

Meeting Report
DRAFT
HIT Standards Committee
Summary of the January 20, 2010, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to this meeting of the HIT Standards Committee, and conducted roll call.

2. Opening Remarks From the National Coordinator

David Blumenthal opened the meeting by welcoming Committee members and indicating that the meeting would feature a lengthy discussion on the recently released Interim Final Regulation (IFR) and Notice of Proposed Rulemaking (NPRM).

3. Overview of the Meeting

Jonathan Perlin, Chair of the HIT Standards Committee, welcomed Committee members and members of the public. He thanked Committee members for their efforts to date, and referred them to a recent editorial by David Blumenthal that appeared in the December 31, 2009, issue of the *New England Journal of Medicine*. The editorial explains the differences between what appears in the IFR (i.e., the work that conveys the standards) and the NPRM (i.e., the CMS document that brings forward the definitions of meaningful use). Jonathan Perlin explained that there is, in the meeting's agenda, a continuity of activity that needs fleshing out from specifications for content, for vocabulary, for transport of information; privacy and security; and then a crosswalk from meaningful use to capabilities and the standards that support them (which also implies a rubric for certification). The IFR and NPRM provide an internal coherence to the material available for individuals in the field from all perspectives to use as an increasingly informed roadmap for future direction; much of the meeting will be devoted to the IFR and NPRM. The meeting also included a discussion on future agendas for the HIT Standards Committee.

John Halamka, Committee Vice Chair, reminded participants that comments on the IFR and NPRM can be submitted to ONC by March 1, 2010. He noted that the HIT Policy Committee will be reviewing the NPRM in depth, and suggested that Standards Committee members focus on the IFR. The HIT Standards Committee will vet comments and take action on IFR comments at its February 24 meeting. He explained that his interpretation of the IFR is that it does not purposefully remove specificity, but rather, tries to allow evolution so that standards development organizations and this Committee have the flexibility in providing implementation guidance and reference implementations going forward.

Action Item #1: Minutes from the last meeting were approved by consensus.

4. Review of the Interim Final Rule (IFR) on Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHRs

Doug Fridsma provided an overview on the issues addressed in developing the IFR and pointed out some of its key features. Principles guiding certification criteria include assuring providers that electronic health records (EHRs) can support meaningful use, utilizing key capabilities that can be tested objectively, and having a minimal set that supports innovation. With regard to standards, key principles include incrementally building the capacity, recognizing common methods for secure transport, pushing industry to adopt specific terminologies, and requiring strong security functionality while allowing future industry advances to satisfy requirements. He noted that much of the IFR development process was guided by the meaningful use objectives; certification criteria were established, as were standards to support the criteria. Jodi Daniel pointed out that there is a certification criterion for every meaningful use objective to ensure that the technology is capable of supporting meaningful use. However, there is not a standard for every certification criterion.

Doug Fridsma described the IFR's organization, explaining that the initial set of standards are organized into the following four categories as recommended by the HIT Policy and Standards Committees:

- Content Exchange Standards – standards used to share clinical information such as clinical summaries, prescriptions, and structured electronic documents.
- Vocabulary Standards – standard nomenclature used to describe clinical problems and procedures, medications, and allergies.
- Transport Standards – standards used to establish the communication protocol between systems.
- Privacy and Security Standards – authentication, access control, and transmission security, for example, which relate to and span across all of the other types of standards.

Doug Fridsma noted that recommendations from the HIT Standards Committee played a large role in the development of the IFR. There are some differences between the Committee's recommendations and what appears in the IFR, however. For example, the Committee recommended inclusion of the CCD and the CDA template or HL-7 2.5.1. The IFR, as adopted by the HHS Secretary, includes CCD or CCR as part of the certification criteria; the Standards Committee will be asked for input on how to begin constraining the choices moving forward. With regard to quality reporting metrics, The Committee recommended using the CMS CDA; the IFR specifies the CMS PQRI. There were also a number of differences between the Committee's recommendations and the IFR. For example, the Committee recommended local or proprietary codes or candidate stage 2 standards for the medication allergy standard. The IFR

did not adopt a specific standard in this area, but recognizes that it will need to do so in the future (with input from this Committee).

