

# Health IT Joint Committee Collaboration

A Joint Policy and Standards Public Advisory Body on Health Information Technology  
to the National Coordinator for Health IT



## Health IT Joint Committee Final Transcript January 20, 2016

### Presentation

#### Operator

All lines are now bridged.

#### Michelle Consolazio, MPH – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

This is a Joint meeting of the Health IT Policy and Health IT Standards Committee. This is a public meeting and there will be time for public comment limited to three minutes before lunch and after at the end of today's meeting. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. And we'll go around the room to take roll and we'll go this way, we usually go the other way, so this is Michelle Consolazio.

#### Jennifer Brown - Office of the National Coordinator for Health Information Technology

Jennifer Brown.

#### Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology

Dawn Heisey-Grove.

#### Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology

Steve Posnack.

#### John S. Scott, MD - Program Director, Clinical Informatics Policy, Office of the Assistant Secretary of Defense, Health Affairs - Department of Defense

John Scott.

#### Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates

Dixie Baker.

#### Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Floyd Eisenberg.

#### Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School

Josh Mandel.

**Kim J. Schofield – Advocacy Chair – Lupus Foundation of America**

Kim Schofield.

**Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)**

Andy Wiesenthal.

**Angela Kennedy, EdD, MBA, RHIA – Head of Department & Professor of Health information Management – Louisiana Tech University**

Angela Kennedy.

**Anjum Khurshid, PhD, MPAff, MBBS – Director Health Systems Division – Louisiana Public Health Institute**

Anjum Khurshid.

**Elizabeth Johnson, MS, FHIMSS, CPHIMS, RN-BC – Chief Clinical Informatics Officer & Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

Liz Johnson.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Cris Ross.

**Rebecca D. Kush, PhD – Founder, Chief Executive Officer, President & Director – Clinical Data Interchange Standards Consortium (CDISC)**

Becky Kush.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Karen DeSalvo.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Jon White.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

John Halamka.

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Arien Malec.

**Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society**

Lisa Gallagher.

**Jamie Ferguson – Vice President, Health Information Technology Strategy & Planning, Fellow, Institute for Health Policy – Kaiser Permanente**

Jamie Ferguson.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Leslie Kelly Hall.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Rich Elmore.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Patty Sengstack.

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Jitin Asnaani.

**Anne LeMaistre, MD – Senior Director Clinical Information Systems & Chief Medical Information Officer – Ascension Health**

Anne LeMaistre.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Troy Seagondollar.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Anne Castro.

**Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects**

Eric Rose.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Donna Cryer.

**John F. Derr, RPh – President & Chief Executive Officer – JD & Associates Enterprises, Inc.; Founder – LTPAC Health IT Collaborative**

John Derr.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Chris Lehmann.

**David F. Kotz, MS, PhD –Champion International Professor, Department of Computer Science – Dartmouth College**

David Kotz.

**Elaine Hunolt, FACHE, PMP, CPHIMS – Health Acting Program Manager, Health Interoperability Service, Virtual Lifetime Electronic Record (VLER) – Veterans Health Administration/Department of Defense**

Elaine Hunolt.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, so this is an exciting meeting it's always exciting when we have both the Policy Committee and the Standards Committee together. It's also a sad meeting though because we're going to be losing some of our very valued members of the Standards Committee and most importantly John Halamka our Co-Chair or Vice-Chair, I should say, of the Standards Committee. So, it will be a very sad meeting but thank you so much for everything that you've done for the committee John and with that I will turn it over to Karen and Jon.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Thanks, Michelle, good morning everybody and Happy 2016. It's nice to see all you beautiful faces, thank you guys for making time and being here and to those who are on the phone. We have quite a lot to cover in our meeting today. I'm looking forward to the opportunity for the Office of the National Coordinator to provide some updates. I had just a few general things that I wanted to make sure I said and I think I have some slides, Michelle do you want me to use these now or after we make some general introductions? Where is Michelle?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Oh, she is coming back.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Do you want me to do my slides now or do you want to wait?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Let's do it!

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Yeah.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Sure. Okay, so let me just say we were busy yesterday and first a couple of things that relate to MU and a staffing announcement Jon's going to talk about some other staffing changes that we have within our family at ONC as well.

We did make an announcement yesterday that we'll have a Principal Deputy National Coordinator joining the team at the Office of the National Coordinator starting on Monday. He is from Louisiana. I promise there is not a conspiracy but I think you all will find him to be, Dr. Washington, Vindell Washington, he's the Chief Medical Informatics Officer at an organization called FMOLHS in Louisiana which takes care of a substantial portion of the population in that state but his roots in health IT go back to his time in places like North Carolina and I believe he was one of the star students of Dr. John Halamka about 13 years ago John sorted out at the Harvard School of Business.

He's very astute in health IT, is still a practicing emergency medicine physician and he also runs the physician group at FMOLHS. So he understands particularly the use case around delivery system reform and improvement and he has been living that every day. He's got his hands in having built his own system but also has been in the process of system acquisitions throughout his career. So, I think you all will enjoy getting a chance to know him and work with him. He's someone that some of us from Louisiana have known for some time and he's a very good soul on top of being brilliant.

So, there is that and Jon is going to say a few words about Mike McCoy who we're sad to lose back into the private sector but completely understand and we'll have a chance to say a few words about him in a moment.

In talking with some of the leadership of the committees we thought it might be helpful also if we put a little clarity around where things are with delivery system reform, interoperability and Meaningful Use. So, I have a few framing slides that you all might have seen before that I wanted to use again as a sort of let's go back and remember some of the near-term challenges and opportunities that we're addressing and then have a chance just to maybe bring to life a little bit of what Andy Slavitt and I put out in a Blog yesterday morning, which if you haven't seen I believe is both on the cms.gov website and on the hit.gov website and there was a fair amount of tweeting about it.

There are many use cases and needs for us to have a strong health IT underpinning for the health system in this country. We all know that precision medicine cannot unfold for everybody in this country unless we have a strong health IT underpinning and public health in addition requires strong health IT infrastructure.

Ultimately, we want to all get to a learning health system which is a dynamic opportunity for improvements in individual health and system health and ongoing learning. But we've also been talking about this near-term need and opportunity that we have to get return on investment to see the value in the health IT infrastructure investment that we have made as part of HITECH in particular in the last seven years and that delivery system reform as a priority for our Secretary and for this Administration so how do we get to a place where we have better, smarter, healthier...better care, smarter spending, healthier people and do that in a way that leverages all the opportunities from the health IT infrastructure that we have.

So, again, this isn't the only way that we want to leverage our health IT infrastructure but we believe it's a really important near-term responsibility and need that we have. And as you all may have seen me present before, the Secretary's effort lays out three areas, one is to change the way we pay providers, second is to improve the way we deliver care so that it is really person and community centered and more about teams and coordination, and quality, and harm reduction.

And finally, to see that we're distributing information in such a way that we are able to inform care decisions on the part of the teams that includes consumers and patients and caregivers in the system but also aggregate that data to have more real-time quality improvement and advanced payment reform.

We won't be able to change the business model for one sixth of the economy unless we have an information underpinning that can support it. I don't know how to say that any other way and the Secretary and the Administration certainly understand and respect that so these are all interconnected for us in the work we're doing in the department.

As a reminder...did I take out my value slide, I did, all right, as a reminder for the incentives we had set a historical goal in the department that by 2016 30% of our Medicare payments would be in alternative payment models and by 2018 50% or a tipping point of those payments would be in alternative payment models that we would leverage that opportunity of value-based payments and alternative payment models like ACOs, patient centered medical homes, bundled payments but there are likely to be other varieties to link that to the use of certified technology so that we're moving to a place where we're rewarding better outcomes and using health IT rather than focusing on rewarding health IT particularly.

I think you're seeing this evolution in the way that we're thinking about all of our programs and as we pointed to yesterday in the Blog we're considering how MACRA and MIPS give us an opportunity vis-à-vis the Meaningful Use Program to begin to shift our focus to outcomes-based rewards using health IT compared with really incentivizing the use of health IT as a more near-term strategy that's been successful in the last few years but I think it's time that we can begin to evolve.

The last piece about information I just want to spotlight, which...what has been I think been a pretty central focus for all of us at HHS and the Administration which is that if we really want to make this data that's a part of the digitized care experience for all Americans come to life it needs to be available. We need to have the actionable, usable, electronic health information available for decision-making for consumers and others particularly at the point of care in the near-term.

Our nationwide interoperability roadmap, which you all have been so instrumental in helping us create something that is nationwide and not federal, so something that's a public/private partnership has been live and in action for about four months. We have been delivering on what we said that we would do in that. Steve is going to lay out...Steve Posnack later will lay out some of those top line deliverables that we have been acting on.

And you saw, even just yesterday, what CHIME did with their patient identification announcement and opportunity for there to be further private sector action that's really clear about how we're going to all together get to seeing that usable data is readily available and can help us make better decisions at the point of care and beyond.

I think within that we were just having a sidebar conversation about these commitments. You know as we have been thinking about the manifestation of that roadmap and our approach to health IT the Administration kind of boiled down to what we think are three broad commitments around advancing the health IT landscape.

So as we're moving into this new chapter where it's really more about knowledge that can come from that data as opposed to thinking about the adoption of platforms themselves and how we will make sure that information is there for the consumer when they need it we came up with what we think are the three broad calls, commitments or calls to action in that space. This is really meant to create a big tent.

This language was thoughtfully designed by our technical and our policy teams across HHS and the Administration to set a stage where we think if we all believe in and follow through on these commitments we'll have the kind of open, connected community of health that is where we believe we need to go. And quite honestly what we hear from the community over and over again...and we'll walk

through these quickly and hopefully we'll have more opportunity to talk about them throughout the day.

The first is that consumers should easily and securely be able to access their electronic health information and direct it to any desired location. This, you know, implies that there's going to be an opportunity for consumers to have a longitudinal health record in addition to a discrete health record from one of their care episodes. So, for some of us in this room that's things like care plans but there's also other ways that we might envision how this world would look over time.

If I have one more family member ask me when they're going to be able to go to a single place and get all the immunization records for their kids so they can fill out their camp forms on a Sunday...I think there's a campaign to make sure I get asked that in communities where I go and I'm glad that they do because it's a real world, real-time question and it's the sort of thing that families that are moving from state to state or even as adults are going to retail or other places to get their vaccinations just even that simple use case is a way that we can imagine what that would feel like for everybody in this country if we made it that much easier for them but there are so many other manifestations of this.

The second is that we want individual's health information for care to be shared with other providers and patients as permitted by law and that will refrain from blocking electronic health information. Now this is really meant to talk about what...in some ways what HIPAA is and is not.

So, you've seen some actions by the Office of Civil Rights as a part of this deliverable for the interoperability roadmap to see that we're clarifying what the expectations are around the sharing of electronic health information for consumers so that there's better guidance for providers, it's a common question we get.

We're not finished with that work with the Office of Civil Rights making certain that we're providing additional clarity. We're also working, as many of you know, with the states, with the National Governor's Association to think about how policy across state lines sometimes gets in the way in an unintended fashion.

This question about blocking is one in which we believe, from what we have seen, that there is sometimes knowing and unreasonable blocking occurring, again, sometimes it's just unknowing and reasonable, and that's something we're working with many people across the Administration and the industry to better define and sort out. Blocking happens from all corners. This is not limited to vendors or providers or any part of the health IT ecosystem so let us be clear that this is not pointing the finger at anyone this is just a business practice that I think we need to be thoughtful about and see it doesn't get in the way of someone's information being available for them.

And this last commitment about implementing federally recognized, national interoperability standards, policies, guidance and practices for electronic health information and adopt best practices related to privacy and security.

Let me start from the back end of this sentence which is about security which is physical but also cybersecurity. This is a major priority for all of us. It's a priority for the Administration, even though it's the last word in the sentence I don't want us to lose sight of it. I have a hope that these FACAs are going to continue to and step up their conversations about cybersecurity in the next year or two but we have work to do in this industry to make sure that we're meeting expectations and getting further ahead.

Similarly, in the space of respecting privacy and privacy law, but the beginning of the sentence has gotten the most attention as we've talked with vendors and providers, and others in the health IT ecosystem and I just want to take a moment to talk about that language federally recognized national interoperability standards.

I said the comma when I read the sentence it's really important the comma matters and this is not because of a communications or public affairs this was something we talked about from a policy standpoint in the Administration.

And, you know, we moved last year back to an older approach that we had at ONC which was a sub-regulatory standards list. So those of you all who were around in the Bush Administration you might remember that Secretary Leavitt used a sub-regulatory guidance around standards that were mature so we pulled a page out of that playbook in addition to the new tools that we had around certification and other opportunities and Steve and his team working with many of you in this room has been working on making that more usable and a living document that we can continue to improve. He will be speaking about that later today.

So, the federally recognized, yes sometimes they're going to show up in our rules but also it's a way that we can point to our own systems, VA, DoD, Medicaid that these are the federally recognized standards that we want to use. We want to be the convener around organizing that in partnership with our Standards Committee but we won't have to make all of those, there are national standards that...and I always use FHIR as the example as a perfect example of something that's being developed nationally in the private sector but that we would federally recognize and point to with the list.

I think it's a way that us as a major...we the federal partners as payers, purchasers, providers and developers can make certain we're on the same page with the private sector and that the information is flowing as it needs to on behalf, not just private sector citizens but veterans and soldiers, those in the Indian Health Service and beyond.

So, the language is important. I look forward to continuing to talk with those of you who have questions about why we included it in there. We really want these commitments...and by the way I did...we showed these in October and we've had a lot of conversations with folks about them. I want to continue that dialogue because they're designed to be a big tent.

This is meant to say, these are the principles by which we want to see us go forward into the next chapter of health IT. How we manifest these that's where the rubber meets the road and there is some incredibly interesting and exciting ideas that we have had filtered to us from the private sector, the providers in particular I would say have been incredibly interested and engaged in the opportunity to develop a series of Apps or an ecosystem where those Apps might be and how we can leverage what we already know about SMART on FHIR, I'm trying to get Josh to look up, to create a world which by the end of 16 there could be an array...an array of platform neutral Apps that we would be able to choose from and consumers could really have easy access to their information that would require us to have to have agreed that we won't block, that we'll make it available for care and for self-care and that we're going to use a standard, a nationally...a federally recognized but national standard like FHIR that's going to help us advance that. So, just an example of how we might see that manifest.

So, I may have gone on a little longer than Michelle intended but, you know, when we had talked as a leadership group I wanted to make sure I had the chance to just reset and talk again about the contacts that the here and now, delivery system reform of what we're working on within that for the health IT strategy, how important the interoperability roadmap is to the Administration and as we're looking to execute on that in partnership with the private sector we think if we all follow these commitments as a true north we will be able to manifest this open connected health IT world but more importantly an open connected health system that's going to be the kind of future that I certainly hope to see and I think many of you have articulated for us.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thanks.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Questions before we hand off? All right, thank you, guys.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you, Karen, that was an excellent reminder as we start the New Year this is the goal, it is inspiring, achievable, and certainly worthy of the Administration on behalf of the country and for these FACA groups you have assembled to help provide some input and advice. So, thank you very much.

So, that is the agenda for the country with respect to both delivery system reform and how it affects HIT and now we're going to get into the micro and go to the agenda for this meeting that John and I will share.

Before I do that, just so we don't forget, because we have two sets of minutes to approve, may we ask for...those were distributed earlier, approval for each of the minutes. So, for the Policy Committee members could you...could I entertain a motion that we approve those minutes from the October meeting?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

November 10<sup>th</sup>.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

November 10<sup>th</sup>, sorry. Please?

**W**

**Minutes approved.**

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay. Second?

W

Second.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay and any further additions? Maybe Elise wants to have her name as Elise Anthony? All approved?

**Multiple**

Aye.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

And any abstain or disapprove? Thank you. John do you want to do the same for the Standards Committee and then...

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, as we know we have a consensus process, it is abbreviated. So, for those of you who have digested the meeting's minutes do you have any amendments, any changes, any edits? Okay, well, if there are no objections then we will approve those meeting minutes by consensus. Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So, I'll go over the morning agenda and it begins, as Karen mentioned, with a report from the OCR, Office of Civil Rights. As you know, with respect to interoperability, privacy and security are things that get mentioned as barriers and sometimes they're barriers that are not necessarily real barriers but barriers that are somewhat caused by the complexity of the rules whether it's privacy or security and people's misinterpretations. So, OCR put out a very helpful sort of statement guidance...

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Apparently, I have...I apologize Paul for interrupting you but apparently I was to turn it over to the John's because we had a couple of things we did want to mention that were housekeeping for standards, I apologize...

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

No worries.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Before we jump into the agenda.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

We're flexible.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

That's why I love you.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Yeah, that's okay, Paul, go ahead and finish.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

All right, well we'll just finish the morning agenda. So, Marissa Gordon-Nguyen is going to talk to us about that guidance with respect to HIPAA and clarifications. And as you know, ONC is probably one of the busiest offices in the federal government from its birth and so they're going to give us an update on many of the or some of the activities going on currently.

As Karen mentioned, interoperability is clearly at one of the top agenda items and so we'll review the activities, some of the activities in interoperability in ONC. We'll talk about some of the state related activities and workforce training programs. So, a number of activities we'd like to bring to the FACA committees so we know about some of what's going at ONC. And then we'll have lunch and John will take it away as far as updating us on the afternoon agenda.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, very good and just one quick comment on the morning agenda, which is it's very common that I am asked in my healthcare delivery system "is Skype HIPAA compliant" and of course this is not an answerable question because it's all about risk, it's informing the patient and ensuring that there is good communication as to what it is you're trying to accomplish and the risks involved in accomplishing it. So, I love the OCR material that's going to help us all.

