HIT Standards Committee
DRAFT
Summary of the February 20, 2013 Meeting

ATTENDANCE

The following members attended the meeting:

Dixie Baker
Anne Castro
Christopher Chute
John Derr
Lorraine Doo
Floyd Eisenberg
Jamie Ferguson
John Halamka
Leslie Kelly Hall
Stanley Huff
Elizabeth Johnson
Arien Malec
David McCallie
Jonathan Perlin
Wes Rishel
Ram Sriram for Charles Romine
Christopher Ross
Walter Suarez
Sharon Terry
James Walker

The following members were absent:

Tim Cromwell
C. Martin Harris
Kevin Hutchinson
Rebecca Kush
Nancy Orvis
J. Marc Overhage

KEY TOPICS

Call to Order

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

Remarks

Farzad Mostashari, National Coordinator, remarked that some people are overwhelmed by Stage 3 because they are in the midst of trying to implement Stage 2. Nevertheless, it is important to know where we are going and to know where we are now. Information exchange and interoperability will take place in 2013. Resolution of the inevitable problems that will occur must take place. Forward progress is expected. Stage 2 is about potential. There are tools that will be used for many purposes. He asked that the agenda items be considered in that context.

Review of the Agenda

Jonathan Perlin, Chairperson, acknowledged the presence of a representative from NIST, who was standing in for Charles Romine. Perlin talked about the ecosystem and expanding possibilities. An emerging set of data is becoming available for discovery and research and development. CDS for treatment of patients is being enhanced. Data that are not readily accessible in paper charts are now available. He shared his excitement with new tools and a new cohort of players. He acknowledged the importance of responsibility, protections, safety, quality and compassion.

Perlin inquired about objections, corrections, modifications, improvements, amendments or additions to the meeting summary distributed with the meeting materials and, hearing none, announced the acceptance of the summary of the January 2013 meeting as distributed.

> **Action item #1: The summary of the January 2013 HITSC meeting was approved as circulated.**

Comments

John Halamka, Vice Chairperson, talked about the workplan not necessarily being an answer to the need for standards. However, the workplan identifies a process toward an answer. It entails a plan for maturity of standards. He said that he had reported to the HITPC on the availability of standards in conjunction with the RFC. He declared that feedback from the HITPC was positive. The workplan sets priorities and harmonizes the HITPC aspirations with HITSC's advice on reality. The workplan identifies the right topics in the right order and phases work in a rational way.

2013 Updated HITSC Workplan

Doug Fridsma, ONC, showed slides outlining a quarterly workplan. He emphasized that it was organized by the topics identified in a HITSC meeting. He reported that staff had considered the topics, the type of work required by each, and made assignments of workgroups. He noted that the workplan had gone through several iterations, more of which may yet be required, and that more than half of the first quarter is past. He talked about the S&I Framework projects slide, which had been shown in many previous meetings. The slide lists the various projects and summarizes the current status of each. For example, the Direct project is in production. He talked about the tension between support for Stage 2 and development. He went on to talk about the status of each S&I project, all of which had been previously described.

A member interrupted with a comment or question about structured data capture and harmonization. Fridsma talked about international efforts for atomic data capture. He mentioned linking with SNOMED and LOINC, which are different from, yet can inform, the Health eDecisions model.

Jim Walker inquired about the documentation of lessons learned from and the challenges of each of the S&I projects. Fridsma responded that the information was captured but had not been compiled. He added it to the workplan, noting that learning had occurred and changes had been made as a result.

David McCallie once again expressed his concern about Health eDecisions and similar projects that were not closely tied to vendor activities. Structured data capture may be a similar problem. He admitted that

he had not studied the project. Nevertheless, he stated that projects need sponsors from among the major vendors. Fridsma described some vendor involvement, emphasizing that ONC staff had tried to broaden vendor involvement. Research organizations have been involved. This is a community-driven project. He had discussed it with Becky Kush.

Mostashari commented on the opportunity to step back and look at a more generalized approach for broader standards. The focus could be to solve multiple use cases rather than unique use cases.

McCallie, referring to structured data capture, reported that HL7 is changing and there are new approaches to consider. Perlin mentioned parsimony and finding a common thread. He requested that members take the meeting schedule into account before they comment. Dixie Baker reported on her past work on adverse drug reporting for CDC. ONC can show that there is a standard with multiple uses. Kelly Hall talked about patients.