Another difference between Committee recommendations and the IFR relates to medication lists. Similar to the medication allergies, the Committee recommended local or proprietary codes or candidate stage 2 standards. The current IFR adopted any code set that is mappable or is in the RxNorm data source providers and that are identified by the NLM as being a complete data set integrated with RxNorm. The Committee had the same recommendation in the area of laboratory orders and results; the IFR however indicates that a certified EHR needs to be able to accept LOINC codes if they are provided. Doug Fridsma noted that organizations that do not have a laboratory system in their local regions that can send LOINC codes can still qualify for meaningful use, but their certified EHR needs to have the capability of receiving them when they are available. With regard to transport, security, and privacy, the IFR adopted the recommendations of the Committee to use the transport REST or SOAP. Throughout the transport, security, and privacy recommendations from the Committee, the IFR took them and described them in a functional way, with examples of the things that would support or that would meet those.

The IFR represents an attempt to build together the standards and functionality that are desired for a certified EHR technology. Together, they become part of the certification criteria and, combined with the NPRM, will lead to the ability for to identify certified electronic technology that will help support meaningful use and data exchange. Doug Fridsma characterized the IFR as the first of these building blocks toward interoperability and developing a program for certified EHR technology.

5. Preliminary Thoughts/Discussion on the IFR

The following points were made in discussion:

- Doug Fridsma explained that one of the drivers to be aware of is market indicates is useful for the exchange of information. The IFR does not address what a particular organization may decide to do from a policy perspective. The IFR public comment period is expected to provide us input in terms of what can be improved on and suggestions for moving towards the adoption of technologies for certified EHRs and supporting meaningful use and exchange of information.
- Wes Rishel asked about narrowing the choices and thereby increasing the probability of interoperability. Doug Fridsma commented that this is a difficult issue; many different levers and motivators will be required in the areas of market forces, regulatory forces, certification criteria, and policy. External mechanisms will also drive this process.
- Wes Rishel also asked, given that there are in the meaningful use NPRM specific levels of lab results that must be imported in structured data and the transfers of patient information that must be reached, whether the inability of potential recipients of incentive money, because of local problems adopting a standard, constitute a market force. David Blumenthal commented that he envisions a certain type of dialog between market and regulation. As

market forces identify solutions, they can be adopted by regulation if needed to systematize them. In instances where the market creates a demand for government to intervene, the government can intervene. Congress has created a set of financial incentives that reward certain behaviors. When those financial incentives become available and the market moves toward doing the things that are necessary to get those monies and cannot do so without help, the government, with advice from the HIT Standards Committee, will assist.

- John Halamka asked for clarification and whether it is true from a regulatory standpoint that HL-7 2.5.1, without specific limitation guidance, is in the regulation, not just the preamble, but the statement of TLS IP set is not in the regulation, it is just in the preamble as an “e.g.,” or “for example.” Jodi Daniel indicated that this is the case. Dixie Baker asked whether the implication is that when industry moves to HL-7 version 3, regulatory change will be required. Jodi Daniel explained that this is correct.
- Doug Fridsma explained that in developing the IFR, efforts were made to describe issues in a functional manner that allows for innovation in future different versions of authentication and other systems. Many of the security and privacy standards are included to provide functionality that providers can use; it is recognized that security and privacy is more of a process than a standard.
- Anne Castro asked about the distinction between EHR modules and complete EHRs. Jodi Daniel explained that for an entity to qualify as a meaningful user and qualify for the incentive program, it both has to have certified EHR technology and then meet the requirements of meaningful use. To be certified EHR technology, it has to meet all of the standards and functionality that are specified in the regulations. It does not mean that each component has to meet all of the standards and criteria; it means that as a package it has to meet all of the standards and criteria.
- Anne Castro commented that her group is working on a health information exchange (HIE) project in South Carolina—most vendors in that area are frustrated and waiting for a clear message on how to proceed. Without this clear message, the objective of reaching adoption may be compromised. John Halamka noted that the balance between regulation and industry innovation will provide a set of industry-created standards or implementation practices that should make it very easy for this HIE to decide what to do.
- Cris Ross explained that the term EHR previously was thought of as the entire suite of the technology used by a practice. However, in many practices, an EHR is understood to have only a subset of that functionality. And a broader term is probably needed for all of the technology within that suite.
- Jodi Daniel explained that all of the comments received regarding the IFR will be made publicly available online at www.regulations.gov.
- Walter Suarez commented that in reality, the “standards” that have been identified for security are really statements of the types of standard applications that can be used, a general statement that describes different types of possibilities. The challenge is on the

