every threshold had some providers on the borderline. Drug formulary, immunization registries, and patient list are the frequently selected menu objectives for EPs. Advance directives, clinical lab test results, and drug formulary are the most frequently selected by EHs. Little difference among specialties in performance is seen, but they vary in exclusions and deferrals. High performance on both menu and core objectives continues. Among returning providers, there was a slight upward trend among EPs and a slight dip among EHs.

Q&A

David Bates asked about the profile of nonparticipating EHs. Anthony responded that, as reported at previous meetings, rural hospitals and CAHs continue to face hurdles. The Centers for Medicare and Medicaid Services (CMS) staff is examining the types of objectives that are difficult for these EHs.

Gayle Harrell reported that some Florida hospitals do not have the resources to participate. She asked about plans to help them with purchases. Anthony replied that CAHs are reimbursed on cost. CMS staff recently met with AHA representatives from rural hospitals and CAHs. Funding is an issue. CMS and ONC are attempting to educate officials of these hospitals on available resources, including grants.

Certification & Adoption Workgroup Recommendations on Health IT Workforce

Larry Wolf, Co-Chairperson, reported that the Health IT Workforce Development Subgroup identified three sets of workers: health workers at the point of care, and those that support them; IT and informatics

professionals; and information systems technologists, including developers, operators, and implementers. He said that the subgroup focused on the first group of workers. He referred to the competency model depicted in the slides. Finally, the following recommendations, along with rationales, were presented:

ONC has funded several workforce development programs. Recommend that these programs be summarized and the results of those programs should be publicized.
The above programs identified core competencies. Recommend that these competencies are summarized and widely disseminated.
There are many resources available. Recommend publicizing the resources and best practices.
Healthcare of the Future - emerging need for soft and hard skills related to team-based care, population health and patient engagement. Recommend new program development to address these emerging needs. Recommend additional funding for new workforce programs.
Learn from what is happening with the current workforce. Recommend funding studies of the impact of HIT on the workforce – traditional measures – like turnover, enrollment in healthcare vocations (schools), plus new jobs, like nurse informaticist.
The current Standard Occupational Classification does not address HIT. Recommend ONC hosting SOC input process from the HIT community.

Discussion

Tang asked about coverage across professions and disciplines. Wolf said that the subgroup did not specifically address disciplines or professions. Tang wondered about sufficient emphasis on the incorporation of IT into workflow. Wolf responded that micro training may be required to change behavior and systems. Tang referred to the IOM study on the workforce needs of an aging population. He mentioned that one of the recommendations of that committee was to include patients as part of the workforce and to train and educate them as well. Wolf said that the subgroup had no recommendations on that topic.

Harrell talked about the hands-on workers receiving the least attention. Physicians and nurses, especially the older ones, are resistant and need help. It is not enough to put something on a website. CMEs should be offered. Wolf agreed that the issue was a difficult one. He opined that some kind of peer-to-peer, shadowing approach may be an answer.

Madhulika Agarwal reported that in the VA a number of educational and informational efforts continue. e-Health University pairs workers, and a team approach is used to change workflow. It is important to have patients as equal partners.

Judy Murphy, ONC, asked whether the subgroup had considered the ONC-funded projects. One project developed a curriculum but its funding was not continued. Wolf replied that the subgroup did not explore curricula. But according to the community college representatives, the best result is obtained from training technical people on health. Wolf acknowledged that his personal experience was in the opposite direction: it is better to train health workers in IT. Harrell interjected that the ONC-funded programs gave technical knowledge but no on-the-job training. Murphy noted that several organizations have certification programs and competency exams. New specialties are developing along with several certifications. What about harmonization of certification? Wolf opined that although certification may be necessary to get a job, it is not sufficient to do a job. He declined to make a recommendation.

Bates asked for the relative gaps in skills among the three categories of workers. Wolf opined that integration into the workflow may be the major issue. The need may be greatest among existing workers. Also, managers could benefit from training in use of information.

Judith Faulkner voiced her agreement with the need to train existing workers. Someone should ensure that the formal training programs are realistic. Regarding the competency model and the bottom criteria, someone should validate that the people are the right people and have the competencies on which to build higher level competencies. Wolf responded that Faulkner's comments went beyond the efforts of the subgroup.