And as Karen gave us the introduction this morning, I mean, we've seen this very interesting last couple of days in comments from Andy and then your Blog where, you know, ding-dong Meaningful Use is dead, long live Meaningful Use and then it's a bit like Monty Python "I'm not dead yet." "But you're almost dead." "Not yet." And so...

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

You can have my liver.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Exactly. So, in fact, you know, the way I look at all the things that are going on, as an objective third-party, is there's a process for everything, right? And I think we've heard from Andy, we've heard from Karen there's some really interesting directions we're all heading as we get to more outcomes-based activities and less prescriptive clicking, counting, numerators and denominator computations. So, I will be very interested to hear more details on ONC and the process ahead because it's a process.

After lunch we will cover the Cris Ross and Anita's Certified Task Force, Certified Technology Comparison Task Force and we often use, in the world of standards, the notion of suitability for purpose and is an

EHR or a product suitable for a given task, how do you know, how do you really even measure interoperability is it counting the number of documents that have been exchanged or is the fact the information you need is available at the point of care and actually meets the needs of the clinicians and the patients.

So, we'll hear from Cris and Anita on how their thinking we should go forward as a country. Should it be run in the private sector, the public sector or both, what should be the frameworks, etcetera? So, that will be, I'm sure, a very helpful discussion.

And then this is my very last meeting, it's my 200<sup>th</sup> trip to Washington today.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Wow.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yeah and so remember...because, you know, at the end I will make some comment on where we've been the last 10 years, but it started in AHIC, it started in, you know, federal recognition of standards, it started with Mike Leavitt and all the rest.

So, but I think most sad, as Michelle said, is Jamie and Becky, and Cris and Wes Rishel will also have their last meeting today. So, I will at the end, given time, make just a few comments before I hand over the agenda, before I hand the baton to these folks to my right, because Arien and Lisa will be running the standards activity heretofore. So, look forward to the meeting, it will be an exciting and meaningfully emotional day for me.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Time for a last comment?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

So, just a couple of things, you know, I love working with Karen for a lot of different reasons but in particular I love working with her because she can give you that big policy picture and then I can kind of bring it back to the domestic issues here in the committee which is good.

So, just want to thank you all again, you know, as I've been listening to the comments I've been looking around the table and, you know, I really am just so grateful for the time and effort of such remarkable and talented people. It is a true honor to be able to work with all of you and I thank you both for your effort and your time and your service.

John absolutely mentioned that there are some outstanding individuals that are finishing their service with us today. I too will reserve my comments for the end for that in particular. But, you know, what I

will say is that at our last Standards Committee meeting, you know, I did a little reflection at the end over what the past year has been like and wow what a year, you know, it's been a tremendous amount of stuff that's happened, things that have moved, things that have changed, it's a substantively different world in no small part because of the efforts of you around the table.

Equally so, you know, with the New Year is the opportunity to look forward and it's going to be another amazing year and Arien and Lisa, and I had a chance to sit down in my office yesterday to just kind of talk about where we think things are going and it's exciting, it's tremendously exciting.

You know all the work that we've done over the past several years really is building upon itself and it is driving us to better places. A chance to revisit, to reflect, say what are we doing now that we could be doing better, where should we be going that we have not been and all that is stuff that we're kind of looking forward to. So, again, I am tremendously grateful for your service here and for the service you are yet to give.

I am equally grateful for the amazing team that Karen and I work with at ONC. My colleagues who are in the room I cannot salute you enough times. You are a joy to work with and it's a true...you're true treasures and national resources and thank you for that.

With that I do want to highlight, salute the service and highlight the departure of one of those individuals, Mike McCoy. I didn't see Mike. Mike probably isn't...is he in the room? Yeah, okay, that's all right. I hope he gets a chance to come by before were done so you all can shake his hand, look him in the eye and tell him thank you for his service.

Mike joined us a year ago, brought a tremendous wealth of experience in the private sector both with care delivery organizations and with health IT developers as well as that of a practicing clinician and, you know, again, as I look back over the past year in some ways you can say, well, Mike has only been here a year and he said, okay, that's good, I appreciate it, I've enjoyed my service and I'm heading back to the private sector.

If you look back on the things that Mike has been part of, if you look back on the revised federal health IT strategic plan, if you look back on the interoperability roadmap, if you look back on the information blocking report, if you look back on a proposed rule and a finalized rule both from us and from CMS, and if you look back on precision medicine and delivery system reform what a year of service and Mike has been an integral part, a critical part, a valued part of ONC's team as we have grappled with all of these significant policy initiatives and, you know, brought them forward and he has been, on a personal note, a gentleman and always is very clear about speaking his mind in a respectful and thoughtful way.

One of Mike's favorite personal issues and I'm going to enjoy a delicious moment of contraband here when I say, national patient identifier, one of Mike's personal issues has arisen to the highlight with the CHIME event yesterday and the announcement of that challenge and we're looking forward to seeing that work move ahead. So, a lot of the things that Mike was interested in and hoped to move forward have moved forward in his time here.

So, sad to see him head back to the private sector but grateful for his service he has been magnanimous in saying "please any time you need to reach out and talk with us please do so" and we plan on doing it. So, thank you to Mike wherever you are for your time and look forward to a great meeting. Thanks.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, thank you. So, we'll begin with our morning agenda and Marissa from Office of Civil Rights please.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I'm sorry, I have one more thing to interrupt with. I was remiss in asking for the people on the phone and there are a few folks on the phone that I just want to make sure we know are here for the record. Wes Rishel is here, Scott Gottlieb, Nancy Orvis, David Lansky and Paul Egerman. Is there anyone I missed? Okay, sorry, now we're ready for Marissa.

**Laura H. Kahn, MD, MPH, MPP, FACP – Research Scholar, Physician & General Internist – Centers for Disease Control and Prevention**

Michelle?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes?

**Laura H. Kahn, MD, MPH, MPP, FACP – Research Scholar, Physician & General Internist – Centers for Disease Control and Prevention**

Sorry, hi, this is Laura Kahn calling in today for Chesley Richards.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

All right, is this on? I can't tell. Oh, there we go. As Paul said, my name is Marissa Gordon-Nguyen and I am a Senior HIPAA Privacy Specialist at the Office for Civil Rights and I'm happy to be here with you to share our latest guidance on the HIPAA right to access one's own health information.

The components, if you look at slide two, the components to this guidance are a factsheet and a set of FAQs in a number of subject areas. And so...oh, I have it? Oh, it's this, excellent, okay.

So, if you're familiar with the way that we produce guidance and put it on our website we generally do a factsheet that explains the issues and then have a number of what we call FAQs that provide more detailed examples.

And so these are the issues that we have put out in this initial set along with the main guidance. We talked about the scope, form and format and manner of access, which will probably be of particular interest to this group, timeliness requirements and a couple of additional miscellaneous FAQs that are particularly about clinical labs.

And then what we have still in development are additional FAQs having to do with fees for access and the right to direct access to a third-party which is encompassed in the individual right to access. And we recognize that these are being highly anticipated, that people have a lot of questions about them and we will be providing quite a bit of detail, these are in development.

So, the general right, as many of you know, is to obtain access to and a copy of one's own health information in a designated record set upon request. And this is whether requested by the individual or their personal representative who stands in the shoes of the individual with respect to making decisions about uses and disclosures as well as exercising the individual's personal rights under HIPAA.

And a designated record set is defined much more broadly than either an EHR or a paper, standard paper medical record. It is a group of records maintained by or for a covered entity and the rest of that sentence would be that are used to make decisions about individuals. And it's not necessarily decisions about the individuals whose information is being requested. It is any individual. And then I also have the definition of record up here to round out this definition and really shows the breadth of this.

So, some examples we provide in the FAQs, of course the EHR or paper medical record, any other records that, you know, related to payment, treatment, healthcare operations, clinical/laboratory I'll talk in a moment about things that fall under healthcare operations because you don't get the actual healthcare operations information but you get the underlying data that was used to go into those types of reports.

In a clinical laboratory test reports are part of the designated record set and to the extent the clinical laboratory is part of a covered entity. X-rays and other images, we've had some specific questions about those, a wellness and disease management program information, clinical case notes and old and archived PHI, as well as designated record set or sets held by a business associate which is addressed more on the following slide.

So, ultimately the covered entity retains responsibility for making sure that an individual gets access to their health information regardless of where it's maintained.

But the business associates who maintain designated record set information as well they are required to provide whatever information is needed to fulfill an individual request to the covered entity.

The business associate agreement, the contract between the covered entity and BA can specify that a particular BA will be responsible for satisfying requests either by compiling all of the information by sending it to the individual that is a contractual matter between those parties.

And requests wherever it's held whether by covered entity or BA, or multiple BAs still has to be fulfilled within time limits and I'll talk quite a bit more about the time limits but the basics are that it's within 30 days of the request and with a possible 30 day extension if that applies.

And then with respect to clinical laboratories, the designated record set includes completed test reports, not tests that are still in progress but also underlying data that is used to generate these reports as well as other information that's noted on this slide.

So, excluded information, I mentioned this before, so you don't have the right to obtain the actual records that are for quality assessment or peer review, or customer service business planning all of these things, but you have the rights to the underlying PHI.

So, if a health plan has developed a formulary using, you know...individual's health information aggregated together the individual doesn't have the right to the records that were used to develop the formulary but they have the right to their own information that may have gone into that process.

So, there are unreviewable and reviewable grounds for a covered entity to deny access to an individual's information, psychotherapy notes, information compiled for a legal proceeding and note that the psychotherapy notes to qualify for this denial of access or the exemption to the right to access have to be maintained separately from the designated record set from the medical record.

There are grounds for denial for inmates, that's only with respect to obtaining a copy, they still have the right to access to view and a designated record set that's part of a research study that's still in progress, as long as the individual was informed of this and agreed to the delay when they consented to participation.

A couple of other privacy act protected records and then information obtained under a promise of confidentiality to the person that was the source of the information. So, an example that we use is a family member shares information with a provider and says "I only want to tell you this if you promise not to tell this, you know, person who is your patient that I told you this information." And the doctor can promise that it will be confidential and if sharing the information with the individual would reveal that this particular person talked to the doctor and shared information then that information is not subject to the right of access.

There are a couple of reviewable grounds, reasonably likely to endanger life or physical safety, to cause substantial harm to someone referenced in the record that's not the provider and where access by a personal representative is reasonably likely to cause substantial harm. And a bit more about the first two here on the next slide.

So, details here, reasonably likely to cause harm we expect to be very rare. It's very limited and we say, you know, reasonably likely is to the judgment of a professional that for...the example we provide that really illustrates the seriousness of when this should be applied is if it's reasonably likely that your patient will commit suicide if they obtain access to this information. We say that grounds do not include the mere possibility of psychological or emotional harm. It can't be that the person will become upset unless you think that there is an actual likelihood of harm.

A few additional limitations, the covered entity can't require the individual to provide a reason for the request. They can't say you can only have this for treatment purposes or you can't use it in order to file a lawsuit. And it can't deny access based on a reason that is offered or known by the covered entity without having to require the individual to provide it.

I've already said, of course the BA, information held by the BA is subject to the rights and a covered entity can't withhold or deny access because an individual hasn't paid for healthcare services. So, if an individual has spent the night in the hospital they have a \$7000.00 bill because they don't have insurance the covered entity can't deny them access because they haven't paid that bill.

And you might be wondering then are they allowed to hold the information until the person pays a fee to obtain the information? They are allowed to charge a reasonable cost-based fee, we'll be talking much more about those, the fee issues, in the next round of guidance.

As far as carrying out the denial it has to be provided in writing and it's under the same timelines as providing the access itself. It has to be in plain language, describe the basis, the right to obtain review by the covered entity and how to request that if applicable. You don't get, obviously, the review if it's an unreviewable grounds for denial, and how to submit a complaint to the Office for Civil Rights.

If the covered entity or BA doesn't maintain the PHI but knows where it is, this maybe for example if it's maintained by another covered entity that's not a business associate of the first covered entity, it needs to inform the individual of that and it has to provide access to any other PHI requested.

Often, of course, you know, if you request access to all of your information in a designated record set there maybe aspects of it that...for which there are grounds for denial, but others for which aren't and so any other information must be provided within the time limits.

And the review must be by a professional who wasn't involved in the original decision to deny access. They make a determination about how to handle the request and they provide notice to the individual.

A covered entity can require a request in writing including on the covered entities own form. They must inform individuals of this requirement, they can't just receive a letter from an individual and then just let it lie unfulfilled.

A covered entity can offer the option of making a request electronically but can't require it and they need to take reasonable steps to verify the identity of the requester. It can be orally or through written verification. If electronic access is requested or if access is requested through electronic means there should be authentication controls. And with either of these aspects of making the request, the covered entity can't create a barrier to or unreasonably delay the access.

A couple examples of unreasonable measures would be requiring individuals to go physically to an office if that's not what they want to do, requiring them to use a web portal because as much as access is becoming ever more electronic not everyone has easy access to the Internet still and requiring individuals to mail an access request.

So, form and format and manner of access, this has been strengthened since the HITECH Act and it must be provided in the form and format requested if readily producible, that was always a requirement. Requests for paper copies must provide a copy, it is assumed that this is readily producible.

And here's where we made adjustments in the rules to strengthen the right to electronic copies and if PHI is maintained only a paper the covered entity must provide an electronic copy if it's readily producible and if it's not in a readable hardcopy or form that the individual agrees to.

If there's a request to PHI maintained electronically this also has been strengthened, you must provide access in the electronic form and format requested if it's readily producible. If it's not come to an agreement with the individual about the format and only if the individual refuses every offered electronic format can a covered entity provide access in paper form in response to a request for an electronic.

So, when we talk about readily producible this is based on the capabilities of the covered entity and they don't have to, for example, purchase a scanner to be able to provide a scanned PDF but in many cases it will be readily producible to produce a scanned PDF version while it may not be readily producible to make a Word version of paper PHI.

There is a right to receive information in human readable format. If there is an electronic copy being provided we also expect it to be in machine readable form if possible.

So, I said covered entities aren't required to purchase new software for every possible individual request that could be varied but they must have the capability to provide some form of an electronic copy if the designated record set is maintained electronically and if they don't have any way to do that this could require some investments on the front end and those can't be charged to individuals.

And, as I said, readily producible depends on the capabilities of the entity. And there are a few examples that we provide in the FAQs about formats that might be requested.

So, here's our crosswalk to the EHR Incentive Program. The view, download, transmit requirements in some ways are more exacting but they apply to a narrower range of data of course. If a covered entity uses certified EHR technology of course the electronic PHI is readily producible.

Covered entities can use VDT to fulfill access requests but only if the individual requests or accepts it you can't require the individuals to accept their information through that means. And there's always the right to access PHI in a designated record set that's not available through that certified EHR technology. In the FAQs we have a chart that you can look at that compares the HIPAA right with the individual access opportunities and our thanks to our OCR colleagues, ONC rather, our ONC colleagues for lending their expertise in with...actually all the form and format, and manner FAQs but that chart as well.

So, a little bit more on form and format and manner, a covered entity can provide a summary of the PHI requested instead of providing access or they can provide an explanation that accompanies access but the conditions on both of those are the individual must choose to receive them and agree ahead of time to any applicable fees for creating those documents.

And manner requested, this is the baseline requirement, convenient time and place, ability to do mail and e-mail encrypted or unencrypted. I'll talk more about unencrypted in just a second.

So, readily producible depends here...readily producible manner of transmission that is, depends on the capabilities as well as the level of risk to the security of PHI and this is based on the security rule risk analysis that the entity undergoes.

And then we have a couple of examples here about what the covered entity's risk analysis finds. It must address the potential use of external portable media and it may find that there is an unacceptable level of risk to allowing a connection with the individual's portable media to the covered entity's system.

So, there are a couple possibilities that can be taken here. The covered entity can't require the individual to purchase portable media from the covered entity though.

There is another, direct connection between the covered entity system and an individual's App. If they're capable of doing this and it's consistent with their security measures they must provide access in this manner but its dependent on their risk analysis and the types of risks that they have determined are acceptable.

So, where unsecured transmission is requested often individuals want their information to be provided to them by unencrypted e-mail and this is required by covered entities to fulfill these request. We expect that they have the capability to transparent PHI by e-mail without unacceptable security risks. So, they first, however, must warn the individual of a risk that the PHI could be read while it's in transit and we note that the 2015 Edition Certified EHR Technology is capable of sending unencrypted e-mail directly.

Now we don't make this requirement for unsecured transmission and then allow ourselves the ability to slap enforcement action on the entity for what occurs while it's in transmission in that format. So, we note in our guidance, in the FAQs, that the covered entity isn't responsible for disclosures that occur during the unsecured transmission to the individual as long as the warning has been given beforehand and accepted by the individual.

Breach notifications do not apply and they don't of course need to safeguard information once it's delivered to an individual, that's always the case, once an individual has the information the covered entity is not responsible for that.

They are responsible for reasonable safeguards and these are quite simple in this context. For example, checking to make sure you have the correct e-mail address, double check that before you hit send on the information. Double check that you haven't included a batch of other people's records along with the individual's record when you send the e-mail and we note that in all other context breach notification requirements apply and there may be liability for impermissible disclosures.

So, here we are in timeliness. I mentioned that it's 30 days plus an additional 30 days if they're unable to provide access within the initial 30 days. A covered entity has to notify the individual within the initial 30 days that they can't provide it and the reason for that. And there's only one extension permitted for a request for access.

We have some clarifications here. It does apply to old and archived information, negotiating with the individual on the format depletes the allotted time as does obtaining the information from a business associate or multiple business associates. This is an outer limit and we expect that there are many opportunities in which many situations in which an entity will be able to provide quicker access and we encourage folks to provide information in pieces if the individual wants that. If they want something as soon as possible.