interoperability side, because in reality, looking at encryption, for example, there could be 150 different proprietary-type products that could meet a general statement stated in the rule. He expressed concern on the interoperability directions of the statements and the potential that they would carry with them the risk of not pursuing interoperability.

- Walter Suarez also voiced concerns about groups having to certify their practice management system (PMS) to be capable of doing X12 transactions so that they then can add it into the package of all the different other modules. Traditionally PMS has never been seen as an EHR technology. In most current systems that have these capabilities, claims and eligibility functions are carried out in different sub-systems than the EHR activities. Jodi Daniel commented that this is not addressed in the standards and certification IFR; feedback from Committee members on this matter was encouraged.
- Jamie Ferguson clarified that with regard to content exchange for quality reporting, the Committee recommend the use of PQRI in Stage 1, as well as the quality reporting data architecture, with a proposed migration to the quality reporting data architecture or CDA-based quality reporting for Stage 2. On the vocabulary side, The Committee recommended that the vocabulary for medication allergies should be at the clinical drug level using RxNorm.
- Dixie Baker agreed with the IFR approach of specifying the standards as functional requirements to allow for flexibility and adaptability in general. She noted that certifying privacy and security through the EHR module approach is likely to cause big problems. If every EHR module has to meet all of the security specification criteria, then it will be impossible to achieve uniform, enterprise-wide enforcement of security and privacy policy. Also, if that set of EHR modules includes one or more modules that are security specific, then again, it will be impossible to enforce enterprise-wide enforcement of privacy and security policy, because there is no clear way to ensure that all of the other EHR modules are using the security services provided by those security modules.
- With regard to cross-enterprise user assertion, or the SAML XUA standard, Dixie Baker suggested that an alternate approach would be to examine perhaps certification criteria that would require products to at least support two-factor authentication.
- Dixie Baker also noted that by translating the recommended standards into functional standards, some of the standards seem to slip through the cracks. She pointed to authentication and access control as examples. Neither of these are addressed in the standards component. Before moving to a cross-enterprise single sign-on, she suggested strengthening the individual authentication within enterprises. Ultimately, this will be the weakest link in cross-enterprise exchanges.
- Stan Huff suggested that it would be helpful to have an approach that could create interoperability and, at the same time, have the flexibility to have that change from time to time without having to go through the full regulatory process. John Halamka agreed, noting that the question boils down to what level of specificity can be reached so that the industry

and the small doctor's office can adapt to whatever the requirement is, getting as close to plug-and-play over many years as possible.

- Cris Ross explained that when providers are confronted with supporting both CCD and CCR, they essentially face a least-common-denominator capability. Least-common-denominator specification could erode the specificity and the utility of the information that providers would be managing.
- Jodi Daniel explained that the standards and certification criteria must be in the product in order for the product to be certified, and the eligible provider or hospital must be using a certified EHR technology to qualify for the incentives. It may be possible to meet meaningful use without using a particular standard or without using a particular standard in every instance. There is a difference between what is required for the technical capabilities and what is required for implementation and for use of that technology. Those are two different sets of requirements.