Art Davidson asked about the VA program: What has the VA done regarding the veterans' use of technology? Has ONC identified what is necessary to engage consumers? Agarwal talked about the use of the portal and conducting many assessments and soliciting feedback from users. A new initiative directed toward care givers of seriously injured victims will give them iPads. Other mobile applications are being introduced. Murphy talked about the ONC 3As – access, attitudes, and action. However, she acknowledged that it was not designed around competencies.

Tang emphasized that training the people who have the tools is essential. He said that boldness is essential as well. He suggested that more specific proposals could be made by the subgroup and asked whether the members agreed. Mostashari declared that competencies in addition to those that are IT-related are required. Modeling games can be used to teach population health management. RECs have a role. He hopes to see a business cases for these services. A challenge is that any training not offered by vendors may not be too helpful. Product-specific training is needed. What are creative ways to do this training? Faulkner said that specialist-to-specialist training works best. Training must be role specific. Tang talked about the specialist's knowledge of the workflow and changing behavior.

Neil Calman observed that discussion continues to focus on "putting things in the system" rather than on what are the specialists actually training. They are probably teaching shortcuts to the old work and not on how to use IT to change processes. He requested that the CMS data report show break outs by vendor. Then one can begin to identify best practices and workflow changes. Agarwal agreed with doing more to improve workflow. She pointed out that to change workflow management must get buy-in from all workers.

Bates referred to market forces and ACOs, saying that ONC can help with information sharing across these entities. Support for the training of specific groups, such as in informatics, is needed. The need for training for managers was repeated. Bates told the members that he agreed with the recommendation on occupational classification.

Harrell observed that training and education is still at Stage 1. She talked again about resistance.

Tang acknowledged that the same lessons about implementation and training are being learned by each new adopting organization repeatedly and painfully. Information on best practices should be readily accessible. Mostashari wondered about videos and vendors' intellectual properties. Calman replied that one is not allowed to use video screens and put the video online. Faulkner emphasized that although vendor screens are intellectual property, a video could be used with users of the same vendors. Calman compared the vendors and videos with requirements that pilots must be certified for each plane they pilot. Mostashari proposed that the EHR associations might work with vendors around Faulkner's idea. Faulkner pointed out that it is very difficult to get users to stop and view something, let alone video it. Vendors have user webs but they are typically used only by high performers. Calman suggested starting with reporting outcomes and looking at best practices to get to the outcomes.

Office of the Chief Privacy Officer Update

Joy Pritts, ONC, reported on the HITECH modifications to HIPAA. The Office for Civil Rights (OCR) published the Final Rule on January 25, 2013. The compliance date is September 23, 2013. The Final Rule: finalizes the breach notification rule; extends the use and disclosure provisions of the HIPAA

Privacy Rule and most requirements of HIPAA Security Rule to business associates; and clarifies the patient right to access electronic health information and the patient right to restrict providers disclosing health information to plans when paying out of pocket. Pritts described Executive Order 13636 – Improving Critical Infrastructure Cybersecurity, which was published February 19, 2013. Health and public health care is considered to be a critical infrastructure sector (since 2003). The order increases government sharing cybersecurity information with private sector critical infrastructure and state and local governments. The National Institute of Standards and Technology (NIST) was designated to lead development of a framework to reduce cyber risks. She emphasized that the Final Rule sets a very high bar in identifying infrastructure at very high risk. She reported on a NIST project. Resilient Network Systems, in partnership with the American College of Cardiology, American Medical Association, LexisNexis, NaviNet, ActiveHealth Management, the San Diego Beacon eHealth Community, Gorge Health Connect, the Kantara Initiative, and the National eHealth Collaborative is implementing a Trust Network infrastructure to enable convenient multi-factor, on-demand identity proofing and authentication of patients, physicians, and staff on a national scale. The pilot's use cases will facilitate patient-centered coordination of care among a group of primary care physicians and cardiologists by enhancing existing automated systems for secure, HIPAA-compliant access to electronic referral (eReferral) and transfer of care messaging and an advanced clinical decision support service.

She went on to describe ONC projects. The Public Health Service Act Sec. 3002 (2) states that the HIT Policy Committee shall make recommendations for at least the following areas: ''(i) Technologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law." Pritts reminded the members that the Privacy and Security Tiger Team held a hearing on technology in summer 2010, which resulted in recommendations in September 2010. Recommendations were: technology is promising but is in early stages; need to further experience and stimulate innovation for granular consent; ONC should make it a priority to further explore; and find evidence (such as through pilots) for models that have been implemented successfully. She noted that ONC staff had reported to the HITPC in the fall of 2012.