So, here we have another crosswalk for the EHR Incentive Program. Providers can use covered EHR technology tools to make information quickly available. The reason that we don't require faster access even though a lot of technologies are available to enable this is that there are still some circumstances in which additional time may be needed to locate and obtain requested PHI. And we say that we will continue to monitor developments and consider again in the future whether we need to set higher expectations for all requests in a blanket manner.

Then with respect to timeliness the clinical laboratories are sort of a special case. You see that we still have the 30 and 60 day limits but the difference is that a test result only becomes part of the designated record set when it is complete. So, if a test will not be complete within the 60 days max, after the request is received, then the individual has the right only to PHI in the designated record set at the time that the request is fulfilled.

So, the right...to clarify, the right does not include only what's in the designated record set at the time the request is made. It is when the request is fulfilled. So, you...and in addition, you have the right to obtain other information from the lab related to the test even if the test is not complete.

If the lab knows that a test report is going to take longer than the 60 days from the time they receive the request than it needs to inform the individual of this and the individual may withdraw or withhold their request to ensure that they get access to everything they need and they don't need to go and make, you know, another separate request at a later time.

And then a few last...oh, no, I have another slide after this, but, a few last notes on clinical laboratories. They're not required to interpret results under the privacy rule, they can refer patients to providers, they can provide educational or explanatory materials or other statements. We don't have any limitations on what they can provide along with the requested information.

And here's a little bit about fees and I mentioned that we'll have much more about this in upcoming FAQs, but the general rule is that the permitted fees are reasonable and cost-based for labor, supplies, postage and preparation of the explanation or summary that I mentioned but only if the individual agrees ahead of time.

It doesn't include costs associated with verification of the individual's identity with documentation, searching, going to obtain, you know, sending a member of your workforce to go to a warehouse and find paper materials that are in file boxes. We think that the 30 or 60 day limit is designed to encompass that time and we don't permit charges for that.

Maintaining the systems and recouping capital among other costs are not permitted even if they're authorized under state law. That's a key note here.

So, there's also encompassed in the right to access is the right to direct PHI to another person. This was made clear in the Omnibus HIPAA Final Rule. We require the request to be made in writing and it must include the name and contact information for the third-party as part of the request and otherwise the same requirements for providing access apply.

And we note in state law, if there are requirements to provide access on a shorter timeframe this is not in conflict with HIPAA. Covered entities are responsible to comply with any applicable shorter timeframes but contrary laws are pre-empted by HIPAA and if they're contrary for example they may deny access to information that would otherwise be part of the access right in HIPAA and HIPAA would preempt that and does.

All right, there we go. We have a new and improved website which some of you may have noticed already. It's easier to navigate so I encourage you to take a look and look at the full access guidance.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Good, thank you, very much Marissa it's very, very helpful.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Sure.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Questions? Please?

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

So, first off thank you for the overview and for the frequently asked questions on the website. These are tremendous resources. They are very clear. The guidance is very practical so I really appreciate that. I have, I guess, a high-level question and then some lower level questions.

But on the high-level I was wondering if you could help explain sort of where these frequently asked questions come from and how OCR decides when to address new ones and whether there is a community process by which people can see what other questions folks are asking and say “yes, I care about that too.”

And then in terms of lower-level questions, I am wondering, in terms of manner of transmission, I love the fact that unsecured e-mail is a requirement if patients want it. I think that’s very clear guidance. I’m wondering if there is an opportunity to say something a little bit stronger about some kind of secured submission too.

So, for example, if a patient came and said “here’s the URL, the website I’d like you to go there and upload my record. If you go there there’s an upload button and then please upload it there.” Is that the kind of thing that a patient can say and then assuming that the provider has a web browser that they would be required to comply with or could a provider say “no, we don’t want to do that.”

And then the last piece when it comes to manner of transmission the notion of the security analysis. It would be helpful to clarify whose security analysis on behalf of the covered entity when they do this analysis it would be helpful to clarify that it’s about risk to the covered entities and not risk to the patient.

So, like in the case of removable media the security risk is that if I take your flash drive and stick it in my computer I might get a virus. When it comes to sharing data with your App the covered entity shouldn’t be worried about risk to the patient’s security they should be worried about risk to their own security in those cases. So it would be helpful to clarify.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Right, so we do say that it is about risk to the PHI on the covered entity’s systems and so it wouldn’t apply as you say to risks to the individual’s systems.

As far as a request to upload PHI to a website that the individual request that, like any other manner requested, would be part of the...the entity would determine whether they have the capability and whether it would pose unreasonable risk to the PHI on their system. So, if they determine that it wouldn’t pose an unreasonable risk and they’re able to do it then they would be required to do that, to upload the information to the website as required by an individual.

As far as how we developed the FAQs, many of them come directly to us through, we have an e-mail address that people can go on our website and send us questions and we get so many that we’re not always able to reply to them directly but we do keep them and determine if we’re getting a lot of

questions or if it's a particularly pressing question that we try to address them in FAQs or guidance when we're able to.

And we also get the through our enforcement activities. Sometimes we get a lot of complaints in a certain area and we get requests from our regional offices who are doing the investigations who say, well, we need to know so we can tell the covered entities what their obligations actually are in a more specific way than is provided in the rule and existing guidance and so we'll put that on our list and say, okay, we need to address this in more depth so that there can be clarity for the regulated community and individuals as well as our own investigators.

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Thanks.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Sure.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Great, thanks. Arien?

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

So, first of all I just want to double down on the thanks to OCR and ONC for this clarification. Invariably, people complain about right to access and invariably people are wrong on the facts on HIPAA and what HIPAA permits and requires and this kind of clarification is extraordinarily useful.

I have two maybe detailed questions. I was really pleased to see the clarification on obligation and lack of obligation for breach in the case of providing the patient access to unsecured means and making it very clear that there's sort of a boundary layer where there's breach on the covered entity side and then there's patient responsibility for disclosure when the patients...when the data is effectively in the patients hand or being transitioned to the patient in means that they've requested.

I'm having a hard time...so what I interpret here is that if we think about the App case that Josh raised it seems very clear to me that covered entities have the ability to offer the patient general App access to an App that's of the patients choosing. They may want to put a disclaimer if it's not one of their approved Apps and there's every possibility that the App the patient chooses may send their data to China or some other nefarious place and that this obligation is on the patient. I believe that the FAQ is very clear in making that statement.

What I'm having a hard time figuring out is whether the combination of form and format, and access requirements constitutes an obligation to covered entities if they have the means to do so to open up their APIs to any App. And I understand that's subject to a risk decision and a risk assessment but are there risk assessments that are deemed, if the security spec protects, ensures that the patient is in control of that access, does that constitute an obligation to the covered entity even if their own risk assessment comes to a contrary conclusion?

And the second one, and this may be addressed in your subsequent FAQ on fees, but my understanding is, from your FAQs, that fees are cost-based and that means that even if I have the right under state law to charge five cents a page for a copy of my chart if I have 100 page chart I don't have the right to charge

five dollars if it didn't in fact cost me five dollars to produce. If I have the ability to download something to a PDF and offer it for a lower total labor cost I don't have the right to charge the higher fee. And again, if that's coming out in a later fact that's fine.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Right. So, we...yes, we will address that in the upcoming FAQs. Just briefly, state laws do not override our requirements to charge only cost-based fees. So, even if there are...many state laws have prices that entities can charge to get access to information, I want to note, because I neglected to answer when you asked, and this actually links up with your questions about the Apps, that we have...we launched a couple of months ago a website that's specifically to obtain feedback from App developers and others who want to ask us questions and request guidance in certain areas.

And so we have...we've had a number of questions submitted, we've replied to a couple of them so far and we intend to develop guidance that would respond to these things and that includes...there is some work going on with API questions right now and that hasn't been within my purview at this point, so I don't feel comfortable addressing that but it is being discussed.

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Thank you, very much.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Sure.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Kim, please? Go ahead?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

That's Donna.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Donna, I'm sorry.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

So, thank you very much for the thoroughness of this and the areas that you've highlighted already. I had two questions one of which I think was partially addressed by the fees question. But, my concern is or I'd like to understand a little better the rationale behind the 30 days.

I understand it is an outer limit but the 30 calendar days in providing access as being seen as timely coupling that with the 30 days for a response to someone that a request may even be denied then another 30 days possible extension. A patient or family member has died 10 times over in that timeframe. So, particularly when there is the ability to respond to the request so much sooner by a majority of entities.

And I understand that you're encouraging those that can to do so but really should we not be setting a shorter default and placing the burden on providers to justify a longer timeframe for response to truly have access?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, just to make sure that we're clear, the denial and the provision of access don't...those timeframes don't add upon each other. So...

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Right.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Right.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

But a patient might not even know that you've denied their request until day 29. So, they're still thinking that...

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

I see.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

You maybe haven't received that information within 30 days, they don't even know in that 30 day period when they're waiting, you know, by the fax machine or what have you for their information that it's going to be denied.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Right, I see what you mean. So, we expect that if it is possible the entity will comply in less than 30 days.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

What's the basis for that expectation though as written now?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

How do you mean?

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Is it because...the language says 30 that they have 30 calendar days. So, expectations...

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, we say...

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Are really nice but they don't...

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Right.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

They don't really help.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

We say as soon as possible and no later than 30 days from the time of the request. So, if we go in based on a complaint that we receive and it seems evident that the covered entity could have easily responded in a shorter timeframe then that's something we may take into account in doing an investigation for example.

So, we...it's all down to the specifics of the circumstances. And I think that, you know, for...at this time we are...we decided we were going to stick with encouraging faster access but we're going to continue to keep a view on the situation and see if we want to apply a stricter timeframe across the board to everyone and not...and decide that it wouldn't be reasonable to extend the timeframe for example to have, you know, getting all the information from multiple business associates or to go to an off-site storage facility to go find paper records. So, we'll be looking at that and update it if we think it's appropriate.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Okay. And then the second part on fees, just to clarify further on the point made earlier, so I understand preemption, thank you for that, making sure that others do as well. So, would fees apply only to physical copies just to sort of put it in layman's terms?

So, if you're just...if a practice is simply taking something from their EHR and making it...clicking to make it available in their portal there should be no fees attached to that, are there...can we clarify...are there areas when there really should be access, patient access to their own data when provided in an electronic format is just free?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Are there times when it should be free? I would say the simple answer to that is if there are no costs for labor and copying are those permissible costs? So, we will address those questions more in the fee's guidance but that's the straightforward answer.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

So, the still...the framework in which we're working is that patient data when mixed with healthcare system work is healthcare system property because that's the only way that you could charge me for information that's about me.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, the charge isn't for the information and it's not even for retrieval of the information it's for the labor that may be required to collect all of the information and possibly the cost of, you know, a disk to provide it in that format.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

So, we've made a decision then...I want it to be clear that we've made a decision that that's not part of the provider's cost of doing business that that's a cost that should be passed onto the patient/consumer?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

That is part of the rule.

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

From an agenda time point-of-view we are over. So, if we could make the questions really brief and we'll try to get to the ones that are remaining right now. Chris?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you for an excellent presentation. I have a hopefully quick question. You define the record set rather broad in one of the earlier slides and I have a question about products that historically have been never been seen by patients. So, I'm thinking about handoff, sign-off tools that in a paper world at the end of the shift would go in the "HIPAA box" and be destroyed and as a result of electronic health records now may be retained without any further use. Do they...are they included in your record set?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

If they're maintained and they're used to make decisions about individuals. So it's possible that this type of information isn't used to make decisions about individuals if it is then it would be part of the designated record set and need to be provided to the individual.

We don't place limitations on the ability of the covered entity to explain to individuals the breadth of information and the mass amounts of information that could be included in the designated record set and offer the individual the opportunity to limit the scope of the request to what they're really looking for.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, thank you and I can't see the person next to Josh.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Lorraine Doo.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Lorraine, yeah?

**Lorraine Doo, MSWA, MPH – Senior Policy Advisor - Centers for Medicare & Medicaid Services – Health and Human Services**

Thank you. Just excellent presentation and I just have a quick question. On the right to request access for another individual for the PHI it says it's requested...they have to do it in writing. So is that a paper written request or can it be electronic via e-mail?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

It can be electronic.

**Lorraine Doo, MSWA, MPH – Senior Policy Advisor - Centers for Medicare & Medicaid Services – Health and Human Services**

Oh, it can, okay, great, thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Lisa?

**Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society**

Yes, thank you, I would say the FAQ is exceptionally written and very clear. So, my questions are more around redress for the patient and also enforcement. So, with regard to the patient, you know, I'm asking these questions based on some personal family experience, if patients encounter a provider that doesn't have a process at all and isn't cooperating, you know, what do they do? Because I looked on your website and I can't really see any place to deal with that except for perhaps as a submission of a privacy violation that's my first question.

Second of all, do you plan to address this issue in the HIPAA audit that you're doing this year?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

So, with the first question that, is a failure to provide access, is a violation of the privacy rule so filing a complaint would be the appropriate action to take in that case. And what happens with complaints is that they first go to our central intake unit and many of those can be taken care of without even farming it out to the regions for investigation. We have our central intake unit can call and provide technical assistance to particular providers which sometimes can, you know, make it happen a little bit more quickly and explain their obligations.

If the provider then doesn't, you know, cooperate with us and provide the information to the individuals then it would go to the investigation stage.

And the one...we're very interested in this right we see it as a foundational individual right in the rule and we have, you know, our example of civil money penalty that has been imposed was for a covered entity that, you know, denied access to 41 individuals over a period of a couple of years and failed to cooperate with us, which is one of the reasons it took so long to get this resolved, and we imposed a several million dollar penalty for that failure. So, we see this as very important.

As far as audits, I haven't seen the latest protocols for the upcoming audit.

**Lisa Gallagher, BSEE, CISM, CPHIMS – Vice President, Technology Solutions – Healthcare Information & Management Systems Society**

It seems to me that there's, just from personal experience, a lot of noncompliance with this. So, it might be good to try to get some sort of level set as to, you know, what set of providers just aren't providing this capability at all and, you know, aside from an FAQ maybe a little bit of a stick in terms of we're going to enforce this.

And also, going to the privacy violation process to make a complaint on this seems cumbersome and time-consuming for the patient. So, you know, if you all have a way to sort of gauge where providers are

on this and move it forward aside from the onus being on the individual to complain that might be...I mean, it's just so common and, you know, it's unexplainable to me, so just some input, thanks.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Sure, thank you, I'll take that back.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**  
Okay, thanks, Dixie, please?

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**  
First I do want to thank you for this guidance and for your presentation today. I can tell you that the patient advocacy groups and labs that I work with were both really pleased to get this guidance, it answered questions that they had been asking for some time. I have a suggestion and a question.

My suggestion is, the guidance that came through my e-mail was fantastic that Lisa was talking about but it's hard to find on your website.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Okay.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**  
And in looking...I had to go back to the e-mail to get the link to find that, oh, it's under guidance for professionals not guidance for patients and I think that it should be easily accessible for both, guidance for providers and guidance for patients.

And secondly, so that's my comment/suggestion. And my question is regarding the right to direct PHI to another person. How specific must that request be with regard to a person? For example, can the person be a hospital? Can it be a department or does it need to be an individual? What's the guidance there?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
That will be addressed I believe in the upcoming next set of FAQs when we go into more detail about the right to direct to a third-party. As far as...I appreciate the comment about the website. We do have it right now as prominently on the landing page, the main page, so you don't have to click through to for consumers or for providers.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**  
I couldn't find it.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
There's a big image on the right side of...

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**  
Okay.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Just our main landing page.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Okay.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

And I think the reason that we have to under providers is because it's written fairly technically and we always try to make it accessible enough that people can understand, but it's not written to be directed toward so much people that have to...that don't have to comply with it and we're working on additional materials that will be more accessible to the general public. But if you think it would be helpful to also link to it in the consumers than I can bring that back as well.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Yeah, I think it has a lot of content that consumers would have no problem at all digesting.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Okay, thank you.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Good, thanks, Devin? Devin? It is Devin isn't it?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

David Kotz.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, that's a long way.

**David F. Kotz, MS, PhD –Champion International Professor, Department of Computer Science – Dartmouth College**

So, I wanted to follow up on the designated record sets. I guess I'm just curious how would a patient know which records to request? Is there an expectation that they can see or ask for a list of the types of records that are available so they can make a well formulated request?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, they can certainly ask for a view before they make the request for a copy so that can be part of the process of narrowing down the information that they're really looking for.

**David F. Kotz, MS, PhD –Champion International Professor, Department of Computer Science – Dartmouth College**

In that case a view would be for everything that is about me and then I would choose what I want a copy of that would be one approach?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

That's one approach. They could also...I mean, often patients have an idea of the kind of information they're looking for even if they don't know what part of the record it might be in. So, entities would be expected to, you know, communicate with the individual and help them figure out where in the designated record set that information is.

**David F. Kotz, MS, PhD –Champion International Professor, Department of Computer Science – Dartmouth College**

Okay. A related question, is it...is there information about which parts of my record have been shared with whom something I can request as part of my download?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, you can request an accounting of disclosures.

**David Kates – Director Interoperability – The Advisory Board Company**

Okay, that's separate.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Another individual, right, under the...

**David F. Kotz, MS, PhD –Champion International Professor, Department of Computer Science – Dartmouth College**

Okay.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

The privacy rule.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

And Michelle is there someone on the phone?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

It was Paul Egerman but somebody asked his question.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, great, thank you. Troy?

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Thank you, Paul. It seems like slide 28 is getting a lot of attention. The...I think the right to direct PHI to another person...I'm glad to hear that there's going to be a follow-up FAQ with that because it does raise a lot of questions and I really wouldn't have asked it until...but you included it on the last slide so I figured I would do it.

I'm really curious about the requirements for providing access. I know Lorraine asked about it and Dixie asked about who, what and how that would actually work but the...how does this tie into the opt in/opt out provision that's already there?