6. Overview of the Notice of Proposed Rulemaking (NPRM) on EHR Incentive Program for Medicare and Medicaid

Karen Trudel explained that the CMS EHR Incentive Program NPRM provides the definition of the terms meaningful use and hospital-based eligible professional. It outlines the requirements for the Medicare Fee-For-Service EHR Incentive Program, Medicare Advantage EHR Incentive Program, and Medicaid EHR Incentive Program. The NPRM also includes the normal information collection and regulatory impact analysis. It does not include information about ONC grants, changes to the Health Insurance Portability and Accountability Act (HIPAA) related to security and privacy, the IFR, EHR certification requirements, or procedures for becoming a certifying body. The NPRM: (1) harmonizes meaningful use criteria across CMS programs as much as possible, (2) closely links with the ONC certification and standards IFR, (3) builds on the recommendations of the HIT Policy Committee, (4) coordinates with the existing CMS quality initiatives, and (5) provides a platform that allows for a staged implementation over time.

With respect to the definition of meaningful use, statute requires that it includes quality reporting, electronic prescribing, and information exchange. Karen Trudel presented a slide illustrating the conceptual approach to meaningful use, starting with data capture and sharing, moving to advanced clinical processes, and then leading to the ultimate goal of improved outcomes. Meaningful use is being defined in three stages through rulemaking. Stage 1 is what appears in the NPRM and represent requirements for 2011. Additional regulations for stages 2 and 3 (representing requirements for 2013 and 2015, respectively) will be informed by ongoing deliberations of the HIT Policy and Standards Committees as well as input on the 2011 requirements. For Stage 1, the meaningful use criteria were displayed in terms of the health outcome priorities developed by the National Priorities Partnership. These priorities include: (1) improving quality, safety, efficiency, and reducing health disparities; (2) engaging patients and families in their health care; (3) improving care coordination; (4) improving population and public health; and (5) ensuring adequate privacy and security protections for personal health information. Rather than requiring that eligible professionals and hospitals who are not adopting

in the first year to jump on board to later in higher sets of requirements, a stairstep approach was developed.

With respect to the meaningful use criteria, there are 25 objectives and measures in the NPRM for eligible professionals and 23 for eligible hospitals and critical access hospitals. A 90-day reporting period has been proposed for the first year, to give participants as much time in that year as possible to adopt and demonstrate meaningful use. In subsequent years, the full year has been proposed as the reporting period.

In addition to the meaningful use criteria, the NPRM proposes a number of clinical quality measures. For example, in 2011, providers will be required to submit summary quality measures data to CMS by attestation. In 2012, providers will be required to electronically submit quality measure data to CMS. Eligible professionals are required to submit clinical data on two measure groups, core measures and a subset of clinical measures most appropriate to their specialty. Eligible hospitals are required to report summary data on 43 quality measures for applicable cases to CMS. Hospitals only eligible for Medicaid will report directly to the states; for hospitals in which the measures do not apply, they will have the option of selecting an alternate set of Medicaid clinical quality measures.

Karen Trudel reviewed differences between the Medicare and Medicaid EHR programs and then noted that, as was the case with the IFR and HIT Standards Committee recommendations, there are some changes between the NPRM and recommendations made by the HIT Policy Committee. For example, the NPRM increased the clinical decision support rules that are required from one to five. Clinical quality measures were greatly expanded to accommodate the diversity of specialists meeting the definition of an eligible professional.

With regard to the incentive payment timeline, Medicare can begin to pay incentives to eligible professionals in January 2011. Medicare can pay eligible hospitals and critical access hospitals no sooner than October 2010. Medicaid eligible professionals can receive payments as early as 2010 for adopting, implementing, or upgrading EHR technology. In terms of next steps, input from the HIT Policy and Standards Committees is being sought, and a public comment period closes on March 15, 2010. After that, CMS will review comments, the final regulation will be drafted, and the NPRM will undergo CMS/HHS/OMB clearance. It is expected that the final rule will be published in the Spring of 2010.

7. Preliminary Thoughts/Discussion on NPRM

Discussion included these points:

- Janet Corrigan emphasized the need to make the case that the set of measures for data capture are going to be related to significant improved outcomes in the future. Many of these measures are grounded in national priorities, and in those cases, there is a clear evidence base about what the expected outcomes are. There is a need to capture and communicate this. There is also a need to develop a succinct communication plan that indicates where measures are important to achieve specific outcomes and try to quantify them.