Wes Rishel expressed doubts that a standards program that's spaced over time, like meaningful use, can ever introduce fundamental change. He said that he agreed with McCallie on the opportunity to explore other approaches. Regarding esMD and CMS post-hoc information to support claims, he said that there may be potential for development and replacement of existing workflow. He suggested having the topic as an agenda item for another meeting. Fridsma responded that the digital author of record may be generalized, which could be used for pre-authorization. Rishel noted that the past work was built on a structure that grew over time and should now be revisited.

Fridsma continued with the presentation of the workplan, saying that it covers six quarters; everything can be worked on. He reported that he had attempted to allocate the activities across quarters and scale them to the HITSC schedule of meetings. The HITSC meetings can be used for decisions on recommendations and the background work can be done in the workgroups and power teams. He talked through the items on the workplan, giving the assigned workgroup(s) and describing the tasks involved:

- Additional standards to support transport of data to and from patients - NwHIN Power Team and Privacy and Security Workgroup
- Standards for image exchange and variety of use cases- Clinical Operations Workgroup and Consumer Patient Engagement Power Team
- Standards which address current content gaps, such as HL7 version 2 lab orders, formulary downloads, cancel transaction needed for hospital discharge medication e-prescribing, and representing genomic data in the EHR - Clinical Operations Workgroup
- Standards for securing data at rest, especially genomic data and consumer downloads - Privacy and Security Workgroup and Clinical Operations Workgroup

Moving to the second quarter, Fridsma continued.

- Improvements to the CCDA standard to facilitate unambiguous parsing, longitudinal record sharing, and bulk record sharing – Clinical Operations Workgroup
- Standards to record advanced directives and care preferences – Clinical Operations Workgroup
- Standards for application programming interfaces supporting modular application integration – Clinical Quality Workgroup and Clinical Operations Workgroup
- Standards which support flexible platforms for measuring and reporting quality (QueryHealth, QRDA and HQMF) – Clinical Quality Workgroup
- Standards for clinical decision support, both knowledge representation and application programming interfaces (APIs) for query/response to knowledge resources – Clinical Quality Workgroup and Clinical Operations Workgroup
- Standards which support defect reporting to PSOs – Clinical Quality Workgroup and Clinical Operations

- Standards needed for registry support including structured data capture and transmission to third party
- Repositories – Clinical Quality Workgroup and Clinical Operations Workgroup

Perlin instructed them that as they discussed the workplan to think about the ramifications for specific workgroups, general comments that apply across standards, and questions specific to a topic in that order to facilitate an organized discussion.

Fridsma talked about third quarter activities:

- Standards to support closed loop referral workflow – Clinical Operations Workgroup
- Standards which support Record Locator Services – NwHIN Power Team and Privacy and Security Workgroup
- Standards which support query and response of provider and patient identity in directories – NwHIN Power Team and Privacy and Security
- Standards which support consent in a query and response architecture such as granular patient privacy preferences hosted in a managed service ("pull") and sent as part of the request for records ("push") – NwHIN Power Team and Privacy and Security Workgroup
- Standards to record care plans/care team – Clinical Operations Workgroup
- Standards supporting data segmentation for privacy – Privacy and Security Workgroup and Clinical Operations Workgroup
- Standards for clinical documentation supporting new payment models (includes ICD10, smart problem lists, computer assisted coding) – Clinical Operations Workgroup
- Standards which support query of data within organizations and targeted query for patient data – NwHIN Power Team, Clinical Quality Workgroup and Clinical Operations Workgroup

Fourth quarter activities came next.

- Standards which support measurement of HER usability – Clinical Operations
- Standards to support representation of patient generated data including consumer device data – Clinical Operations Workgroup
- Standards to support data comparability across entities including detailed clinical models – Clinical Operations Workgroup and Clinical Quality Workgroup
- Standards supporting Digital signature – Privacy and Security Workgroup
- Standards and certification criteria that anticipate broad NSTIC adoption – TBD
- Standards which support query of data within organizations and targeted query for patient data – NwHIN Power Team, Clinical Quality Workgroup and Clinical Operations Workgroup

These activities are designated for 2014.

- Standards which support redundant data identification and reduction – Clinical Operations Workgroup and Privacy and Security Workgroup
- Standards to support consumer friendly terminology – Clinical Operations Workgroup and Consumer and Patient Engagement Power Team

Discussion

On behalf of the Implementation Workgroup, Christopher Ross and Liz Johnson volunteered to work with the Clinical Operations Workgroup on several items.

Noting the tremendous workload required for the workplan, Walker inquired about staffing. Fridsma indicated that ONC managers are committed to the allocation of sufficient staff resources.