And looking at established business associates, much like what was just asked about, the different components of the medical record, I mean, if a provider is sending someone to a specialist or to home health, or physical therapy will the patient be required to look at the different packets of information and say, yes, that looks appropriate to be shared with another provider or business associate? I mean, does the same provision hold true? Do they need to give that permission as far as like what specific items within the medical record are shared with whom? Would that come out in the FAQ?

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, we wouldn't have...the patient wouldn't need to decide, you know, which packets of information, as you say, they could receive. They could say, you know, I want all the information about this and if information about their particular condition is held within the same entity by, you know, a specialist, their primary care provider then the covered entity would need to compile all that information about that condition for the individual. So, there certainly wouldn't need to be request made to each different department within a covered entity.

And as to opt in/opt out I'm not sure to what you're referring to with that?

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Well, the standard provision is that, you know, if you agree to go to a specialist and the physician says, you know, we'll need to share this information you've basically opted in, but what I see here is actually you have to give permission to have that happen in writing and whether it's in electronic form in an e-consent or whether it's through an actual form. It just seems odd to me that if I agree to go to see another provider that I actually have to give a written consent to have that action happen.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

No you don't. There doesn't need to be a consent to share information between providers for treatment purposes that is a permitted disclosure under the privacy rule. So, covered entities are permitted to obtain consent to do that type of disclosure but we don't require it, the individual doesn't have to sign anything to have their primary care provider share information needed for their treatment with a specialist or with any other provider really.

So, the difference here is that you have to, you being the covered entity, you have to comply with the request to provide information in accordance with the access request which is different from sharing the information with another provider which is good for your care but it's not required of the initial provider and even filling out an authorization for them to share information with someone does not result in a requirement that the covered entity share that information. So, this is the way to make sure that if you need your information for yourself or to give it to someone else for whatever reason then this actually requires the covered entity to provide it.

**Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente**

Okay, thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you and finally, Eric?

**Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects**

Thanks I think this will be great guidance for providers. I think among the audience for the meetings of this committee are the EHR vendors and more and more EHR vendors are actually storing PHI in the cloud for providers and more and more we see scenarios where a provider will stop using a cloud-based EHR so the provider no longer has access to the PHI.

And I'm interested to know what the law is going to require of the EHR vendor who presumably has a status as a BA in this scenario. How can the healthcare consumer get the PHI that they have a right to from the EHR vendor? What are the responsibilities of the EHR vendor? Keep in mind also that these EHR vendors may get acquired, merged, go out of business and they need guidance I think on what provisions they need to make in order to ensure that the data never gets...becomes inaccessible.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Right. So, a few pieces to that, one is that we're working on guidance specific to the cloud. We have a whole series of questions and answers that we've been developing that are related to cloud providers and their, you know, respective responsibilities of the covered entities and their providers as a general matter...and a general matter they are business associates of the covered entities.

As far as ensuring access to individuals the covered entity is responsible for ensuring at the front end when they make their contract with the BA, whether it be a cloud provider or whoever else is going to maintain information with them, they're responsible to ensure that they will have the ability to fulfill individual's access requests.

So, if the covered entity doesn't maintain certain information and it's only maintained by a particular business associate the covered entity has to make sure that they are able to obtain that information to provide it to the individual.

**Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects**

That would be an important thing to, I think, publicize because I doubt many, especially small practice physicians, are aware of that responsibility.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**

Well, they also have a responsibility under the security rule to make sure that there is availability of information they need to access in an authorized manner. So...and we will be talking about a variety of these responsibilities in that cloud guidance.

**Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Well, thank you, very much, again, Marissa, this has been a...one, thank you for putting out the guidance in the FAQ. Two, as evidenced by the response and questions you got this really touches a lot of folks interests and I think we're just partly reflective of the broader community. And three, how complex the

world has become from a technology point-of-view. I mean, what Eric just brought up was one of those things you don't think of often, but these are all questions that are coming down the pike.

So, we look forward to your future guidance and thank you for your generosity in coming here and your answers you provided, they were very clear in this very complex field.

So, thanks to everyone for your forbearance. I thought this was so interesting and useful, and reflective of broader national opinion that we should continue. But we are running behind so we'll transition. Thanks, again, Marissa.

**Marissa Gordon-Nguyen, MPH, JD - Senior Health Information Privacy Specialist - Office for Civil Rights**  
Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, we'll transition to the ONC updates and we have Elise, Steve and Andrew on deck.

**Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology**

Good morning everyone, so we are running a little bit behind so between the three of us we might go through this pretty quickly. I will try not to bring back my New York fast accent too much but I'm going to try to move us along. If you do have questions on very specific parts of this we're happy to stay behind and answer them on the side as well or to do a follow-up presentation.

So, today we're going to talk a little bit about kind of ONC generally and some of the updates we're doing across the office. So, I'm presenting on behalf of a number of offices here not just in terms of the Office of Policy we are definitely a team and this is one of those indications.

So, today we're going to talk about some of the recent releases we'll do a programs update, some of the work that's happening in the Office of Programs and then we'll talk about our continued work to support the care continuum at a broad level.

So, first, this is actually a CMS piece but we worked very closely with them and there is an RFI that's actually out right now, comments are due back on February 1<sup>st</sup> it focuses on CQM certification. It's partly an opportunity for us to learn more about the needs as well as to learn about some of the burden that might be associated with CQM certification and what's being experienced on the ground.

The impact on it is not just in terms of EPs in terms of MACRA for example but it's across the field so it's EPs, EHs, cause and health IT developers generally and any other stakeholders. So we do encourage you to please take the time, if possible, look at the RFI and if there is some interest among you or your organizations to please submit comments. Again, the deadline is February 1<sup>st</sup>.

Second, we'll talk about the State Health IT Policy Levers Compendium and this is a project of our Office of Care Transformation that's led by Kelly Cronin. This is a great project and this really speaks to our work not only from the larger landscape but also to look at what's happening at the state level and in some ways to help to provide resources for those states to see what's out there.

So, in some ways you can think of it as best practices another way you can think of it is in terms of providing examples of how accomplishments are being made at the state level regarding health information exchange, regarding the movement of information even things down to risk adjustment and so forth.

So, the compendium is available on our website, on the health IT dashboard, it focuses on peer-to-peer learning and it supports a variety of use cases, so not just MU which tends to be the buzz word that we hear a lot, but really across the landscape in terms of what states are doing.

This is part of our work to support the roadmap and implementation of the roadmap which calls for state focused calls of action. So, we're hoping that this would be a resource to states to see about the amazing work that's being done.

There are three key parts to it, one, the policy lever directory is a list of 32 distinct policy levers and includes an amazing range of activities, accountable care activities, advanced directives, advanced primary care, eQMs, even episode care risk as well. So, it's a diverse spectrum that you can search and you can see what are the activities that you as a state or someone involved with states is interested in learning about and what states are actually doing that work. It provides a really great summary of the type of work that's being done as well as contact information for the states that are doing the work.

And here I won't spend too much time here, but it's pretty tiny, but for those who are looking on the webcast it might be a little bit bigger. So, this provides kind of a quick snapshot of what it looks like and as you can see it's very much a kind of chart-based system, it provides a really good overview of the program and how they're accomplishing it. So, please check out the health IT dashboard for that information and if you have more questions please feel free to reach out to me or Kelly, or anybody else on the team.

So, next we're going to do an update and I'm going to breeze through these pretty quickly given the time but these are some of the programs that the Office of Programs is working on in terms of reaching out to a variety of sectors and impacting health information exchange and interoperability at diverse levels.

So, first is the Advance Inoperable Health IT Services to Support HIE Program. This was launched in September and it works on leveraging investments and lessons learned from the previous State HIE Program. It's a \$29.6 million dollar investment, has 12 awards that span over 2 years.

The goals are things like technical assistance, training, education, exchange services and really focused on that send, receive, find and use of health information. Likewise, the goal is to also provide technical assistance and workflow design support, which obviously we hear a lot about as well, and to incorporate the use of data from these external sources into the daily clinical activities. And this is a list of the awardees.

The next is the Community Interoperability and HIE Program and the purpose of this one is a smaller set, smaller focus in terms of the grant awards but to create projects at the community level to increase HIE adoption and use among care providers.

One of the key things I wanted to point out here is you'll notice from the target population a number of them do focus on behavioral health and this is part of our work across ONC to think about how to

support the broader care continuum and what are the needs and where are the gaps and how do we figure out how to address them. So, you'll see behavioral health is noted here. We're also working with SAMHSA in terms of the execution of this project as well.

And the Community Health Peer Learning Program, this is a \$2.2 million dollar project over two years focused on helping clinicians, organizations and communities learn and improve the health of the residents. As you can see here this is a project that's being run by Academy Health and we're working with them very much on the functions and their operating as a national office for this project. The goal is really to think about best practices again and tools that can be used across the care spectrum.

And then the last one I want to mention is the workforce training to educate healthcare professionals in health IT and this one is a \$6.7 million dollar over two years to update training materials from the original program. There are four key focus areas population health, care coordination, value-based payment in new care delivery models and healthcare data analytics.

Across those four however there is a woven thread of patient-centered care and it's something that you've heard a lot of from us as an office and particularly the Office of Policy is very focused on this as a number of positions and what we're doing from our rules as well as our work with different agencies such as CMS on this.

In addition, this program will also train 6,000 incumbent healthcare workers and this again is part of making sure that the health continuum includes those new providers who are coming in, in terms of the use of health IT and how to incorporate it in their daily practices. And these are the awardees for the workforce training program. So, I think I'm doing pretty good, going pretty fast. Okay, I got the okay from Michelle so that's good.

All right, so supporting the care continuum through the ONC Health IT Certification Program, many of you who have heard me speak this is pretty much my mantra, I say it all the time, we're thinking about the diverse health IT spectrum, how do we make sure, how do we ensure and how do we incentivize the use of health IT at a variety of levels. Part of that is through supporting innovation, part of that is making sure that there is a baseline of functionality that's able to be used as well as the standards-based work that Steve is doing and can talk about in a little bit.

So, here's a quick refresher. So, the 2015 edition final rule which was released in the fall is in effect. Steve is doing a great job of implementing that rule as we move forward in terms of test procedures and such, but I did want to highlight, again, some of the key goals that we sought to achieve in that rule and that you will see weaved throughout our work in the next...in the coming years.

So, improving interoperability and that's including things such as the common clinical dataset, what is the core set of information that should be able to move, updates to the base EHR definition, including provisions on care planning for example, the optional provision of data segmentation for privacy. So there are a number of different things and ways that we are thinking about the diverse care spectrum.

We've also updated the privacy and security capabilities in the rule as well and focused on health disparities and what does that mean. So there are things that we thought we could do from a health IT perspective to enable providers and to enable the learning health system to be able to think about how to better serve patient populations whether that's your particular patient population within the practice or looking a little bit more broadly.

So, with that in mind we included some criteria optional on social determinants of health as some would put it. Those include things like psychological data, educational data, etcetera. We've also included, as I mentioned, the DS4P standard.

And then we included deeper standards on race and ethnicity and the goal there is to really build on the OMB standard which is a pretty high standard, high-level standard in terms of what's included there and to allow providers to better see what's happening within their populations.

Other parts we included were data access and exchange, so updating provisions in our rule related to that, patient safety is another key part of that and Andy is here as well on the safety side.

And then transparency and that goes to thinking about data moving and how to have data move in an effective way to the benefit of the patients and to the benefit of providers and we think that requires the entire health IT landscape from developer to patient, to provider and all other stakeholders.

The last two at the bottom are what I want to focus on a little bit here today and that's supporting the care continuum so we're thinking about, obviously, the EHR Incentive Program and how that program is evolving over time and we're also thinking about other settings.

So, here, and I'm just going to focus...I'm going to go all the way down to the bottom bullet because you've seen this slide if you've seen previous presentations I've done where there are a number of different programs that point to our work and they say use health IT, use certified health IT standards to accomplish what you want to do and those are requirements or part of a variety of different programs.

But MACRA is one of the main ones that we're hearing about lately and how certified health IT will be incorporated in that is something that you'll see come out and be kind of part of the conversation in the coming months and that's part of the MACRA rule that we expect to come out in the spring as well as some other activities that we'll be working on.

And with that I just want to highlight a couple of key pieces from MACRA. This is a part...some of these pieces you've seen before from Kate Goodrich's presentation to us in the fall so I'm highlighting a couple here in light of some of the great things that we've heard in the past few days.

So one, what is MACRA, so MACRA is an update...a law that was passed in April of 2015, it focuses on two key programs that I'm going to highlight here but there are many great pieces to MACRA but I do want to highlight the APM and advanced models as well as the Merit-based Incentive Program. So, those are the two that you'll see a lot of conversation about certified health IT and those are weaved into and incorporated into those programs. So, ONC looks forward to continuing to work with CMS to determine what's the best way to incorporate that into those particular programs.

So, the who is a little bit different from what you guys might have seen in MU under HITECH. So, under HITECH it's eligible professionals as well as eligible hospitals and CAHs, and Medicaid as well. Under MACRA it's really a focus on those EPs so it does not include eligible hospitals, it does not include Medicaid providers.

As Dr. DeSalvo and Administrator Slavitt mentioned yesterday in a Blog, we do look at and are considering how best to align what we're seeing or what we're thinking of from MACRA with the other programs. So, look forward to that and please keep your eye out for some of our work in that space.

In terms of how MU fits into MACRA for those eligible professionals there is a 25% composite score under MIPS and there's also pieces in the APM section but in terms of MIPS there's a 25% composite score and that focuses on the Meaningful Use of certified health IT technology so we're working hand-in-hand with CMS as we think about what that looks like and how best to move the use of certified health IT forward to the benefit of providers and to patients.

So, I talked a little bit about this already in terms of Medicaid and EHRs and in terms of our continued work to align and make sure that we're thinking about the entire health IT spectrum as we move forward.

Listening and learning, and this is a really key part of what we do, and we've been doing a lot of this and that is indicated by what we've done in the fall with the request for information that was released on MACRA and that went out, comments have been taken in and we will be using those, along with CMS obviously, to think about certified health IT and what it should look like in terms of MACRA.

In addition, when CMS released the Stage 3 component of their EHR program rule in the fall they included a public comment on Stage 3. Those comments as well will help feed into and help us think through what would be helpful as we move forward to a new world focused on the next step for use of certified health IT and use of health IT as we think about what is necessary for the provider as well as to the benefit of the patient.

So, generally, as we think about moving forward, and I think Dr. DeSalvo and Administrator Slavitt did a wonderful job of articulating this in the Blog, we're moving towards outcomes, we're moving to how to think about certified health IT in this next step. We've had a lot of accomplishments in terms of the adoption of health IT and as we move forward we are listening and we are learning as we move to this next stage.

So, the ONC certified health IT program will continue to flourish in this environment. We'll continue to think about it. We'll continue to incorporate it across HHS as part of delivery system reform, as part of MACRA, as part of a number of other programs. For example, it's also included in the chronic care management provisions in CMS rule.

So, we are a...in some ways you guys have heard me say this, we are a buffet of sorts in terms that we provide a number of different functionalities and capabilities in our rule. And our goal is for those be of use...to be of use to a variety of programs and we work very closely with our federal partners to do that.

And we also recognize that there are number of different settings that benefit from the use of certified health IT and we've been working with them as well. So, for example you've heard a lot of conversation and what we've been doing in terms of long-term post-acute care providers, behavioral health for example, and we will continue to do that work. So, we look forward to working with all of you as we embark on this next stage of adoption of health IT.

And here I just noted some of the resources that are already available, as I mentioned, Kate Goodrich did a wonderful job presenting on MACRA and her presentation is available on the [healthit.gov](http://healthit.gov) on the FACA portal website as well as the Blog that was released yesterday, please take a look at that.

There are some limits to what we can discuss, obviously, and I'm going to put on my Office of Policy hat here. There are some limits to what we can discuss because we do expect a lot of this to rollout in the spring but do engage with us and continue to keep your ears open. And I will stop at that because I think we're short on time. Hopefully, I didn't lose too much. I'm going to turn it over to Steve now.

**Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

I need the clicker. All right I'm going to give a couple of quick updates, many of my colleagues, including Karen earlier stole some of the thunder about some of the updates that I have. So, one of the things just to thank everybody again is for your participation in the interoperability standards advisory process. We've published the 2016 version at the end of the year. So, thankfully stuck with our process going forward. That kick starts our 2017 process in this kind of annual, continuous feedback loop as we engage with folks.

So, one thing I wanted to call out to your all attention is we did open the comment period on the final 2016 version yesterday, that will be open for a round. That will then feed into additional work that we've got going forward with a new reconstituted Task Force to take a look at the standards advisory as it's been shaped now.

Important to mention, as we finalize the version that we published in the fall, it includes a significant expansion of the amount of context that we put around the different standards and implementation specifications and that's in part due to your all feedback as well as other industry stakeholders and I think that is really important in terms of providing both as we look to our federal partners that may look to the standards advisory, as well as those of you out in the field, the relative adoptability and maturity of the particular standards or implementation specifications represented therein, as well as giving us an opportunity to kind of baseline where we're at with particular interoperability needs and how we're meeting them with particular standards.

So, there is a Task Force that we're going to assemble in the work so if you wanted to be on it last time and you didn't get a chance to be on it this time the opportunity is evergreen and we will certainly appreciate your input, as well as looking at where we need to make improvements in getting some additional expertise, SMEs, for particular areas of the advisory.

The other thing, as Elise mentioned already, we are hot and heavy in finalizing all the 2015 edition related program execution components. We've published close to 50% of the finalized test procedures for the 2015 already and are scheduled to publish the remaining 50% by the end of this month.