- Karen Trudel explained that based on public comment and input from the HIT Policy and Standards Committees, it is hoped that the large number of measures proposed for 2011 included in the NPRM will be refined.
- David Blumenthal commented that the development of the NPRM was informed not only by the HIT Committees, but also by work of the National Quality Forum. He encouraged Committee members to provide comments, either during this meeting or afterwards, to help craft the final version of the NPRM.
- Walter Suarez asked about Medicaid and the degree to which flexibility exists in the regulations for a state and state agencies to expand or to modify some of the meaningful use requirements. Karen Trudel explained that the requirements are proposed to be a foundation that will cross Medicare and Medicaid, and that the states can add to them. Additionally, states have been provided with some advanced funding to develop a plan that would cover both their implementation of the Medicaid incentives program as well as some other aspects of their health information technology environment.
- Jodi Daniel emphasized that there is an acute awareness of the need to ensure that the IFR and NPRM synch up and fit well together before they are finalized.
- In response to a question, Jonathan Perlin described the IFR as almost the final draft of a document, and the NPRM as a rough draft of a document. This was not to suggest that the work on either was any different in completeness, but to indicate that a final drafts get polished, whereas rough drafts may be revised. Jodi Daniel explained that legally, the IFR is final and is law 30 days after it is published. Both the IFR and NPRM required an incredible amount of work to develop.
- Jonathan Perlin noted that there is a differentiation between what ultimately is regulated in the process and what is practical in terms of workflow. While the HIT Standards and Policy Committees offer implementation and similar guidance, they will also likely face a number of questions that relate to workflow.

8. Future Agendas for HIT Standards Committee Workgroup Chairs

Before the HIT Standards Committee Workgroups presented their future agendas, David Blumenthal provided a high-level overview of current ONC activities. He explained that the ONC was given the responsibility to implement a very broad, ambitious agenda that was laid out by the Congress less than 1 year ago in the stimulus legislation. The goal was not to produce regulations or grant programs, but to promote the creation of a nationwide, interoperable, private and secure, electronic, health information system. To assist these efforts, Congress provided some direction and resources. Congress did not define meaningful use, but outlined it as a key concept and indicated the need for the IFR. Congress also indicated that a certification process should be created and allocated \$2 billion to the ONC to help promote the agenda they had laid out.

A foundation to this work has taken the form of a series of grant programs. One is helping less well-resourced providers of care to become meaningful users. The ONC has allocated \$643 million for the creation of up to 70 Regional Extension Centers, which provide guidance, technical assistance, support and advice, and information and knowledge for program and office and workflow redesign in hospitals, primary care, and other physician offices and nursing settings. The ONC also has invested \$560 million in state HIE. It is hoped that the states will provide valuable leadership that is closer to the local health care market than the federal government. Additionally, the ONC has put \$118 million towards training a workforce to support health information exchange and adoption. The Office has created a framework of four separate complementary programs that will support that training function for approximately 45,000 professionals.

The ONC has invested in research through a strategic HIT advanced research program that will fund four centers to advance the capabilities of HIT in targeted areas. More than \$60 million has been put towards accelerating the progress of the Nationwide Health Information Network (NHIN) as an infrastructure for exchange. The Office also is considering whether there are complementary, consistent alternatives to the full NHIN as ways of undertaking exchange.

John Halamka asked Committee members to provide any and all comments on the IFR to the in the Workgroup areas of privacy and security, clinical operations, and quality. The Workgroups are ready to move forward and address the challenges the IFR has created in terms of standards harmonization and making sure that it all cohesively works together.