Floyd Eisenberg pointed to the overlap in assignments for the Implementation Workgroup and Operations Workgroup. For CDS and other functions, coordination will be required throughout the completion of the workplan. Perlin suggested that the workgroup chairs and co-chairs and Fridsma communicate regarding

overlap and the distribution of assignments. Kelly Hall mentioned patients' interests. Derr informed the group that he is scheduled to report to the HITPC on LTPAC in April. He requested an opportunity to make a presentation to the HITSC. Perlin agreed. Walter Suarez also expressed concern about the workload, noting that many of the items will require workgroup meetings throughout the year. The items will not be completed in the quarters in which they are listed; therefore, the cumulative work is likely to require weekly meetings. Halamka said that the workgroups can evaluate their assignments and determine what they can and cannot do and so inform him and Fridsma. Perlin interjected that the first task is to divide the work into the doable and not doable. Fridsma reminded them that he had used the items called out by the members for work. He tried to anticipate the needs and plan out the work, but he admitted that the plan may not be realistic. Nevertheless, he said that he needs help with timing the activities and identifying milestones. Perlin tried unsuccessfully to move the discussion. Walker observed that although the workgroups have been very productive, they need strong staff support. He suggested that the workgroup members think about the most critical issues and questions and focus on priorities. He said that not all members participate in the workgroups. Attendance is better when tasks are very specifically delineated. Until the workgroups meet to determine what can be accomplished, it will not be known to what extent the plan is realistic. Perlin asked Fridsma for his commitment to working with the workgroups to prioritize assignments and determine resources required for their work. Fridsma said that a meeting of chairs may be convened. Resource needs will be identified. Additional members may be needed for select workgroups.

Perlin requested again that the members focus their comments on crosscutting content. Baker pointed out that in order to apply the NwHIN Power Team's scheme to assess standards readiness, someone will have to figure how to do it since the Power Team will not have time to assess standards assigned to other groups in addition to its own assignments. Fridsma acknowledged the importance of her idea, saying that perhaps a "train the trainers" approach could be used or one member of each workgroup could be designated to coordinate the assessment of standard readiness.

Jamie Ferguson spoke about standards life cycles and noted that on page 4 of the workplan, there was a reference to "improvements to the CCDA." He announced that he is not convinced that "improvement" is the answer. Criteria are needed for determining appropriateness of improvements in existing standards versus work on new standards. He indicated that he agreed with McCallie.

Arien Malec asked for an update on the implementation and testing platform at a future meeting.

Christopher Ross asked about the assessment of industry readiness, saying that the Implementation Workgroup members want feedback from the industry on the ability to absorb new standards. Fridsma stated that the industry did not show up for most of the S&I projects. Industry participation is needed to support implementers. He referred to two communities, development and implementation, for outreach. The latter folks should drive standards. He talked about using triage on how to solve problems – new or improved standards. It is a resource issue. He recognized that the CCDA is not the final solution, but it is on the path to a solution. FHIR in HL7 is driven by two people. He informed them that although he is tracking it, he wants to know that it will work. There are many stakeholders and different opinions that ONC must negotiate.

Chris Chute observed that the workplan is a bottom-up approach to the issues: How will top-down be coordinated? He wondered who, if anyone, is responsible for strategic planning insofar as he did not see a strategy in all of these items. Fridsma talked about tension between bottom-up and top-down. Similar to city planning, the strategy here is to build the infrastructure. The HITSC can assist with strategies. Perlin remarked on the need for sufficient specification to coordinate, reminding them that the purpose of the FACAs is to seek public input.

Malec agreed with Chute, opining that the HITPC's Stage 3 workplan is a bunch of stuff without an end. On the other hand, the HITSC workplan implies an end but it does not match the HITPC plan. He

declared the need for a broad adoption of capabilities based on standards as well as to articulate the gaps and the timeframe. He revealed that he is terribly worried about the Stage 3 timeline. The two workplans must be harmonized. He volunteered to do whatever work is necessary to remediate them. Halamka said that in order to ensure the standards are ready, the schedule for the NPRM may need to be changed. Perlin commented on the importance of being grounded in reality. They must focus on what can be done and when.

McCallie suggested that the workgroups or their chairpersons prioritize their assigned standards based on importance and urgency with regard to timelines. Some may be easy and others hard. Regarding the life cycle, consideration should be given to whether to stop and begin a new standard.

Observing that the agenda was not on schedule, Perlin said that Halamka had agreed to shorten his presentation and that Fridsma would remain at the meeting to take up any remaining questions.