We're also, and I think you'll hear from your colleagues presenting on the EHR comparison related activities, working on finalizing the development and transition to what we're calling the open data CHPL which will have kind of an expansive set of the computable data relative to the products as well so that's kind of our contribution to the data that will be available to use that have gone through our program.

Many of you have seen, but I wanted to update you on efforts afoot with our cooperative agreement with HL7. They had, prior to their most recent workgroup meeting a couple weeks ago or a week ago, an implementation-a-thon related to the Consolidated CDA, yes, yet another "thon" to keep track of, but it

was really helpful and it got a lot of feedback from the participants. I think my value judgment of the feedback was, you know, folks asking why they hadn't had that before which was really good feedback.

We also kicked off a challenge with HL7 about how to better render the C-CDA, so getting at some of the user experience as well and that challenge period is open through May, if I'm not mistaken, so that's one thing to look out for. There is going to be more implementation-a-thons, there is going to be other work going through relative to C-CDA as well.

And then, all of this really rolls into the interoperability roadmap and I think it's suffice to say to be succinct. There is not a speck of dust that is being collected on that roadmap. We are actively working on it and using it as our guiding kind of document as we look to our 2016 plans, 2017 plans, as we look across agency collaboration, the milestones that have already been highlighted in terms of the guidance released by the Office of Civil Rights, work that Elise has highlighted by some of the other ONC offices, and I think that probably wraps up what I wanted to cover today with my remarks. So, I will turn it over to Andy.

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

Good morning, thank you. This is an update from a little bit of a presentation I made last summer and I'm not going to revisit it, but I want to remind you about the context. This is essentially five years' worth of serious documents around health IT safety.

What's happened over the past year is, as we spoke about in July, we came forward with a roadmap for perspective health IT safety collaborative. Now whether you call it a center or a collaborative, a collaboratory the word doesn't matter, the name doesn't matter, but what it is, is a non-regulatory, public/private partnership with seed funding from the government that over a five year period is anticipated to be self-sustaining.

It is still a proposal and in order to go forward a number of things have to happen. It's also important to talk about the safety-enhanced design that was incorporated into our rule in the fall. So, as you see what we're trying to do. We're trying to incrementally advance the consideration of safety in software design and development.

I think anybody who's actually been a clinician using this recognizes though that this is not quite enough and so we have to look beyond just the certification programs. We have to start looking at things like total quality management, how institutions choose to implement the EHR and then also how clinical users take the responsibility to learn how to operate it safely.

In order to comment on safety we have to be able to measure it. If you don't measure it you have no data, no baseline, no opportunity to improve. So, we're partnering with NQF, this is one of my colleagues, David Hunt's initiative, and NQF is prioritizing and identifying patient safety measures. Those measures will again inform a baseline.

So, Level 1 measures addressing safety concerns. Level 2 ensuring the safe use of technology and avoiding unintended consequences, something that we've seen. And then Level 3, which is really where we all want to get to, and believe exists in many ways today, that's using health IT to make care safer.

Going back to the roadmap, well, what happened? We brought forward a roadmap last summer, what's happened in the interval? And so what we've done is...not to implement the collaborative but to test some of the hypotheses that were brought forward by the Roadmap Task Force is we've continued to work with RTI to identify a specific opportunity and then to use the process that's envisioned as a methodology to explore how the roadmap would work.

We've chosen, actually it was a group choice, medication management and that work has kicked off and we're pretty excited about it. So, the first challenge in that is, could we convene a group and we've been very successful in convening the group. I'm going to skip that slide and try and make up a little bit of time here.

So, we have convened a group. We are acquiring the research evidence to support that and depending on the outcome we expect to disseminate that and that may be additional tools, guides similar to the SAFER guides or it could be an understanding that some institutions or entities actually do this really well today and trying to disseminate their tools or resources more broadly.

And as I've come in to the safety group I'm impressed at how much content we have and how little it's been disseminated and understood by the broader community. So, we will continue to work on that.

We also want to call out some of the private sector initiatives. ECRI Institute has a partnership for a health IT patient safety that we're participating in. They've had two workgroups focused on some of the thornier issues that we face, Copy and Paste Workgroup and then a current workgroup Patient Identification Workgroup had a wonderful meeting yesterday on that topic and I will not violate any of the rules Jon but I will say that it is a passion for many of us having to clarify and improve how we identify patients.

I had on my slide also the CHIME kickoff, yesterday's million dollar Hero-X challenge prize, a number of us worked behind the scenes to support that initiative. AMA and MedStar have a partnership on EHR user centered design, an evaluation framework, that we anticipate good things coming out of.

And then the PEW Foundation had engaged in health IT relative to the implantable devices and UIDs which are now part of our regulatory requirements. They've also hosted an EHR usability meeting and now they're currently exploring other initiatives in health IT.

So, the federal government is not able to do all of this work on its own. We depend on the private sector and support and acknowledge the important work in the private sector.

I've gone very quickly. I believe I'm done. So, if you have any questions for any of the three of us please have your cards up.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's great, thank you. Thanks for going through so quickly and it's an enormous amount of work that goes on all of the time in this office. Floyd?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is a great summary and thanks to all three of you. I do have a question about the measuring EHR safety issue. I know it's challenging and the issue is just looking at the EHR from a certification stand-

point is it necessarily sufficient, it's how the EHR is used in the setting to see...there with two components how it's used in any one setting not just what the EHR can do.

And the concern I have is about the challenge we've had with trying to get data from EHRs to measure quality which I'm not sure we're close even. And we don't want to necessarily overburden providers with extra work to prove safety, on the other hand is the EHR data that's captured in provenance may not be enough to get us there. How is that being approached and how do you see that working?

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

Those are great questions, thank you. First of all, I think my personal belief and the belief of many at ONC is we have burdened our clinical community far too much with expectations for reporting and I believe it's up to us, the broader community, to continue to go down the road to better relate evidence of quality and safety that will not require burdensome reporting.

Having said all of that it's a lot harder to come up with some of the clinical quality measures that are all electronic that don't require some engagement but I think we're committed to doing that and my team is certainly collaborating with other folks who are in that space both CMS, AHRQ and NQF. So...and that process today is pretty challenging, we're looking for ways to streamline it.

On the safety side, what we've proposed is a collaborative that we will have, with statutory additional protections, the same kind of protections for developers that currently providers have and hospitals have relative to discovery of safety processes. We believe that's important. We believe that the EHR developer community will welcome participation in this and will be able to share between themselves in a very positive way that's not currently happening with deference to intellectual property rights that each of those companies have.

So, that's what we're thinking but there are also some other methodologies that have to do with if I prescribe a medication and then cancel that medication or do an order and cancel it and then reorder something that is an inherent single in the system that we can look at. A number of researchers have already gone down that road. A number of researchers are starting to look at the incorporation of patient pictures in pick-lists to do the internal within a system identity improving identity management. So, there are a number of things that are emerging that I think are quite exciting.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Arien?

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Thank you. Thanks to all of you this question is mostly for Elise. There's been a lot of confusion I think about the place of the Meaningful Use Program and I'm just going to repeat back what I think I've learned over the last few days with Karen and Andy Slavitt's Blog post and your presentation.

In summary, far from being dead Meaningful Use is actually legislatively required both for EPs in context of MACRA and MIPS and for eligible hospitals, and critical access hospitals, and the Medicaid Program. The provisions of the HITECH Act that require Meaningful Use are still there, still in place and still exist, so that's number one.

Number two is at the same time CMS and ONC acknowledge that there's been a level of frustration and burden on providers and are seeking to reconcile and harmonize the various programs and reporting under the various programs that are in ways that are more outcome oriented and more streamlined some of that will come in the MACRA NPRM and some of that may come through other approaches to streamline and harmonize programs and that's been consistent with what Karen and Andy have said.

And then I think the third piece that maybe has escaped many providers is that because CMS operates in a two-year measurement year to payment adjustment year the MIPS portion that incorporates Meaningful Use was well as quality measurement and quality reporting and measurement would be 2017 for a 2019 measurement adjustment year under MIPS. So, this stuff is not theoretical it's actually coming and coming rapidly. But the general sense is that CMS and ONC are working very hard to align programs making them easier to report and making them more outcomes oriented. Do I have that as a general statement relatively right?

**Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology**

Yeah, I think generally. I think your last comment actually really sums it up. ONC and CMS, you know, we've worked hand-in-hand in the past all the way going back to the early pieces of the health IT adoption and now as we move towards a more outcomes oriented environment we're listening to what we're hearing from stakeholders whether they are on the patient's side or the provider side, or the developer side, or any other part of the health IT equation to really think about how to update the program and prepare us for this next age of innovation.

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

That's great, thanks. Patty?

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Thank you. This question is for Andy. Andy thank you for your work in patient safety and health IT. I have a concern and maybe you can set my mind at ease. It seems like over the last couple of years there have been a lot of entities and organizations that have been jumping on this health IT bandwagon.

So, just jotting down a few, you know, we've got ECRI, there is NIST, FDA, NQF, PEW, AMIA, MedStar and the Association for the Advancement of Medical Instrumentation that you and I have involved with.

So, my concern is that how can we ensure that there's no redundancies in efforts here and also that these different entities aren't creating different standards?

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

Patty that's, as always, a great question and a probing question. As most of those entities engage with us and we participate with all of them I think what could potentially be duplicative and overlapping is unlikely to be so because of that cross-fertilization and it's almost no matter which meeting I go to it's the same lovely group of people who are really committed to this.

And in fact one of the things I worry about is how do we get a broader group of people engaged in the same way. AMIA, the meeting that's happening actually today...

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Right.

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

Which is where Mike McCoy is representing ONC, is working hard to develop standards, it's a standards organization development. It looks very differently than the ECRI Initiative which is a consortium of folks who've come together to look at some of these problems.

Our proposed collaborative is anticipated to be hosted by an organization already doing health IT safety work. And so whether it is...and it would be inappropriate for me to comment on potential placements before the program is even fully funded and authorized, but it makes sense that those communities will be synergistic with the collaborative. And if you look at the Task Force to the roadmap almost everybody you mentioned was involved in that roadmap development. So, that gives me confidence that we're not going to have problems.

**Patricia P. Sengstack, DNP, RN-BC, CPHIMS – Chief Nursing Informatics Officer – Bon Secours Health System**

Okay, thank you.

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

You're welcome.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Great, thanks. Dixie?

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Thank you. My question also is for Andy. And I have to admit I haven't read these reports so this maybe a naïve question, but I was wondering to what extent security is considered such as denial of service attacks and attacks on data integrity where the data are actually corrupted. And also, you know, even involvement with the health iFacts, you know, threat reporting and all of that, and all of these, obviously, have safety implications and I was just wondering is that considered like, well that's what they're doing or is that an integral part of what you're doing?

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

So, Dixie your questions are always very well spoken and articulate. The security aspects that you mentioned are things that we certainly think about and are obviously part of the security rule and we think about them in a safety context as well. I think when I think about the collaborative though we're not trying to bound it in terms of what they cover.

If you look at the...it's about a 35 page report that is on the website healthitsafety.org, I'll make sure I get it to you, it talks about different work streams and I would imagine that this issue that you brought up would be a work stream but those work streams would be identified by the director in the oversight group based on the group's perception of what are the most significant risks.

The reason we chose medication management is in the reports that have come out in the past year whether they were the Joint Commission Report, the Pennsylvania State Authority Report, the CRICO Reports, medication errors or errors in the medication management continue to be the number one issue. So, again, it's...we're taking the Willie Sutton approach, go to where the money is. I hope that helps.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

But data integrity does effect medication management.

**Andrew Gettinger, MD, FCCP, FCCM CMIO – Chief Medical Information Officer; Acting Director, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology**

Absolutely, absolutely, I completely agree.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Thank you.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Jitin?

**Jitin Asnaani, MBA – Executive Director – CommonWell Health Alliance**

Thank you. So, first of all, thank you all for summarizing all the work that's going on. I know trying to summarize all this activity in a handful of slides and presenting in a few minutes is not easy, so thank you for doing that so eloquently.

This question is probably primarily for Elise and the question, it's actually not a question it's really just some advice. This...I'm looking at the Advanced Interoperable Health IT Services to Support HIE Program, first of all we might want an acronym for that.

But second of all, I'm looking at the target areas of focus around behavioral health, etcetera, etcetera here on slide 10, I guess it is. These are extremely important areas totally underserved today, very appropriate that there is some time and money and effort being spent on trying to figure those out.

Here's where the advice is. There is a goal...the first goal outlined here is expand the adoption of health information exchange technology \$30 million dollars through a grant program is not going to do much to push that, you know, in by itself but it can do a lot in concert with other waves of adoption being driven through the industry. Both vendors who are...who are just producing more better interoperable products, data sharing networks like CommonWell, eHealth Exchange who are going national and groups of health exchanges whether it's HISP or HIEs who are getting together and just getting work done and interoperability done at a national scale.

In any of those cases make it a proactive sort of connection between the work that's happening here and the work that's happening in those communities because you'll get the scale from those

communities not from the \$30 million dollar grant program. So, that's really all it is. I'm sure it is being thought about it just didn't pop out from the slides.

But I'll tell you one thing, the most...one of the most interesting experiences I had in the last couple months, which was almost a shock for me, was somebody from ONC, I think it was Jonathan Coleman from S&I Framework, called me and said we have something that might be interesting to your product roadmap and we want to talk to all data exchanges about it and he called me and we actually...he presented it and it actually became something that we are now thinking about how to incorporate in our roadmap and it is 100% aligned with ONC it actually came from ONC. It was not one of four zillion things happening at ONC, which we had to somehow keep track of with a staff of just one person, that's myself, and then figure out when to plug ourselves in.

So, there are opportunities to do a little bit, there are little things that actually make a big difference in the scalability and you guys are handling a ton of programs. So, just want you to make sure that you're continuously thinking about how do you get that scale beyond the pulpit of being, you know, ONC where everybody is otherwise looking to.

**Elise Sweeney Anthony, Esq. – Acting Director, Office of Policy – Office of the National Coordinator for Health Information Technology**

Thank you. I think that's a great point. So, a couple of points I will add there. I will definitely share that feedback with Dr. Tom Mason and...who are leading the Office of Programs and leading this work. Also, I think you raise a good point in terms of we are doing a lot at ONC, there are a number of different programs and a number of different offices that are accomplishing a number of different tasks and we are all excited about that work and we definitely want to continue to have a forum where we can share that work with you.

So, we will throughout the year and throughout these meetings continue to have these ONC updates on different parts of our work stream so that can hear feedback like that from the FACAs in terms of what we can do and how we can incorporate it better into the everyday on the ground work that's happening.

You'll also see a lot more, I won't say a lot more, but we're also doing a number of different ways to reach out not just to the FACAs but to other stakeholder groups, we did this with the webinars that we did for the 2015 edition, we did that with the resources that we created, we created a complete resource tab on 2015 edition pieces. Steve has also done this with the CCGs the Companion Certification Guides and those are just a couple of examples of where we're really trying to create easy access avenues for stakeholders to be able to consume the myriad of work that we have underway. So, I definitely take your point and I appreciate it.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you. Richard?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thank you very much for your presentations and just a general comment I'd like to echo what Arien summarized that, you know, any opportunity we have for simplification, particularly as it relates to MU3 I think was very smart that there was a comment rule put in to reduce burden on providers I think is going to be a good thing for the industry and the ability to align programs really want to applaud you for whatever steps you're able to take in that direction.

My question is for Steve, there's been, you know, a number of calls for more interoperability sooner, there's, you know, certainly language in MACRA, there's other legislation pending that pushes in that direction much sooner than the interoperability roadmap calls for. There's been some discussion about whether or not there's something that we can do more quickly as an industry using ADT as a part of a solution.

I was wondering what ONC is thinking about how do we achieve best national scaled interop soon? Where are you placing your bets?

**Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

A, I thought I was going to get out of this without having to answer a question because it was getting around to the end.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

So, close.

**Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

And B, that is probably an entirely loaded question. So, you know, the roadmap itself lays out different milestone periods that we're aiming at, the first being the standards to be defined and used in this initial 3-year milestone period that is where we're placing our focus in terms of where we can work with industry to identify interoperability that works to meet those needs around that priority area.

And I think we're also looking to, one of Jitin's points, just some feedback on that, where there may be opportunities to do one more round of testing on something, a concept that people are working on and then get it to scale.

And I think as we're looking at opportunities it's really the scale issue that I think, at least as part of my interest, going forward how we can move things from tangible concept piloted with actionable results to move forward and then move it to scale and that last step seems to be one of the bigger challenges that we're facing as well in terms of both the resource investment and understanding what that's going to be and the type of work that either is a balance between some government push or some government stepping away and other actors in the field taking their shot at moving this forward.

It also gets to aligning either underneath or on top riding, you know, side-by-side, whatever metaphor I can mix into that, the payment and regulatory drivers that we're working on, you know, mostly with our colleagues at CMS, but even other procurement opportunities that the department has where, you know, there are large sums of money that go out either through grant mechanisms or other procurements that can have an effect on helping to scale some of the work.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you and Loraine did you have a question or...

**Lorraine Doo, MSWA, MPH – Senior Policy Advisor – Centers for Medicare & Medicaid Services – Health and Human Services**

Yeah, given that I'm your sister in collaboration over at CMS I think your last comment was really well received. We are the administrative standards and I think that's a huge opportunity for us. And the risk of kind of stampeding for the collaboration we're kind of almost there. So, the national standards group and ONC have a wonderful opportunity, particularly with payment and, you know, I keep wanting to pay with a watch getting to that last hurdle really is a big deal.

But the thing that I had wanted to also say is sort of in our eagerness for this collaboration one of the things that we really do have to check is make sure that we've got everybody at the table and that we're not doing something without each other and so the one item on the testing usability for the EHRs is just to make sure that we really have just double checked that we've got everybody at the party because there's other groups that are doing that as well. So, as long as we stay in lockstep I think we really do have this opportunity.