Clinical Operations Workgroup

Jamie Ferguson explained that there are longer-term (e.g., approximately 6 months) and shorter-term (e.g., about 6 weeks) priorities that relate to the IFR. Longer-term priorities for the Clinical Operations Workgroup include generating further recommendations on content exchange, vocabulary, and code set standards. The shorter-term priority for the Workgroup is providing comments on selected key points of content exchange and vocabulary in the IFR. The Clinical Operations Workgroup's Vocabulary Task Force will be focusing on value sets and subsets of controlled vocabularies that are needed by implementers. These include both the convenience subsets (e.g., the most frequently ordered lab tests, the most frequently used problems, etc.) as well as the value sets that constrain the particular codes that are required (e.g., for quality reporting). The Vocabulary Task Force will discuss and ultimately make recommendations on some of the processes for the development and maintenance, the management and communications of both the value sets, as well as the convenient subsets of the controlled vocabularies.

The following points were raised in discussion:

- Jonathan Perlin asked whether the Workgroup has been able to contemplate a way to segue from “best in class” recommendations in a particular domain to a harmonization trajectory to move from raw material to the useable code and the implementation. Jamie Ferguson explained that the Workgroup has not had this discussion yet, but it is on their agenda.

- John Halamka noted that in the IFR, HL-7 2.3.1, 2.5.1 is cited for very specific purposes. An interesting question is whether one could, with HL-7's CDA template idea, take a CDA construct and use a templetized set of data in CDA for multiple purposes, both primary and secondary use.
- Jodi Daniel asked whether the Clinical Operations Workgroup will be examining the related certification criteria as well as the standards in the particular areas on which it is focused. Jamie Ferguson indicated that this was the case.
- John Halamka noted that there is no HIT Standards Committee Workgroup focused on X12, 4010, 5010, and payer/provider interactions. Jamie Ferguson suggested that this fits with previous Clinical Operations Workgroup efforts that considered all of the different content exchange packages, including making recommendations on the administrative simplification transaction.
- Judy Murphy suggested that in terms of implementation guidance, this Workgroup could take the lead on simplifying the information. The "crosswalk" slide presented by Doug Fridsma could be extended to show examples of implementation guidance, reference implementations, etc.
- David Blumenthal emphasized the valuable functions that the HIT Standards and Policy Committees have. The HITECH legislation, speaks of the Standards and Policy Committees as being forums in which these issues are discussed and advice is formulated. Although they do not speak for the entire nation, these groups bring incredibly valuable and diverse perspectives to bear. Jonathan Perlin reminded the group that the Committee's activities are driven by the goal of reaching consensus from a breadth of backgrounds and perspectives geared toward providing recommendations to the ONC.
- Cris Ross commented that there may be a need to have the Workgroups combine or coordinate their efforts, because there may be more than one way to accomplish a particular outcome based on standards that are already articulated by one of the Workgroups. Communication is essential to avoiding duplicative efforts.
- Carol Diamond suggested that it may be beneficial for the Workgroups to operationalize a set of criteria from a process standpoint for issues to be addressed going forward.

Clinical Quality Workgroup

Janet Corrigan outlined the short- and long-term priorities of the Clinical Quality Workgroup. In the short term, the Workgroup will hold a conference call on January 27 to review and comment on selected meaningful use provisions in the current rules, with particular attention paid to selected performance measures. A set of core measures was developed by the Workgroup, and there are additional ones—a challenge will be examining these additional measures to determine how well they correspond with the quality framework put forth by the HIT Policy Committee. The Workgroup will also look at whether there are any harmonization issues in terms of how those are specified. It also will try to determine whether there are any implications for all of the

retooling work that is getting underway or the continued evolution of the quality data set. Long-term priorities for the Clinical Quality Workgroup include reviewing the HIT Policy Committee's objectives and measures for 2013 and 2015, and identifying existing standardized measures and measure gaps.