Summary of Public Responses to HITPC Request for Comment

Jodi Daniel, ONC, reminded the members that the RFC was posted on the ONC website on November 16, 2012. The comment period closed January 14, 2013. Staff presented a summary at the February 6th HITPC meeting. The HITPC workgroups will examine detailed comments respective to their scope. Michelle Consolazio Nelson reported that staff had identified several overarching themes of the 606 comments. Commenters advised focusing on clinical outcomes in Stage 3. Many wished to empower flexibility to foster innovation, in turn limiting the scope of recommendations. There was too much focus on functional objectives and the recommendations are too prescriptive. Much concern was expressed about timing. Experience from Stage 2 should be examined before increasing thresholds, accelerating measures, or moving from menu to core. Like the HITSC, people were concerned about the readiness of standards to support Stage 3 goals. Interoperability limitations should be addressed. Meaningful use is only one of many provider responsibilities. It is important to continue to invest in quality measurement alignment, infrastructure and standards. Patient safety should remains a high priority and any related requirements should be synchronized with meaningful use. Not everything can happen in the EHR; other technologies are available. Many commenters were confused by certification criterion-only items.

She went on to summarize comments specific to the CDS objective, saying that comments referred to too much being in one objective, the increase from five to 15 interventions , alert fatigue, relevancy to specialists and others. She moved to the specific questions:

> What is the best balance between ease of clinical documentation and the ease of practice management efficiency? Most commenters favored improvements in overall usability that could be expected to make this balance more manageable. Natural language processing was identified as a usability improvement. It may be possible to reallocate practice workflow to evenly distribute the work and increase overall practice efficiency. The question is out of scope.
>
> Should there be a requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance? Comments were overwhelmingly in opposition to a requirement, which was said to be premature, but support for the need for EHR users to do a safety assessment was supported.

Kory Mertz reported on information exchange. Regarding query for patient record, many commenters expressed support for the inclusion of this objective in Stage 3. Quite a few commenters seemed confused about the focus and scope of the objective. Many seemed to think it was focused on requiring providers to utilize a HIO leading to concerns about the level of access to fully functional HIOs. Quite a few commenters expressed the need to complete additional work around the privacy and security implications of this objective. A number of commenters stated that HIE and HIOs should be able to support providers in achieving this objective. The majority of those who commented on the measure suggested it should be based on a percentage rather than a raw number. They requested additional detail on how the measure will be calculated. A few commenters on the patient-matching objective requested that ONC establish explicit

standards to support patient matching. A few commenters said that it was important to establish a national patient identifier to support correctly matching patients. In response to provider directory, he reported that most commenters agreed that there are not sufficiently mature standards in place to support the criteria at this time. Comments were fairly evenly split on whether the criterion should be kept in Stage 3. The majority of commenters on data portability said that the criterion is important and that further progress is required around data portability. A number of commenters felt this criterion was unnecessary or duplicative of other criteria. A few commenters questioned the added value as substantially more data would need to be migrated to maintain continuity.

Jesse James reported on quality measures. Twenty-eight comments supported the concept of an innovation track. Five comments offered support with reservations and six were entirely opposed, including CHIME. Twenty-two comments favored the conservative approach and 33 an alternative approach. Regarding population measurement and support for software and standardization, the majority of commenters, especially the providers, saw a role for increased standards and possibly certification for population, and a number of them referred to specific evidence of value, especially in chronic disease management, managed care and public health.

Will Phelps reported on the privacy and security questions. Regarding reconciliation with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification, which strongly encourages the re-use of third party credentials, many comments stated that strong identity-proofing and multi-factor authentication should be required for Stage 3. Existing standards such as NIST SP 800-63, CIO Council Guidance, FEMA, and OMB, and DEA standards were also suggested for consideration. Not everyone agreed, calling out that the deadline to implement multi-factor authentication is unrealistic, a considerable burden would be imposed and multi-factor authentication is not a core competency of EHRs. Suggestions for possible approaches to testing for two-factor authentication in certification criteria were: develop a checklist to verify the system set-up, while also requiring appropriate documentation; require vendors to attest to having an architecture that supports third-party authentication and demonstrate examples; check for use of a federation language standard; develop a model audit protocol for the community to use to self-test; develop an iterative and phased testing program; and consider existing standards and guidance. Phelps moved to another question: Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third-party authentication service provider? He indicated that many of the 30 comments received supported both models. Comments included suggestions for how it could be done. Many suggestions were also made in response to the questions about security risks that should be subject to attestation in Stage 3. The majority of the 30 comments in response to the question on the feasibility of certifying the compliance of EHRs based on the prescribed [ASTM] standard for audit logs said that the prescribed standard is feasible, although a number of reservations were stated. Regarding attestation that such logs are created and maintained for a specific period of time, the majority of the 37 comments were neutral, citing a need to wait for the final Accounting of Disclosures Rule and to investigate feasibility.