**Steve Posnack, MHS, MS, CISSP – Director, Office of Standards & Technology – Office of the National Coordinator for Health Information Technology**

Yeah, thanks, Lorraine. You know the other one point I'd probably just emphasize in response to Rich as well is, you know, we pick a lot of modifiers to put in front of interoperability, true, seamless, continuous, you know, the list can go on, you know, we're looking at what's after it. Interoperability that solves a business need, interoperability that solves the problem that providers, you know, that providers are trying to solve or the challenge that they have, interoperability that works for the types of data exchange that they have. So, I don't know that I could tell, you know, whether or not something is true or not.

Not to pick on some colleagues that use that word in front of interoperability but, you know, the proof is going to be in the pudding afterwards in terms of what's happened as a result of the types of standards that we've chosen to put in place, that we piloted, that we tested and, you know, where certification could be a helpful accelerant or amplifier, or lubricant to whatever the processes are, you know, we're certainly interested in that.

Another example is, you know, we're equally participating in the Argonaut, you know, work as well to both learn and keep track of what is going on. So, those are new models whereas, you know, we're happy to be a partner in these activities and, you know, kind of lead from within or on the side or behind compared to having to, you know, always have to be the tip of the spear because then the spear is, you know, ginormous.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

All right, well I want to thank the ONC team this is a fabulous team as Jon alluded to and Karen as well, ONC's staff are just stupendous and the three in front of us Elise, Steve and Andy represent the incredible work that's going on, so thank you so much for the update we're obviously very interested and want to hear more and more. Thanks. Okay, we're going onto our morning session of public comment before breaking for lunch.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Before we open the lines if there's anyone in the room who would like to make a public comment please come up to the table. As a reminder public comment is limited to three minutes and I will turn it over to Alan now to open up the lines.

**Public Comment**

**Alan Merritt – Interactive Specialist, Digital Communications Services – Altarum Institute**

If you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press \*1 or if you're listening via your telephone you may press \*1 at this time to be entered into the queue.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Go ahead?

**Jeffrey Smith, MPP – Vice President, Public Policy – American Medical Informatics Association (AMIA); Senior Policy Advisor – College of Healthcare Information Management Executives (CHIME)**

Good morning or actually good afternoon everyone, Happy New Year. My name is Jeff Smith I'm the Vice President of Public Policy at the American Medical Informatics Association, known probably to you all as AMIA, and I apologize for reading but I'm going to try and get through this statement really quickly.

So, the OCR guidance discussed during today's Joint meeting of the Policy and Standards Committee represents an opportunity that we think both providers and developers should embrace. By providing patients with a complete copy of their data maintained in designated record sets in a computable format we will enable patients and providers alike to have better data liquidity.

Data liquidity is important because it will ensure more complete information is known about the patient when it's needed, it will enable physicians to switch EHRs more easily without losing as much data or paying as much money as the switches cost today. It will bolster initiatives like the Precision Medicine Initiative and it will better facilitate a learning health system.

In the near-term the negotiation on form and format, and manner of access make sense but longer-term AMIA would like to see a requirement of certified technology be able to provide granular data access that maintains computability so that both structured and unstructured data is transmitted to the patient.

Obviously, implementation of these policies will be difficult and the means to ensure such functionality is unclear. But if ONC prioritizes such functionality it will fuel a system of discovery of innovation and of learning. Thank you.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. And it looks like we have no more public comment on the phone. There were a few public comments via the chat that we will distribute to the committee following today's meeting.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you. So, at this point we will break for lunch and return at 1:15. Thanks a lot.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I know Jon White is not back yet but I say that we get started if that's okay John and Paul?

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

What happened is we left Jon White at the restaurant with the bill. He's paying as a private citizen no government funds are being spent.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

And here he is perfect timing. So, the lines are open so I think we can just get started with Cris and Anita.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I just need to brief the topic, as I said this morning, this is a Standards Committee presentation we'll hear about, from this Task Force, their recommendations do we build, do we buy, is it private sector or is it public sector, how do we provide all the various stakeholders large and small with information on the suitability for purpose for various products in the marketplace.

And we'll have a presentation and a discussion and we've been given an hour and a half and I don't think we will take the full hour and a half. So lest we worry about running out of time it probably won't happen. So, please Cris and Anita go ahead.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, thank you John, I think you just jinxed that we'll be here an hour and 35 minutes now. I'm really happy to co-present with my co-chair Anita Somplasky. We are going to go through the materials here relatively briefly and we'll get to questions as soon as possible.

To begin with here were the people who are on this Certified Technology Comparison Task Force. I won't say that this is the best looking and most talented Task Force but I'd like to see one that was better looking and harder working than this Task Force. A really, really great team that I think represented the industry well from consumer groups, small practices, regional focus, vendors, government and all the rest and I would also thank Dawn Heisey-Grove who she might not be the hardest working employee at ONC but I think she should be an candidate for employee of the month is all I'm saying.

This was our charge. So this came to us directly from the MACRA legislation. Congress requested specifically that the Secretary of HHS conduct a feasibility study regarding the need for certified health IT comparison tool. And as part of that ONC convened this Task Force and our charge is listed below.

We were going to identify different health IT needs for providers across a variety of spectra and needs. We were going to identify what are the user needs for a comparison tool. Congress presumed that this

would be something that would help the market. And then last, identify gaps in the current tool marketplace and barriers to addressing those gaps. So, if the private sector is not addressing this issue successfully why is that and what can the government do to engage and improve that.

We had met for about eight weeks, nine weeks from start to finish. We held virtual hearings with five different panels two whole days of testimony from a variety of groups and we are going to walk through what our findings are and what our recommendations are.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Oh, I turned it off.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Ut-oh.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Maybe we're not...I don't think this...one of the things that we found is that there is absolutely going...there is a need for ongoing comparison tools for the providers not just those who might be making their first purchase but those who are considering some of the modular needs that are going to be required to meet health IT reporting. Those who are doing the rip and replace, but interestingly enough those who are developing an ongoing IT strategy to try and be proactive to determine what products there are in the market and to assess for future purchase and reporting needs.

We are well aware that there are existing tools that are very well respected. They do have brand recognition and they do conduct some extensive market research. And existing tools have also developed robust comparison platforms that meets specific needs of members for certain organizations.

However, current tools do not necessarily meet the needs of all providers particularly those providers who are in small and/or rural practices which we know is over 50%, those who are in specialty practices and those who lack technical support. In many of the small and medium practices that person, that medical assistant who rooms the patient is also responsible for all of the IT support in that practice.

Most tools lack empirical sources of comparison for quality reporting which we all know we've just been talking about MACRA and MIPS is going to be even more important going forward. Objective usability information which we also heard about before lunch. Comparative product costs and information about products ability to integrate with other health IT. Some of the tools, many of them do have a cost associated with it and those costs are prohibitive to those smaller and under resourced practices. So, something that we wanted considered.

Comparative objective data may encourage competition and actually drive innovation where there's been an absence of that kind of comparative information for example around usability. There's been less incentive to compete to date. So, we talked about the fact that this may actually drive some innovation.

Anybody who has done this or assisted with it...purchasing health information technology is really complicated and so anything like a comparison tool that can simplify the process would be greatly appreciated. Tools that would provide objective comparisons and evaluation information that the

provider or practice based on their characteristics could help them make the right decision. And that's you.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I just want to talk about some of the recommendations that we had that came out of that. So, the materials that Anita just walked through were reported to us in the hearings that we held and we tried to represent the consensus viewpoints across a variety of views and we'll talk about some places where there might be some differences.

The next two slides, before we get to some specific recommendations, identify some information needs specific information needs across comparison tools. We're going to talk about six different attributes which are the rows in these two charts and the columns in these two charts is what are some potential expanded role that the federal government might take with things for instance like data reported through CHPL or a stakeholder expanded role that would be what could existing or new entrants do in this space.

So, as an example, some of the comment was around the targeting of markets that not all information is needed by all consumers and that different consumers have different kinds of needs. So, identification was that the federal government could take an expanded role with things like voluntary reporting by developers on previously identified categories.

Stakeholders could take a role around including only audience specific information or providing some way of filtering that data so that the right data gets to the right users.

A tricky issue was around usability. We had a lot of discussion around usability. The federal role might include things like formal evaluations based on objective data. Now we understand that there's a lot loaded in that sentence, are there very many formal evaluations, is there objective data but it's clearly something we would aspire to. The other would be safety surveillance data that could be made public which would be an indicator of the usability of a system if we look at things like error rates for example.

So, if that was a federal role a private role might be in the second column things like peer-to-peer and crowdsourcing subjective reviews. Those of you who might have listened to some of the testimony or participated in will know that we invoked Trip Advisor and Yelp, and Amazon, and Fandango, and IMDB, and pick your favorite rating and judging crowdsourcing peer evaluation tool.

There was significant, I think, belief that those kinds of data are important. That the way that I can understand what might work for me might include a combination of objective data that I might get from an authoritative source like the federal government via CHPL through some sort of advisory firm but I'm also going to want to look for hospitals like me or small practices like me, or a solo doc like me and figure out what's going to work for me.

Some comments quickly then, because I think you get the gist from that, from product costs we felt that the government might take a role in terms of providing information about base costs understanding that full cost of ownership is a tricky issue to try and represent accurately and fairly. Product cost might also be amenable to peer-to-peer and other kinds of evaluations that would get to things like price expectation.

Overall satisfaction that's something that works well in a peer-to-peer kind of mode, it's difficult to have a government agency report for instance on product satisfaction.

Quality metrics, again, ONC or the federal government could take a role in terms of voluntary developer reporting around things like exportable data, file types and reporting capabilities of a number of types. Stakeholders may be able to provide other kinds of metrics.

The final characteristic that was a tricky one was product integration issues especially for those who want to consume EHRs in a modular fashion. How do you think about putting these things together or how do you think about putting your EHR in context of a practice management or a revenue cycle system.

So feds might have a role in voluntary development reporting around things like number and type of products that have been successfully connected that's a good checklist item. You could also talk about which products it connects to and numbers and types of devices supported when you think about things like biomedical devices and so on. And product integration from a crowdsourcing perspective would be amenable to things like subjective reviews on ease of installation and use.

So, at this point I think Anita and I walked through some of the feedback and recommendations. I'm going to get to the kind of money slide here next. But we had a transition in our thinking, which was a lot of our conversation was along the lines of wouldn't it be nice if somebody did X in a kind of...kind of way, if we had complete insight, if these tools existed wouldn't the market be better if tools were available.

We then moved to the really important question of well now who exactly is going to do this? Who is the right person to do it? How does it fit within the market as a whole and what are some things that we recommend and not recommend?

So, we recommended that ONC ought to do four things. We suggested that they should advance data sources like CHPL as an information resource for private sector tools. And we put a footnote on this to suggest the CHPL in and of itself maybe very powerful for some people to go to directly but we wouldn't suggest that CHPL should be a proxy for our replacement for the kind of comparison tools and rating tools that exist in the private sector. That what we're recommending around CHPL would be aligned with the recommendations in the previous two slides.

Second recommendation is that ONC should consider contracting with one or more tool vendors to ensure tools are accessible to and meet the needs of specialty and small practice providers especially around issues of affordability and there have been other instances where ONC has licensed content and other kinds of materials which has made them generally available to the market which has helped to spread the effectiveness of the technology. So, that's something to consider.

The third is communicate about comparison tool availability to healthcare providers through whatever mechanisms ONC may have available to it or HHS may have available to it for practices that are looking for help and tools.

We're all familiar with and Anita is deeply familiar with what Regional Extension Centers and others have done over the last couple of years to help provide tools and resources out to providers. Is there a continued role to let people know what's out there in the private sector that might be useful.

Fourth, we recommend essentially ONC or HHS in its role in the bully pulpit. How can we make recommendations for private sector consideration that are based on some of the recommendations in the previous slide.

ONC could have a powerful role in continuing to push for the need to have usability, affordability information, goodness of fit information and to advocate for informed consumers getting information from highly effective private sources.

We recommended that ONC should not do two things. We suggested that they should not develop or maintain a comparison tool we recommended that in parallel that they should not expand CHPL to serve as a comparison tool. CHPL is an important data source but it's not a buyer guide.

We recommended that ONC should not endorse one or more tool vendors. It's hard to pick winners/losers but we included that recommendation because it's a parallel to recommendation number two that they might contract with one or two vendors to meet specific targeted needs but distinguish that from somehow giving an imprimatur to one of more tool vendors that they have a preferred place in the market for example.

So, that concludes our recommendations and I think Anita is going to walk through the appendix which had a lot more richness around some of these other attributes that might be in these, an idea tool.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

I won't go through each of the attributes but just want to hit on them. As Cris mentioned, we had a phenomenal Task Force that provided us with some really great input and we had a lot of thought provoking discussions.

The ideal tool attributes should...the tool should allow for filters that would narrow choices for targeted audiences and filtering should be permitted across multiple categories simultaneously which is just not something you necessarily see right now and then there are several subcategories under there to think about.

Comparison tools should be accessible to all levels of technical ability and I get back to you shouldn't have to be a CIO or CMIO in order to understand what's out there to be compared.

Comparison tools should be geared towards small and rural practices and really need to provide some cost transparency.

And given the modularity of certified health IT, tools should be available that allow for comparison of products for a variety of topics. And here we kind of broke it down into high, medium and low priority not to suggest that medium and low priority are not important it's just that there are some that are absolutely, you know, burning issues that have to be dealt with and others that are needed for day-to-day practice but not on the comparison tool side.

Tools should include both objective and subjective information on product usability, you know, when Cris referenced the different mechanisms out there now so many of them are subjective and we really wanted to make sure that there are objective criteria that are available for comparison to make good decisions.

Objective data about non-certified health IT should also be available for comparison as appropriate. Practice management systems are what keep the doors open in these small and medium practices so while it's not a certified requirement for certification there certainly should be comparison information available for that.

And comparison tools should be flexible to help providers select health IT that meets evolving needs of healthcare delivery system reform, all the things that we were talking about that are on the minds of the providers and practices that are out there.

For robust comparison the tools should include information from vendors, independent third-parties and peer reviews. We didn't think it needed to be silo'd to just one or the other.

The government should make available more objective data and health IT products that could be utilized for comparison tool developers.

A collection of subjective data should be in the purview of the tool developers and medical societies and there we were thinking, you know, the peer-to-peer and crowdsourcing reviews, comparison of the health IT products and then also rankings of the health IT products. And that is it for us.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, thank you and just as a quick comment about the importance of subjective data, and as you say, this is not to endorse any existent incumbent entity that measures but KLAS has been working over the last several months on measuring interoperability. And I ask the question, if we were to publish a list of all the numerators and denominators of everyone who attested to Meaningful Use is that going to help the next purchaser of a piece of software? It probably won't.

I mean, great, you know, your numerator was 43 as opposed to, if I asked 100 customers of Cerner, EPIC, Meditech, eClinicalWorks, athena, McKesson whoever, so was the data available at the point of care when you needed it for the care coordination, population health or care management business case you had at the time, and a person could say, well, much of the time, some of the time, none of the time. Well, was it easy to get or hard to get? Was it cheap to get or expensive to get? I mean, these are things that are very hard to measure with a counter and you really need this sort of Yelp-like function.

And so I can imagine a variety of data sources, as you say, some of these could be QIOs, some could be independent private businesses like KLAS and others producing this kind of subjective information and then sharing it wisely.

So, I knew...see we have a number of folks whose cards came up and, you know, Paul this is really hard, you know, I've got glaucoma so all I see is sort of a...it looks like, is that Eric, "hello."

**Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects**

Ahoy, so thanks, I think this, you know, strikes a nice balance between trying to find ways that ONC can facilitate the things that need to happen without being too heavy-handed. One thing that I mentioned at the last meeting I want to mention again is that there's still an obstacle to open sharing of opinions about EHRs by their customers in the restrictive clauses that might be in their license or user agreement.

And I think this is an opportunity, I don't know if ONC has the statutory authority to say that these kinds of comparison tools would be a safe haven and you can't basically gag your customer from reporting their...in good faith to such a tool if ONC doesn't have the statutory authority maybe Congress could give it to them.

And the other thing I'm wondering is do you have any thoughts about how to make sure these tools are on the up and up or how to make sure that the degree to which they're on the up and up are visible to the users of them. For instance, how do you know that an EHR vendor can't pay to have a negative review removed that sort of thing.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right. I'll take a shot at it. Eric your point is a really good one. I would say broadly we actually had some provocative and good testimony from a couple of people who said, well, look if the broad issue is what keeps people from being able to acquire the right product that best fits them, there's a whole bunch of things that get in the way that could help make that problem better and a lot of those were around market transparency kinds of issues. We were focused at a comparison tool at what we were looking at but I think it would be remiss if we didn't remark that your kind of comments make sense.

You know it was in the news that a couple of peer rating groups had been criticized because of the belief of, you know, fake reviews and those kinds of things. So, you know, I don't know what power ONC would have or not have in that sort of space. And the ability to intervene in a private contract for example, is it a legal question that I don't think we're prepared to opine about.

But what you're pointing out generally is this is a complex market with lots of barriers and non-transparency generally speaking is a big issue. These are also very complex procurements. It's not like I'm comparing relatively similar products for relatively limited, you know, focused purposes. These are, in some cases, you know, even in the smallest practice a complex interconnected multifaceted product evaluation and purchase.

All that said, I would, you know, defer to ONC about what legal authority they might have to intervene in terms of, you know, eliminating or restricting, or creating a safe harbor around limitations on what you can say under a contract, don't know.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

To your point, the information that is allowed to be shared has really been stifled particularly around cost. Practices have not been allowed to share that to date, which has made it really hard for, again, those small, medium, independent guys out there who really need that information to make an informed decision. So it is absolutely something that we really pushed for as a part of the recommendation that cost absolutely has to be a part of it.