Pritts continued, describing several accomplishments. A Data Segmentation for Privacy Use Case document was designed. It includes electronically implementing existing laws including: 42 CFR Part 2: Federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations that protect specific health information from exchange without patient consent and specify that the recipient may not re-disclose without patient consent; and Title 38, Section 7332, USC: Laws protecting certain types of health data coming from covered Department of Veterans Affairs facilities and programs. Staff developed an implementation guide on recommended standards for privacy metadata, organized by transport mechanism (SOAP, SMTP, and REST). A DS4P Implementation Guide Test Procedures was produced. Staff worked with OCR and plain language specialists to develop materials and tools for the security of mobile apps. A security video game was produced and is on the website. Pritts noted that the meaningful use requirement for a security risk analysis had increased providers' awareness of the need for an analysis. Staff is updating the Guide to Privacy and Security of Health Information and making it more interactive as requested by users.

Q&A

The website has a mobile tab. This is the link to the video game: http://www.healthit.gov/providers-professionals/privacy-security-training-games

Privacy and Security Tiger Team Recommendations

Deven McGraw, Chairperson, reminded the members that the team's recommendations on scenarios 1 and 2 had been accepted at a previous meeting. Since then, the team has continued to deliberate on scenario 3 – non-targeted query for direct treatment. Scenario 3 assumes a patient's previous providers are not specifically known, so this is an initial query to find the locations of a patient's record(s). It may require the use of an aggregator service (such as a record locator, data element access service, master patient or health information exchange) to find possible sources of a record. With regard to the question on whether or not they are included in an aggregator service that permits queries from external providers, the Tiger Team said yes.

Regarding whether querying entities should be required to limit queries (e.g. by geography, list of providers, etc.), the team gave this answer:

> The Policy Committee has already approved recommendations from the Tiger Team on queries that include providing individuals with meaningful choice re: listing with an aggregator service; requiring the use of audit logs for queries which must be provided to patients upon request; and creating an environment where providers can have reasonable assurance for responding to external queries, consistent with their professional ethical and legal obligations. Assuming these recommendations are adopted, the Tiger Team sees no need at this time to establish additional policy to place limits on queries. We may decide to revisit this issue if other recommendations are not adopted and/or nationwide query models increase. (Today, many non-targeted query models are naturally limited by geography.)

Discussion

Mostashari wondered what circumstances would trigger a re-examination of the recommendation. McGraw said that the committee had approved recommendations on false positives and matching rates. She was worried about creating an unnecessary limitation on exchange without a clear policy objective. Tang asked about the most common privacy violations – accessing VIP records and records of staff. McGraw told him that organizations are already required to have procedures for policing users. They are sufficient, and the Tiger Team did not see a need for additional policy. Tang referred to speed limits as guard rails that back up to laws that specify driving at a "safe speed." He expressed concern that the lack of a recommendation on scenario 3 may undermine the thoughtfulness of scenarios 1 and 2, since it would provide a loophole in the protection of privacy during HIE. McGraw pointed out that nowhere is it said that anyone is ever required to release data.

Calman attempted to work with McGraw on how this would be explained to a patient. She said that a patient would give consent to be listed by the aggregation host, which could be a HIE or a provider. The service is expected to give meaningful choice. All of this is within a treatment context. Calman wondered about a way to segment provider types, such as mental health providers: Can anything be excluded by provider type? McGraw responded that the team did not go to that depth of granular limits. Calman explained that if patients had ways to segment, they may be more likely to participate.

Pritts interjected that she recognizes that issue and she is looking at ways to mark data by its source, which could offer granular choices. She emphasized that she is just starting to look at the topic.

Faulkner asked whether aggregator services are required. McGraw assured her that nothing was said about such a requirement.

Harrell said that patients require education about locator services. They cannot make choices without more information. There is a possibility for misuse. McGraw referred her to the language of the proposed recommendation. Tang opined that the lack of restrictions for scenario 3 will undermine the recommendations for scenarios 1 and 2. McGraw explained that the recommendation maintains the status quo. The Tiger Team does not have an additional recommendation for scenario 3 at this time. One option

may be not to recommend anything and to say something about monitoring over time. The record holder decides what to disclose. Mostashari attributed the somewhat disjointed discussion to not having at hand the totality of the recommendations on which scenario 3 is layered.