In discussion, the following points were made:

- Jonathan Perlin noted that it is impossible to think of the Clinical Quality Workgroup's efforts simply in data terms. One needs to consider these activities from the perspective of the implementation.
- John Derr pointed out the importance of taking into account the "other providers" (e.g., nursing homes, home care agencies, etc.) and how they fit into this work.
- Stan Huff noted that the Committee may have a higher obligation or need to consider how individual institution goals and quality efforts impacted by the IFR. Janet Corrigan suggested that there needs to be a balance between the measurement that is externally required versus that which represent the priorities for any individual institution.
- Jim Walker reinforced the need to, as soon and as much as possible, focus on the entire health care team with quality measures, communication standards, etc. Hospitals, clinics, and case managers have difficulty getting visibility into the long-term care facility; it is extremely hard to manage the care of patients that go into and stay in those facilities.

Privacy and Security Workgroup

Dixie Baker explained that the Privacy and Security Workgroup will, over the next 6 weeks, be focused on reviewing and commenting on the IFR. The Workgroup has established a timeline for providing its recommendations to the full HIT Standards Committee by its February 24, 2010, meeting. Privacy and Security Workgroup members were provided with and asked to respond to a set of seven questions that relate to the general approach that the IFR takes and to the solicitations for comments that are embedded in the IFR. Beyond review of the IFR, the Workgroup will: (1) focus its efforts on aligning standards work with policy recommendations from the HIT Policy Committee's Privacy and Security Workgroup; and (2) plan for an incremental update of standards, implementation specifications, and certification criteria. It is expected that the Workgroup's future activities will be much more related to patient engagement and personal health records than they have in the past.

General Discussion

The following points were raised during discussion:

- David Kates noted that there are many potential questions and comments that the HIT Standards Committee could pose related to the modular certification process as related to the IFR and NPRM. The Implementation Workgroup may be an appropriate forum for these discussions. He also noted that although it has been stated that the intent of the IFR is not to

presuppose an architecture of a technology implementation, some of the language and semantics in the IFR imply architecture. For example, the clinical decision support requirements imply that there is a clinical decision support system within the EHR, which may or may not be the case. Aneesh Chopra explained that the Implementation Workgroup will be discussing these issues in an upcoming conference call.

- In response to a question about how this Committee's efforts integrate with the SHARP projects, David Blumenthal explained that the SHARP program is a commitment by the ONC to moving the science of informatics and the technology forward in a way that is both short- and long-term focused. SHARP centers will not be tasked with helping reach meaningful use by 2011, but will focus on fundamental breakthroughs. Additional information on this program may be presented at a future Committee meeting.
- Cris Ross suggested that the Implementation Workgroup focus on particularly difficult implementation problems where there are known major conflicts (e.g., between small-scale and large-scale practices) as potential investigation areas for SHARP grants. Those may be able to provide some real-life experience or laboratory experience on how to solve some of these problems.
- Aneesh Chopra explained that it is hoped that these SHARP centers will be centers of excellence and serve as models for the rest of the federal government on how to carry out cutting edge research while having relevance on key priority areas for the country.
- Jonathan Perlin noted that it would be helpful to track the assignments made to the HIT Standards Committee in the IFR. Doug Fridsma agreed, adding that it also would be beneficial to examine, from ONC's perspective, what progress has been made by the Committee.
- John Glaser commented that there appear to be three major threads of activity for the Committee in the coming months: (1) commenting on the IFR, (2) providing clarity to industry so that it can move forward, and (3) developing a timeline for 2013 meaningful use.

9. Public Comment

Richard Singerman of BioQuest commented that the IFR appears to indicate that the requirements and standards for the consumer, or consumer access to the EHR, will be coming later (i.e., 2013 and 2015). The Group Health organization adopted a PHR before the actual EHR and had a tremendous uptake initially that facilitated its internal, true EHR adoption. Given that there is a modular approach for EHR adoption, it could be very interesting to seed one or two consumer applications early on (e.g., maybe lab availability). Having patients use and get excited about these features could move adoption forward more rapidly. He encouraged a closer look at the consumer focus and reminded the group that it could benefit not only consumers, but could have the added benefit of accelerating physician and provider adoption. Aneesh Chopra indicated that the 2011 provisions around the consumer access to the summary within 48 hours are in the IFR for precisely these reasons.

SUMMARY OF ACTION ITEMS

Action Item #1: Minutes from the last meeting were approved by consensus.