**Eric Rose, MD, FFAFP – Director of Clinical Terminology – Intelligent Medical Objects**

Thank you.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Great, well, thank you. I think next we have Leslie Kelly Hall?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Thank you. Thanks for the great presentation and work and I echo and support a lot of your findings and have a couple of questions. I think your point on slide number 14 cannot be more amplified more...I mean needs to be amplified even more and that is that what we are today and what we are tomorrow are very different and so people looking across multiple categories simultaneously in a tool is very important because today there's something, tomorrow there might be something else and the third day they might be acquired. So, this is really a moving target so I appreciate those comments.

The other is, had you thought about attributes for consumer health products within HIT and would that provide any differences in your recommendations than you have today, one question.

And then the second is, how would you apply these things to maybe forward thinking items, standards that might come before this body and go to recommendations would we then think about maybe accompanying those recommendations with attributes to determine how those recommendations could be implemented if that makes sense. So, forward thinking ideas and then the attributes for consumer health.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Forward thinking makes a lot of sense and I think we tried to accommodate that. Consumer, clearly, all of the kinds of characteristics around objective and subjective data that would effect for instance usability of patient portals or other kind of certified technology would...you would think that these recommendations would apply pretty directly.

Our focus was on advising providers and hospitals around acquisition of technology as opposed to something that would go directly to a consumer. It wasn't in our scope but you could easily imagine that this work could be extended further. I have to say I'm not sure I quite understand the third...your third question and maybe Anita does and can take a swing at it but...

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

The forward thinking idea was just how do you couple maybe future recommendations that ONC makes with new characteristics for the selection process. Did you think about that?

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

We did think...we thought about that just as part of...what initially alternative payment models was something that we thought was going to be a lower priority until we really got into the discussion and while we don't necessarily know what those models look like it's something that we all felt that the tool was going to have to encompass and be nimble enough to incorporate.

With respect to consumer, we did have several discussions around quality improvement aspects of an EHR so patient centered medical home, being able to deliver education those are things that right now are not straightforward out of the EHRs and that can fall under usability but it was absolutely something that we were thinking of under that whole quality improvement and the attributes under there and being able to call that out especially with the importance of PCMH recognition going forward.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Thank you.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Andy?

**Andrew M. Wiesenthal, MD, SM – Director, Health Care Practice – Deloitte Consulting, LLP – International Health Terminology Standards Development (SNOMED)**

Thanks, John and thanks Cris and Anita for an important presentation. I heard loud and clear your emphasis on small practices, specialized practices, rural practices as a kind of underserved group and I wonder if you had...and then you also said, and yet in those practices very often the tech support is the lowest paid, least sophisticated person because they just have a little time to learn how to turn on PCs in the morning.

So, is there an alternative model that's kind of staring us in the face here? Should some service be developed that does this assessment for the small practice that they can subscribe to?

You know would you, just to confabulate a little bit, say that the state supported academic medical center in any one particular state, this is harkening back to the Regional Extension Center idea, would they do these evaluations for small practices for a nominal fee in the state or something like that rather than hiring ONC contracting with vendors to do special case software tools for little places? This doesn't seem to make as much sense.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

So, I admit, I cannot be totally objective. We served...I was the Director for both the Pennsylvania's Regional Extension Centers where we helped over 6000 physicians adopt certified health IT. I think that there absolutely needs to be something like that going forward whether it's something that's going to be sponsored through AHRQ, if there is a way to somehow have some semblance of the Regional Extension Center Program continue.

We went through and tried to do this in the beginning and do it for every practice that we served to be able to go through, show them what they needed to know, what they needed to be thinking about and we were shut down on cost. So, I mean, so it came down to only being able to do the one-on-one with the practices as opposed to being able to put out something that would give them an objective comparison across the board.

And to Eric's earlier comment, you know there were things that we couldn't share that were in contracts. But, I think absolutely there needs to be some sort of support. If this tool isn't going to be really straightforward and easy to use and helping them there needs to be some other form of support to help these small and medium practices.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I think we have Paul, is that Chris in the back? And Dixie. So, Paul?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Great, thank you. Thanks for the reporting out on the work of the Task Force. So, I'm missing...there's a missing link that I want to just sort of clarify. So you talked about the respective tools that are there. You talked about the sort of four things that are missing that are critical to folks, cost is one of them but also

the quality reporting, usability and ability to integrate and you came up with a recommendation that ONC not pursue these but let the private sector do this and then you enumerated some ideal attributes all of which sounded great. What motivates the current private sector tools to address your ideal attributes and what if they don't?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, we had a panel that included vendors in this space and one of the questions we wanted to get at was what's keeping you from meeting your customer's needs. Are there barriers in place and can government action somehow resolve some of those inefficiencies. Anita is going to, I'm sure offer her opinion, I frankly didn't hear a clear smoking gun "we could really do a great job if only."

I think what we heard, generally speaking, is this is a complicated domain that it's not easy to create a kind of level playing field comparison across products, across customer types.

You know John made some points about the power of sort of, you know, peer comparison and where that would be used. I'd make the argument that the market is now growing the use of recommender tools precisely because of this problem. When you have a very complicated problem set that's not amenable to a limited number of objective measures that are applicable in your domain what do you do? You turn to someone who says "you look like me, what did you decide what to do?"

And I think we heard that over and over to be perfectly honest, Paul, we did not hear from the vendors and actors in this space that "if you only did these two things" or "if the government would do this we would be able to do a much, much better job." Now they had lots of recommendations many of which are included in here around access to additional rich forms of data.

John gave an example of one organization asking "would it be useful to report on this measure." I think we have a lot of experimentation on the edges from these kinds of firms as they seek to serve this market.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So, let me try to interpret what you said. So, the private toolmakers can't do a better job because it's complex so it's not as if the government could do a better job than what exists. And I sense your answer to the feasibility of the comparison tool is that it's not feasible, at least in an objective manner and just go back to the qualitative people like me. Is that what you're saying?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This would be my opinion and I think it would be represented by the consensus of the group but...is I guess my opinion in listening to the testimony I think that this is a complex problem and in fact, you know, even with perfect data and perfect transparency it might be difficult to get an exact matching of the right kind of objective attributes that are going to allow a variety of different stakeholders to compare a tool for their particular purposes.

I think about what my institution went through as we tried to select an EHR future and, you know, we mined enormous numbers of sources, we did extensive peer calls, you know, we have all the resources that one might want to be able to look at this problem. And at the end of the day could we reduce down to a sheet of paper something of a score of 35.9 to 41.2 and pick one versus the other, we did not. We

used a variety of attributes to come to a conclusion even with all the riches and resources we had at hand.

So I would let the comparison vendors speak for themselves. They may say, I'm nuts, we can do a great job, that guy should stop talking, but I think we heard loud and clear trying to match the scope of the problem with really the ability of human beings to do this kind of cognitive work there's a mismatch.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thank you.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Chris?

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you, great presentation. I wanted to focus a little bit on specialty specific needs. In our other agencies like CMS and AHRQ have now recognized or are beginning to recognize that there is a great need to look into EHR functionalities based on the specialty that's actually using it. An example is the model EHR that was produced by AHRQ and then in 2015 was reduced to a top set of functionalities required for taking care of pediatric patients in an EHR.

Reality is that in 2012 only 8% of pediatricians were using fully functional EHRs that had pediatric functionalities. So, there needs to be an ability to be able to drill down on specialty specific requirements.

The American Academy of Pediatrics had for eight years an EHR comparison site. So if you're an AAP member you can go in there and you can see other people, you know, their experience and a variety of attributes across the fields about their EHRs.

So, my question to you is, how will you incorporate the fact that, especially vulnerable populations, you know, children are at the highest risk to have medication errors related to EHRs, how will you allow specialty specific needs to have higher, you know, priority or emphasis in the work going forward?

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

That's a great question. We talked about the specialty specific just being able to have those filters in there for the different specialties and to be able to then quickly filter down to the things that they need and that are important to them.

But in terms of having a defined idea on what that finished product would look like, you know, we're miles away from that.

But the other thing that came up was for specialty providers, you know, one of the discussions that we had in our Friday Task Force meeting was related to, you know, what do we think the future is going to look like? Is it going to be one single EHR or is it going to be a number of certified components or registries in order to pull that kind of information that the specialties really rely on and I think that's yet to be defined as well as we see the MIPS Program roll out.

**Christoph U. Lehmann, MD, FACMI, FAAP – Professor, Pediatrics & Biomedical Informatics – Vanderbilt University School of Medicine**

Thank you and I would recommend to involve more of those specialties in the process because that's where you are going to get the needs requirements.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

We have Dixie and Josh. Dixie?

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Yes, thank you. The attributes that you listed on slide 14 or...14 I think it is that's called cloud versus hosted. That seemed kind of like an odd characterization to me. It's kind of like does the product move data around or does it leave it in one data center. And I think that...so I'm not sure exactly what you were driving at there, but it seems to me that a provider would care more about whether they needed to install it and maintain on-site, and hire a staff, you know, a tech staff to maintain it or whether they could subscribe, you know, the pricing model and their obligation to maintain it would be what they would care about not whether it was in a cloud or data center.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I...

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

What...oh, go ahead, go ahead.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, I think you're probably defining it better. I think people sometimes use cloud as a proxy for software as a service and I think that's what you're maybe talking about is locally installed versus software as a service. I think we could replace those words just as easily to be perfectly honest Dixie. I think that's the attribute we were trying to get to.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Okay, then I think that's good because you can also buy hosting services...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, yeah, absolutely.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

That are in a data center, you know, that aren't in a cloud, you know, they're...I think it's kind of misleading.

The other thing I just was curious to know if you considered the attributes that Cris, you know, our Task Force identified for judging the maturity of standards. And I know that that's...standards was slightly different but there were a lot of those attributes that I think are quite relevant here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's a really great point Dixie and I think if we had more time we might drive deeper into granularity because the idea...we discussed it to some degree by proxy. There was some discussion and presentations by vendors that talked a little bit about sort of leading technologies versus lagging technologies those kinds of things which...

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

And adoption and...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, which is a...

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Broad proxy for what you're talking about. I think it would make sense for us to talk about those kinds of things. I think it would be a good friendly amendment of something that could be considered as collectible by CHPL if we could figure out how to do that in a way where the, you know, signal to noise ratio was at the right level.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

And explicitly pick which ones you wanted that would be...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, like many of the interoperability standard characteristics would be a really good area to collect data because that one is measurable and verifiable.

**Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates**

That's one I'm talking about.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So, Dixie, to your point, as I've done procurements of late I've started to categorize, is it infrastructure as a service, your mess running somewhere else. Is it platform as a service you're actually licensing some underlying technology and then writing software on top of it. Is it software as a service you're actually buying a service not hardware or software or is it an outcome as a service people collect your bills for you and that's an outcome you're buying and then we categorize it, but I imagine these private industry vendors could categorize it in some type of nomenclature. Okay and I think Josh are you our last commenter?

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

All right, well, thank you for the overview. I especially appreciate the discipline of trying to separate out the things that would be nice to have and the things that, you know, government can reasonably do and probably can't reasonably do.

In the category of things that government could plausibly do, did you consider the collection of more data that would become public as an outcome of the certification process? In other words, right now...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Vendors show a ton of information to a certification testing body and that information basically just lives within the walls of the testing body but anything from screenshots to videos could be recorded, to documents that were generated which could be captured and made public. There's a lot of material that could, as a condition of certification, be required to be shared quite broadly and could be a good adjunct to these tools.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

We did have a lot of discussion around that Josh because for those folks who are struggling with their current EHR technology they found out how quickly they could not do those things and asked the question, how were you a certified EHR vendor when you can't produce these reports, I'm an OB/GYN, I don't necessarily report only diabetes measures why can't you do better than that, why can't you show me how to get my reports that I need when CMS has sent me an audit letter. Why can't you help me produce the numbers that I need for public...so that I know how I'm doing from a public health reporting perspective. So, we know that it's really fallen short now and we did talk a lot about the need that you have to be able to do that and we did talk about being able to produce screenshots as a part of what is available.

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Yeah and just thinking more broadly, CHPL could...for every certification measure CHPL could link to a YouTube video, you know, showing exactly how this measure was demonstrated.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

Right, we talked...we even talked about, okay, how do we make them demonstrate a workflow...

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Yeah.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

For this. How hard is this going to be to go through this particular clinical scenario.

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Yeah and the nice thing is that gets around some of the gags between providers who have bought these products, because this wouldn't be in the context of a product owner it would be in the context of certification. Are the limitations that prevent this kind of thing from being done? Sorry, if I missed it, I didn't see that in the recommendations that sort of ultimately resulted from this work.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, Eric raised the question earlier and we've heard it from others that there may be contractual limitations on what someone can disclose...

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Based on a contractual relationship between a consumer and a vendor. But aside from that, no, I think our intention was to say, to the extent to which CHPL can collect data broadly it should and the second was, can there be consumer provided data of the type that you just presented so...

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

But, maybe let me articulate that a little better.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah?

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

I was specifically thinking about the testing process, generating some of these artifacts because right now the testing process requires vendors to show to a testing lab many workflows and many scenarios within the software but they're just demonstrated to the testing lab and then a checkmark is generated, and then the checkmark is what's submitted to CHPL, but it would be possible to submit much more than that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Joshua C. Mandel, MD, SB – Research Faculty – Harvard Medical School**

And ONC could conceivably require testing labs to submit all those supporting materials.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

And my suggestion there...you're absolutely right again, right on point. One of the things that we encouraged, because vendors have a set canned demonstration to be able to go through what they needed to get certified. We tried to put them through, you know, the Regional Extension Centers, no, we want a real life scenario and we're going to give it to now. We are not going to give it to you in advance so that you...we want to see how this EHR actually works with real life.

The "oh, by the way" you know I've gone through it, the physician's gone through and diagnosed the bronchitis but then the "oh, by the way, I've had these pounding headaches for the last month and I'm dizzy." That's real life and so we want to be able to absolutely see those types of things going forward and not so much the canned certification process.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, just as a kudo, there's a lot of things that we didn't speak to in here because we didn't have the time to go through things in comprehensive detail. So, if we had walked through the CHPL report my guess is

we would have found lots of places, like the one that you're raising, to say "ah ha, we should recommend that this be included."

Our recommendation broadly speaking is that the CHPL tool ought to be expanded as far as possible to the extent that it continues to add value. The examples you gave were some that we did talk about around how do you demonstrate usability in more than a checkmark way but in a way that the data could be provided that "let me go look at five implementations of this particular version of software" or something like that. All of that is fair game. Our recommendation broadly is ONC ought to take a role of being an information broker where it's possible to do that and to make that data as available as possible to private sector entities so that they can massage it, interpret it, route it, filter it and make it available to consumers.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so Josh, just of interest, all the CIOs in the Boston area got together a few months ago and we asked each other are there any gag orders that exist in any contract you have signed with any vendor that prohibits you from sharing screenshots, experiences or anything else that might be helpful to others and not a single CIO was aware of such a gag order.

So one wonders, I mean, I don't think that there's necessarily an impediment to a lot of this sharing. I know that there may be an agreement with the certification bodies, that's something held in confidence, but more globally I think moving the direction you suggest is appropriate.

Well, I think looking around the room...is it Paul or Kathleen or both?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Both.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Both, okay, Kathleen? Okay.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association**

So just a couple of thoughts one from the quality perspective which does have to do with longitudinal patient registries and the fact that increasingly quality reporting is going to be performed using qualified clinical data registries. And we know that in the last year that it has been very, very difficult for that data to get all the way through to resulting in performance payments either upwards or downwards. So, I think that thinking broadly about these electronic health record platforms and products the registry area is one that is crying out for comparable data.

The second has to do with the recent problem that's starting to be written about even in the lay press that has to do with really the validity of the reviews that are being provided on websites. And that we're finding out that people are being paid to do reviews, companies are pumping out reviews for 5 cents per review not in this arena, I'm really talking broadly about the retail merchandising area not electronic health records. But having seen that experience I think that some comment about having a way of establishing that someone is qualified based on actual use of a product to comment on it would be very

helpful. And there are whole variety of strategies that can be used. But, I'm worried otherwise that we will be inundated with thousands of reviews that come from God knows where.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Good points.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I think that comment, I mean so Amazon, as one exemplar, so a verified purchaser did buy this product and so recently I was involved in doing a review of appropriateness or fitness for purpose of a particular product and my clinician said we have decided that EHRs should be evaluated as “did I get home to dinner faster? Did I look better to my spouse and was I a happier person?” And I said “if you evaluate on those three criteria no product will ever succeed so don't write the review.” And so I think what you want is rational criteria from a rational evaluator who has some, as we suggest, validation that they are a purchaser or capable of such an evaluation. Paul?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think we've papered over a large number of issues here, right, and, you know, who at an institution should speak for an organization, how do you validate it, how do you go back and repeat the information, again, the signal to noise problem is a big deal.

I often...I work in a large institution, I often run into places where someone from my organization has opined about some subject which they're perfectly authorized to do and it's read back to me as though it's a gross institutional opinion when it might be an opinion of one person. So we run into those kinds of problems too, you know, who gets to press the submit button on the peer-rater agency. So, we admit we were engaged in a very imperfect activity not trying to minimize our recommendations but this is a complex and messy space.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Paul?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

I wanted to let you know that the Policy Committee actually had a recommendation very similar to what Josh just put forward which is one of the things to help not only users like perspective buyers can use but also to stimulate innovation in things like usability. We don't have the data and the data really are, how is it used in a workflow that's creditable to the providers.