Calman continued his efforts to understand how the policy would be implemented with a patient. McGraw said that one would tell the patient that the service enables his/her basic information to be listed so that in an emergency, someone can determine where to go to ask for her records. The consent is to look for records. Then it is up to those providers who have the records to determine what steps to take to release the records. She said that two decisions, or two steps, are required. Locator services have different scopes. There is no national service. She acknowledged that disclosing location is disclosing limited PHI. Mostashari advised that they defer the discussion until everyone has the referenced recommendations in hand. Tang indicated that the approved recommendations for scenarios 1 and 2 would not be sent forward without something on scenario 3.

Davidson used the example of a comatose patient at the emergency department (ED) to argue that policy is needed for scenario 3. A query at the geographical level should be allowed. Snowbirds are another example. This query is similar to a phone directory. McGraw stated that she was amenable to a more robust recommendation at some later time. The Tiger Team perceived pressure to deal with scenarios 1 and 2 immediately. Mostashari said that the recommendations provide guard rails. To be silent will not prevent anything. He cautioned about dragging scenario 3 on too long. Faulkner declared that guard rails should not be restrictive. McGraw proposed that she locate examples of where scenario 3 is happening in order to better inform a recommendation.

Harrell admitted that although she is a member of the Privacy and Security Team, she did not participate in the meetings on query. She advised getting more information about what is going on. People with information should be invited to team meetings. More information on record locator services is needed.

Tang summarized. One action is to accept the recommendation on scenario 3 and to put it in the package with scenarios 1 and 2. The alternative is to send it back to the team for additional work and then act on and submit the package. Members indicated consensus on the latter.

> **Action item #2: The Privacy and Security Tiger Team's recommendation on query scenario 3 was not approved and was returned to the team for additional work.**

Public Comment

Robertson announced the three-minute limit and that the committee is not expected to respond to comments.

Maureen Boyle, Substance Abuse and Mental Health Services Administration (SAMHSA) IT team lead, commented that resolution of privacy concerns is critical to the integration of behavioral health into primary care. She asked the HITPC to take steps to raise awareness of the regulations on privacy, particularly on the re-disclosure of information. Standards for communication of privacy policy are needed.

Deborah Peel, Patient Privacy Rights, asked about the data segmentation pilots. She expressed concerns about data exchange and funding. Funding for data segmentation is critical. She said that she wanted an answer about the funding. Robertson informed her that according to the FACA procedures, the committee is not required to answer questions posed in public comments. Robertson offered to respond to an e-mail question. Peel continued. She observed that data segmentation technology has been in use for more than 10 years. Most EHRs are capable of segmenting out erroneous information; the same technology could be used in concert with patient wishes. She highlighted that Faulkner is incorrect when she talks about the

difficulty of segmentation. The law gives individuals the right to segment. Therefore, the industry should build systems to do it. Robertson called the three-minute limit.

HITSC Workplan Points for Clarification

John Halamka, Vice Chairperson, HITSC, reported that the HITSC workplan attempts to mirror the work of the HITPC. He said that Doug Fridsma recommended that the HITSC seek clarification on several of the items being proposed for Stage 3. Clarification on the use cases is required before work on standards can commence. Halamka moved through the items listed on the workplan and asked questions. Regarding the transport of data to and from patients, Halamka delineated several possibilities and Tang indicated which he had in mind. Next, they discussed standards to support image exchange. Halamka said that he needed use cases; there are many types of images and many solutions. Tang referred to the exchange from one system to another. Christine Bechtel reported that direct access to another PAC system is not acceptable. Resolution is another issue. Patients want access to their images. Halamka explained the different between diagnostic quality, images for review, and images for patient show and tell. DICOM is of high quality. Bechtel said that one purpose of image exchange it to avoid repeat tests. Tang said that images can be exported in various resolutions. Calman said that images transported in high resolution can be used by other providers to reduce duplicate tests and costs. Faulkner suggested linking to the Internet instead of transmitting a copy. She referred to a process being used in Sweden. Mostashari asked about challenges around query, saying that it is desirable for the patient to be the medium for exchange without the need for provider agreements. Halamka agreed that the patient could be given an URL that can then be given to others.

Regarding genomic data, Halamka asked about the clinical subset for storage. Bechtel talked about linking genomic data to CDS. Mostashari talked about genotype and phenotype coming together. Part of the question is standardization. One alternative is to focus on phenotype. McGraw confirmed that once data are handed off to the patient, HIPAA no longer applies.

Moving to advance directive, Halamka gave several alternatives – an indicator that a directive exists, a pointer to a directive, or invent standard for recording directives within EHRs. Tang said the group was interested in exploring all the options. Harrell said DNRs are state specific. Therefore, standards cannot be too specific. Tang talked about needing relevant information at the right time. Someone asked whether state variations have implications for not having the indication itself in the record. Are the state variations such that data elements cannot be standardized? According to Harrell, the required elements vary across states.

With regard to care plans and teams, members attempted to recall the requirement for Stage 2. Someone recalled that Stage 2 allowed free text. Tang and Mostashari said that they want to advance from Stage 2. Bechtel reported that the HITSC Consumer Technology Workgroup is looking at standards for care plan. In making recommendations for Stage 2, members could not identify a template. She recommended looking at www.careplans.com. Representatives of some 20 consumer organizations convened to talk about care plans. They want something like a collaborative whiteboard. The template is not static although it contains some required elements. Returning to the topic of advance directive, Bechtel reported that ONC staff was expected to convene a listening session on the topic. The listening session has yet to be planned. One is needed to identify common elements of advance directives.

Halamka asked about the intent of PSO defect reporting. Mostashari responded that the reports may require the secondary use of some information beyond that captured in EHRs. Halamka explained that incident reporting requires different kinds of information than are captured in EHRs. Mostashari asked about differences in EP and EH reporting. Halamka replied that EPs would typically not have the incident report systems used in hospitals. Davidson reported that in his environment both EPs and EHs report using the same systems. EHRs could feed into another reporting system.

Halamka clearly declared that his questions and requests for clarification had been sufficiently answered to proceed with work on standards.

Mostashari asked Halamka about an API Spigot and innovation arguments. Halamka talked about the use of these transactional standards not being practical in a tightly controlled environment. API may be necessary. Although being done at several places, the concept is very novel. Perhaps something could be designed so that an external system presents choices to a provider at the EHR in such a way that the provider is not aware that the choices were generated by the external system.

Bechtel asked about radiation dosing. Halamka confirmed that it is possible to have the dose shown in conjunction with making an order. Accumulated dosage over time can also be shown without manual entry. He acknowledged that, although there are standards, he did not know their source. He promised to find out and to report back. Recording of the UDI is a factor, which would be foundational for this use case. Tang asked who regulates the recording of UDIs by providers.

ONC Updates

Doug Fridsma, ONC, showed slides with quantified data on participation in the numerous S&I Framework efforts and referred to the status of the numerous initiatives as depicted in his portfolio slide. He noted that one of the initiatives can help with the standards for care plan issue. He reported that the structured data capture (SDC) initiative staff will develop and validate standards-based data architecture so that a structured set of data can be accessed from EHRs and be stored for merger with comparable data obtained for related purposes. These include: electronic case report form used for clinical research including patient centered outcomes research; incident report used for patient safety reporting leveraging AHRQ 'Common Formats'; surveillance case report form used for public health reporting of infectious diseases; and collection of patient information used for determination of coverage, as resources permit. Staff will present a series of concerts to solicit input from industry on current practices and trends. The schedule consists of: PROMIS (April 25); PCORI (May 2); USHIK (May 9); Duke (May 16); CAP (May 23); CDISC/IHE (May 30); and CIMI (June 6).

The final consensus-based documents for the public health reporting initiative have been published on the PHRI website – the Public Health Reporting RI Framework and the PHRI Clinical Document Architecture (CDA) Guide. Staff is collaborating with staffs of other ONC initiatives to share with the SDC the experiences and lessons learned from the CDA for the public health pilot projects that used Retrieve Form for Data Capture as a transport for public health reporting.

For Direct, the development of trust bundle publishing tools is proceeding rapidly. Three pilot communities have signed up to pilot publishing and consumption of trust bundles: Western States Consortium, ABBI, and DirectTrust. 371 of 400 comments received on the laboratory orders initiative (LOI) have been resolved. The implementation guide is scheduled for publication by June 15. ONC and NIST are working closely together and plan to release the balloted implementation guide and test framework in tandem.

Q&A

Davidson asked about the application of Query Health to Stage 2 specialized registries. Fridsma responded by talking about the building blocks for big and small data analytics. The first need is for a way to ask questions of EHRs and to get answers in standardized form. If layered on top of authentication and authorization, Query Health could ask question of registries, or ask questions remotely of several registries or records. Organizations would need an information model that can be queried regardless of how the information is stored. Jacob Rider and Melissa Morton are heading work on Health eDecisions to exchange information around CDS and to make CDS a service. Various standards are used for reusable

pieces to support CDS. This effort brings the quality measurement and the quality improvement communities together.