So, I'm wondering, you know, as Josh was saying, there is a lot of data that's presented in the process of certification. One of the important pieces of data is to show me how it does which is...and to record that so that others can view and as I said can stimulate innovation, but since that's come up both in the Policy Committee and in this forum is that something that the Task Force would be willing to incorporate in your recommendations about this topic? I mean, you know, I mean, as an amendment to some of the recommendations you made.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, I think we'd have to poll the members of the Task Force to see if we could get to consensus on that topic. I think broadly our recommendation was...we didn't in any instance say we want to mandate or strongly encouraged the collection of a particular type of data just because we didn't have time to go through it comprehensively and I don't think we wanted to cherry pick one item.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Well, I guess the strength of this is the data is already required as part of the process...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

It's just making that transparent.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Understood.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So you don't have to come up with a new set, etcetera, it's just to make it available.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Totally understand.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

When is this...Michelle, does this have to be approved by this Joint...

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We are hoping to get it approved but we do have a couple of meetings on the calendar in case there is anything additional the group needs to talk through.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I also would comment, staff is also working on an additional analysis report and maybe Dawn you could talk about the other supplemental materials that will go along with our recommendations?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

You talked this morning about a feasibility study or...

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

Right.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes?

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

So, ONC has been tasked with completing a feasibility study, the information from the Task Force is going to be informing that feasibility study.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right.

**Dawn Heisey-Grove, MPH – Office of Planning, Evaluation & Analysis – Office of the National Coordinator for Health Information Technology**

One of alternate ways that we could incorporate the suggestion is in those two tables that preceded the recommendations. We could highlight this as one of the areas that data could be included from the certification process.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Right. I guess I would just comment the reason why I was kicking it to this feasibility study analysis is because it certainly is a good idea to provide richer and better data sources. It raises the question of is it feasible and what is the cost and burden associated with it. Is it something we'd want to recommend that vendors ought to do as opposed to what they're mandated to do. We did not go into evaluation of the market and feasibility at that level and perhaps this analysis by ONC could do that to supplement that, but I would say as a friendly amendment including the kind of data that you and Josh are suggesting would have value is something we might want to recommend strongly.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Great.

**Anita Somplasky, RN CHTS-CP, CHTS-PW – Director, Transformation & Development Services – Quality Insights of Pennsylvania**

We had a lot of discussions...right now a lot of what is being generated for Meaningful Use is not at all meaningful. When you have numerators higher than denominators or 100% of patients showing up as being compliant for having an A1c less than 9 there are problems that still exist and we talked about, you know, any of the data...because we briefly touched on it. How do you know that the data that they are showing is any more valid than what we're seeing coming out of some of the EHRs.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So, I just wanted to clarify because Cris your comment about whether we could mandate vendors to do this. It isn't to generate new data. It's almost just the feasibility of ONC making public the data that they use to justify the certification. There is new data in the sense of recording what was shown that's in a sense capturing the same data but there is no new data produced and I'm trying to make it...so there is

no cost, there is no overhead, it's just it goes back to the transparency which we've used so many times in patient safety and quality improvement.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, I totally understand your point.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And I know the data is collected. I would question whether this had no overhead or no cost to collect that data that's the only issue and I think that raises feasibility questions.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Thanks.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

To just amplify that remark, having done the certification process personally, it's like saying, this is the sausage being made I'm not sure you want to show that video. I mean, that is...the process of going through certification has got bumps and starts, and it's not as just simple show the data and make it transparent and digestible.

So, I think I like what Cris has said which is that we can encourage, there are a whole variety of data sources including some of the artifacts gathered during the certification process that would probably be beneficial. But mandating it and saying it must be the video that you took of this or that that's a little bit probably over specific at the moment. And I like this idea of doing feasibility studies of what additional artifacts might be provided.

So, I guess, Michelle, because you've asked and we'll get to Richard in just a second, that you wanted a general sense of the group as to whether or not we could proceed with these recommendations and since, of course, today we have lots of folks rolling off the committee you change the committee, you change the consensus.

So, I mean, maybe Paul, if it's okay, you know, we'll Richard's comment, we can just generally ask if there's any feedback or objection because there are some additional next steps on supplementary materials. Richard?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

I wrote down what you were saying, I think that there is a need to do feasibility and cost assessment. There is potential burden here that you may not want to ultimately put on the users of these systems and there is an intellectual property consideration as well sometimes involving not only the developer but third-parties of developers are relying on and I think it would be good to have thoughtful consideration of that before the committee acts on that particular recommendation.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Good. So, with that, any further comments on the nature of the recommendations? I think Cris, you know, you had made a friendly amendment that you might change some wording as to make a strong recommendation and of course highlight the feasibility analysis and supplementary materials. Any other changes that folks might want?

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Sorry, if I could understand what the actual recommendations were. Where those the slide with four shoulds and two should nots? And those shoulds were primarily...so these are the recommendations that we are reviewing for endorsement?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

We are recommending these four shoulds and these two should nots.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right, so...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And then the other materials obviously inform and illuminate those recommendations.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And therefore the specific question we're asking is, might we take these four shoulds and two should nots put them in a formal transmittal letter and send them to ONC?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think I'm going to argue with the discussion we just had, you know, our recommendation is that ONC should advance data sources like CHPL that's clearly amenable to the recommendation that Josh and Paul made. I think we'd want to inform that with a little bit of feasibility analysis about, gosh we've heard the Joint Policy and Standards Committee opine on this subject so we did some special analysis on what additional richer as is data and in progress data could be harvested that could go into CHPL.

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Okay and then just one amendment to the second item. I'm not sure if you're specifically recommending a formal contract, maybe you're recommending that ONC work with or contract with a tool vendor, or are you actually recommending that there be a formal contract between ONC and one or more tool vendors?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I think we are recommending that ONC make that tool available through a contract to specialty and small practice providers. I think our strongest emphasis was on small practice providers.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Other comments, revisions?

So, now Paul, I of course want to follow the, since it's a Joint Committee, appropriate rules of order for your group but in general what we have done is we've said, okay, this is a proposal are there objections to moving forward with a letter of transmission that incorporates these ideas and is that cool with you or do you want to do Robert's Rules of Order first, second and vote?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

So, all of the modifications and revisions, major issues like this new recommendation for consideration...so if it's just input and the committee is going to...the Task Force is going to take this, work with the feasibility and then come back with finals for approval that would be one way. Another is it looks fine as presented but we have this new edition now that is significantly new that you'd almost want to get a vote if you wanted to try to capture that today.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

What I would imagine is when the supplementary materials were prepared they would be brought to this committee and reviewed at that time.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Okay, so it's going to come back one more time?

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

But, I mean, so in other words, we would say that for this letter of transmission we would approve it today and then of course supplementary materials when produced would be brought back another time. That was the notion.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

How...

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

What do you want, Michelle?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I think we should vote on whether to include the one recommendation and if we would like to then we'll make that change and the committee agrees, if not then I think it's too much back and forth.

**Arien Malec – Vice President, Clinical Solutions Strategy- RelayHealth Corporation**

Yeah, can we restate the recommendations?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, I like that, to characterize what is the recommendation, I think the idea as proposed I would argue strongly are included in recommendation number one and that there's a lot of nuance in recommendation one that would go above and beyond even the issues that we discussed here that will require discretion by the agency.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

All right if...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

But if we want to be prescriptive around collection of particular artifacts produced during a certification process we can either discuss it here or we could direct the ONC staff to specifically address that during the feasibility analysis that will follow these recommendations.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right and so that was the recommendation I was going to make your later statement that advanced data sources like CHPL, as an information resource or private sector tools, as informed, by a feasibility analysis to be done by ONC. And that feasibility analysis could include the investigation into the release of materials for certification. Does that sound okay? Does that capture your ideas?

**Donna R. Cryer, JD – Principal – CryerHealth, LLC**

You said it even faster John that time.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, remember I haven't had caffeine in 20 years so I wouldn't to start. So Michelle, if we amend number one to include the "as informed by..."

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

The feasibility analysis" to be done by ONC. Does that sound like something we can vote on today?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Yes.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, so that is what is on the table, the slide in front of you plus the amendment to number one and there will be additional work done and of course decisions to be made by this group in the future.

Objections to moving forward with that? Well, none heard, that seems like we can move forward, but again it's a Joint Committee so if you want, you know, any kind of further process?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

I think...

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I know, okay, we have solved world peace, very good. Well, thank you. So, I think that wraps up that discussion and we are now at the point where we are still 15 minutes ahead of schedule, oh, my.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Under budget.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So, thank you very much to Cris and Anita. I guess for the closing remarks, I have some closing remarks, do you guys have closing remarks to make first?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Yeah.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

How would you like to structure this?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

You get the last word.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I get the last word, okay.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

So, can I request...

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Wait, wait, wait, wait.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

While you all figure out who is going to go first can I make one change?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Oh, yeah, go ahead.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I think I'd like to do public comment now because we have a few...there's some snacks and I think it would be easier to do public comment and then turn off the recording so they're not listening to us eat while we're giving accolades to those who are leaving if that's okay.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

That's fine, so moved.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, so if there is anyone in...

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Michelle, before we do that, I really would...Michelle, I agree in general, I do want to make sure as part of our record that ONC wants to acknowledge and thank John Halamka for his extraordinary service to the US in these last 200 meetings.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Ten years.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Ten years, yes, that is true, ten years and it just...it's really hard to capture what John has committed and been willing to do with his intellectual capital and personal time and he is...he's so available all the time to the team and he's given so much of his own thinking into helping advance health IT.

So, I, as National Coordinator, want to make sure we have on record our appreciation on the part of the Administration for his service which has been extraordinary and we hope that we can continue to call on you to be...to call on your great wisdom. Thank you.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Thank you.

Applause

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well...

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Now we can do public comment.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, I mean, it's...what do you think?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

It depends on what you're going to say.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

I want...they're thanking people, so, I mean, so Michelle, you know, if I could just put the thank yous on the public record and of course we can have additional commentary over our snacks.

So, remember that today is a set of important transitions because Jamie will be leaving us, Becky Kush will be leaving us, Cris Ross, Wes Rishel, who I think is on the phone, and although there were a number of departures announced previously you are now beginning to fill those slots. So for example Dixie Baker's slot I understand has been filled and Dixie has been just a remarkable servant, as you say, to this committee and if I look around this room all of us have worked very hard but I think her legacy will live on in published papers and so many of the artifacts that she has produced.

But, Michelle are there any other names we should enumerate for the positions that have actually been filled?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

No, as far as filled, no we can't...that process is still underway.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

So, I will leave it to you whether or not I get to read out the amazing things about the folks that are departing or I can wait until we're off-line whatever you prefer?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Go for it Jon.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

You sure, go for it?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

You can mention their names...

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Okay, all right. So, a number of folks who are leaving, all from my Standards Committee. So, Keith Figlioli is not here with us today, but his service is incredibly valued, thank you, Keith.

Beck Kush, Becky has served on a number of groups during her time on the Standards Committee, the Semantics Standards Workgroup Co-Chair. She has been the Clinical Operations Workgroup member, on the Data Provenance Task Force she was a member and on the Vocabulary Task Force she was a member. Thank you.

Jamie Ferguson, Jamie has served on five Workgroups and Task Forces during his time on the Standards Committee leading three of the five groups, the HIT Policy Health IT Strategy and Innovation Workgroup, the Clinical Operations Workgroup you were the Chair, the S&I Task Force you were a member, the Semantics Standards Workgroup you were Co-Chair and the Vocabulary Task Force you were a Chair. Thank you.

Wes Rishel, still on the phone Wes? Still with us? Not quite fast enough on the mute button.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

No.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

That's okay. So, Wes has served on a number of groups and really has been an amazing contributor not just to the Standards Committee but to the field broadly. He's been a member of the HIT Policy Governance Workgroup, a member of the Health IT Policy Interoperability and Health Information Exchange Workgroup and Health IT Policy Privacy and Security Tiger Team, he was a member, oh, I miss the Tiger Teams. The Health IT Standards Clinical Operations Workgroup as a member. The Implementation Workgroup as a member. The NWHIN Power Team as a member. The Privacy and Security Workgroup and of course my beloved JASON Task Force as a member.

And then finally, because I have separate comments for Halamka, Cris Ross who I will deeply miss, who the staff unanimously acclaim as a superstar. During his time on the Standards Committee Cris served on 10 Workgroups and Task Forces chairing three of those groups, the Certified Technology Comparison Task Force as a Co-Chair, the Enrollment Standards for Business Rules Tiger Team as a Chair, the Enrollment Verification Interfaces Tiger Team as a member, the Enrollment Workgroup as a member, the Information Exchange Workgroup as a member, the Clinical Operations Workgroup as a member, the Implementation Workgroup as a Co-Chair, the NwHIN Power Team as a member, the Steering Committee as a member and the Health IT Standards Task Force as a member.

So, for all of you for your tremendous service I thank you very much.

Applause

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Now, Michelle, I do wonder, because you know I do have an official task to perform and maybe we should do that on the record and that's of course the passing of the baton. And so just reflecting on the last 10 years, because it has been 200 meetings in Washington.

So, with fall of 2005 when Fran Schrotter, who was the COO of ANSI at the time, came to my Harvard Office and said "I know you've really not done a lot of this standards work per se, but we have this thing that Secretary Leavitt wants to create with David Brailer, you know, called HISP, it will take about 8 hours a year, would you be willing, you know, on occasion, to show up in Washington in 2005 or 2006 to help out with some standards discussion." And I said "sure."

And then of course we chartered the organization in January and the heady topics, for those of you who were in the room, were, is your XML better than my XML, you know, we did the CCR and the CCD, and then is your HL7 lab guide better than my lab guide and who would use SNOMED, oh, that's one of those geeky vocabularies, no doctor could use SNOMED. And of course all of these debates that we had in 2005 through 2009, I mean, this is what we actually do in production today without a thought.

And then of course as the Obama Administration came in we then moved to the Health Information Technology Standards Committee and there was a lot of argument, oh, should we go from this public/private mostly private sector unfunded standards harmonization activity to a Federal Advisory Committee, oh, I don't know, just think about what that's going to involve. There will be minutes of meetings and there will be phone calls that are recorded and shared with the public. So, you know, again no one even thinks about such controversies and we had to deal with things like what do we do for content standards and how do we go from the CCD to the CCD-A, how do we formalize in a vocabulary stack something that NLM can distribute to the world for free.

How is it we do transport of data from place to place. And then of course last year, think FHIR and OAuth, and OpenID and of course the work is not yet done. There is much work to do and of course, if I were to continue on, it's up to you guys now, I would say things like solve that patient ID problem, you know, get a provider directory. Ensure that we get APIs, you know, a chicken in every pot, every patient, every provider gets an API, you know, make sure that we're using these standards like FHIR, OAuth and OpenID very, very widely.

And of course, as Karen knows, because, we're really great friends and every time we debate ideas it's truly just to debating ideas and after doing this for a decade I'm weary of blunt instruments, regulation and legislation because sometimes you can lead a horse to water and force them to drink or you could just create better water that makes them want to drink and I think if I heard the discussion from CMS and ONC today that's kind of the direction people are going to, make the water better. So, there is that whole tenuous issue of what you regulate and what you incent through changing alternative payment models and these sorts of things.

So, with you two, I want to welcome you to the leadership of the HIT Standards Committee. Now you will have the privilege of harmonizing standards for years to come. You will get credit for things you don't do and you will get blamed for issues you were not involved in. Everything you write and everything you say will be deemed influential. You will develop karma some good some bad, so keep this in mind, I mean, this is a pretty heady responsibility.

And I would just tell you, you know, in my days, because I used to be in track and field, my job was not to win the race but was to pass the baton so those who followed me are not slowed down. So, I want to formally, you know, this is the leadership moment you now are passed the baton, go run the race, Godspeed and it has been an honor to serve. Thanks so much.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Thanks, John.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Thank you.

Applause

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, Michelle, public comment?

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

And more to come.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yes.

**Public Comment**

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

If there's anybody in the room who would like to make a public comment please come up to the table. As a reminder public comment is limited to three minutes and I will turn it over to Alan to open up the lines.

**Alan Merritt – Interactive Specialist, Digital Communications Services – Altarum Institute**

If you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-6006 and press \*1 or if you're listening via your telephone you may press \*1 at this time to be entered into the queue. We have no comments at this time.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

While we wait there were a few comments shared via the public chat that we'll send around. And it looks like we have no public comment in the room or on the phone.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, well, so does that mean that we officially adjourn the meeting and then we toast?

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

We adjourn but nobody leaves.

**John Halamka, MD, MS – Chief Information Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yes. So, okay, Michelle, if there are no other administrative duties I think then there is a toast in order and our official business is done but please stay. Thank you.

**Karen B. DeSalvo, MD, MPH, MSc – National Coordinator – Office of the National Coordinator for Health Information Technology – Department of Health & Human Services**

Thanks, everybody.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**P. Jonathan White, MD – Deputy National Coordinator – Office of the National Coordinator for Health Information Technology**

Okay, can I get it? There you go, awesome, thank you. Okay.

**Public Comment Received During the Meeting**

1. Sherry Reynolds: Since patients are part of the care team why are they required to sign a HIPAA release if exchange of information isn't required by other providers?
2. Sherry Reynolds: FYI Check out the common measure set (developed via public collaborative) that ties into value based purchasing we are using in WA State - no additional work on provider side <http://wahealthalliance.org/the-common-measure-set-a-transformative-tool-for-benefit-strategy/>
3. Mbanks: From a front line provider, who is on the mean streets of actual patient care, I hope all of you understand that MU is devastating the practice of medicine, forcing EHR vendors to turn all resources to the ridiculous rules and regulations and ignoring pleas from providers for better efficiency, usability, safety and security. ONC is a co-conspirator to these programs and need to understand that front line providers want relief and real improvements, not more of the same or worse, your ideas of "better". We are struggling and disenfranchised. Please know these things.