Jodi Daniel, ONC, reported that eight appointments to the HITPC have expired. Staff is working with Congress and GAO to fill the slots. The members whose terms have expired will serve until new appointments are made. The term of Scott White, the labor representative, expired and he retired from the HITPC. Daniel thanked him for his work. She repeated her report from the previous meeting on the formation of the FDASIA Workgroup, which is mandated in the FDA Safety and Innovation Act. The 30-member workgroup has met twice and is chaired by David Bates. Tang will co-chair one of the three subgroups. The workgroup will meet in person May 30-31 to begin formulating recommendations to direct ONC, FDA, and FCC on producing a report. The report will eventually be available for comments.

Daniel continued her report. The health IT dashboard was updated with quick stats. The governance framework for trusted electronic HIE consists of trust principles, business principles, technical principles, and organizational principles and can be found on the website. The results of the National Survey on Health Information Exchange in Clinical Labs will be made available to the public this summer. NORC was contracted to select a random sample of 12,000 commercial and community labs for the survey, which focused on volume, adoption of standards, and barriers and facilitators for exchange. The Achieving eHealth Equity Report, mentioned at previous meetings, has been posted. The Beacon Snapshots report was released in April. The evaluation report was done by NORC.

Future Agenda Items

Tang asked for suggestions for topics. Faulkner talked about data segmentation. Regarding a hospital service area, she wondered what should or should not be shared in an integrated system. The best way would be to have mental health, behavioral health, and reproductive health on separate systems. Then a patient could compile her own CDA by adding and subtracting data. This approach would put the patient in total control. Tang inquired how to label her topic, and stated that she was asking for more on privacy and security.

Christopher Boone suggested quality, workflow, secondary use of data, and third-party registries. He observed that HHS seems to have no strategy for registries or patient-generated data. Mostashari announced that secondary use of data will be on the agenda for next month.

Bechtel asked for a report from the Quality Measures Workgroup, which has not been heard from for some time. Quality measures should be advanced via all available ONC levers. She expressed concern about the lack of strategy for disparities. She offered to report from the Consumer Empowerment Workgroup on care plan and reconciliation of data implementation of HIPAA by consumers.

Harrell wanted to get stories on successes and failures from Stage 1. Evaluation is needed. She also indicated interest in the use of analytics to improve outcomes. Someone suggested that the ACO Workgroup is the appropriate group to consider those topics.

Davidson voiced his interest in the process for approving registries and how to make participation in registries easier. He referred to a recent piece of registration that mandated a GAO study of registries. Mostashari suggested getting an update from Patrick Conway.

Bechtel had another suggestion: What is ONC doing on using meaningful use as a pipeline for new quality measures?

Calman requested updates from the CommonWell Health Alliance as related to state and regional exchanges. He would like to know what is going on in states' exchanges as it relates to policy work. Specifically, he asked for CMS presentations that break out outcomes by IT vendors. Mostashari referred

to concerns with vendors being the control point for exchange services. Calman continued, saying the cost of systems merits discussion. It is important to recognize that processes have both benefits and costs, and costs must be covered in the safety net. Regarding the conduct of HITPC meetings, he said that the presentations and discussions contained far too many acronyms. He declared that in future meetings he intended to call them out. New acronyms are being added at an increasingly rapid pace, making the meeting intelligible to many persons.

Tang categorized the suggestions. The privacy of sensitive data can be subsumed in the upcoming re-examination of scenario 3. McGraw included minors in that category. The Data Intermediaries Tiger Team can deal with several of the suggested topics. The Consumer Empowerment Workgroup will deal with care plans and patient-generated data. Success stories and Beacon issues can be delegated to the ACO Workgroup, which is charged with management of population health. The Quality Measures Workgroup has new leadership and has shifted strategy. He said that most of the suggested topics related to quality measures can be subsumed under existing workgroups.

Public Comment

None

SUMMARY OF ACTION ITEMS

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

Action item #2: The Privacy and Security Tiger Team's recommendation on query scenario 3 was not approved and was returned to the team for additional work.

Meeting Materials

- Agenda
- Summary of March 2013 meeting
- Presentations and reports slides
- Workforce recommendations
- Privacy and Security recommendations
- HITSC workplan