Phelps continued. Thirty-seven people responded to the question on specifications for audit log file formats that are currently in widespread use to support such applications, citing the following: IHE ATNA Specification, HL7, DICOM, ASTM E E-2147-01, World Wide Web Consortium (W3C), SYSLOG, and UNIX-based operating systems. But others denied the availability of standards. Seventy-four people commented on this question: How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange? Suggestions included metadata tagging and various types of data segmentation. In response to a question on the maturity of existing standards referenced in the *Data Segmentation for Privacy Initiative Implementation Guide,* several segmentation-related initiatives that might be leveraged were mentioned: S&I Framework Data Segmentation for Privacy Initiative (DS4P WG); HL7 confidentiality and sensitivity code sets; SAMHSA/VA pilot; and the eHealth Initiative Blueprint Building Consensus for Common Action.

Nelson announced that based on the discussion at the HITPC meeting February 6, the Meaningful Use Workgroup met February 14 to discuss the comments and identify potential new pathways to stage 3. Subsequently, two subgroups were formed to develop alternative pathways—performance based deeming and clustering and consolidating objectives. The Meaningful Use Workgroup will meet March 15 to hear the subgroups' reports, which will then be submitted to the HITPC April 3.

Discussion

Walker asked James to define and differentiate de nova and retooled measures. James replied that the use of a paper measure template is retooling. Walker stopped him and proposed using de nova only for entirely new conditions or concepts, saying that the use of the terms is confusing to some people. Regarding slide 8, he pointed out that the strength of evidence on which a measure is based should also be published and that well-established standards for evidence should be used, such as the size of the population to which the finding is relevant and the estimated increase QALY. Then the report can be reviewed and accepted or rejected for use as a measure. Perlin observed that Walker's point was an excellent one that should be forwarded to the HITPC for consideration. James said that the comments indicated measure developers understood the concept of de nova, which was defined in the RFC. Regarding the application for a CQM, he said that he was not reporting on all of the specific comments.

Noting the schedule, Perlin asked the members to be brief and pithy when commenting. In response to a question about the time frame for the NPRMs, Daniel said that staff is working on the time line, which apparently may be extended. Eisenberg asked James about expanding the definition of a good measure and using NQF criteria. He asked that James report on the work being done to implement rapid cycle development of quality measures. James indicated that he had updated the HITPC. Perlin instructed Robertson to put an update on the agenda of a future meeting.

Kelly Hall said that the HITSC could inform deeming and consolidation by identifying the availability of standards for proposed objectives. Malec suggested a unifying approach. The HITPC and HITSC can develop a joint strategic plan with broadly adopted capabilities and in conjunction with stakeholders. This joint plan would include a well-defined roadmap. Perlin indicated his approval of Malec's proposal. Halamka interjected that the scope of the draft HITSC workplan can be constrained by using the NwHIN Power Teams framework for assessment of standards. But Malec's proposal may be a better approach. He pointed out that even though the standards may be good, their application may not necessarily improve care. He suggested convening chairpersons to agree on the overall goal of Stage 3. Daniel approved of the idea. Someone said that even though a standard is not mature, it is not necessarily a priority. Both maturity and the possibility for maturity must be considered. Malec opined that a clear statement of need and a clear timeline are fundamental to vendor cooperation. Kelly Hall talked about green fields and the lack of mature standards to support patient engagement. Baker declared that she disagreed with Kelly Hall; there are mature standards to communicate with patients. She agreed on the need for greater interaction across the two committees. Halamka talked about the need to push both ways. Walker reported that based on his experience, combined meetings of the Clinical Quality Workgroup and the Vocabulary Task Force were much more productive compared to separate meetings. Perlin declared that he heard consensus on the recommendation for a unifying approach to a HITPC-HITSC workplan. No objections were heard.

> **Action item #2: Arien Malec's proposal to recommend and develop a unified approach to a workplan in cooperation with the HITPC was agreed to by consensus.**

Public Comment

Robertson announced a three-minute time limit. Robin Raiford commented, suggesting reaching out to health organizations that support patients' ratings of hospitals. She reported on the status of her health

since the January meeting, saying that she found it unbelievable that some providers do not yet use EHRs. Medical errors must cease. She is working to tell her story to Oprah Winfrey.

Gary Dickenson observed that the RFC was focused on proceeding regardless of lessons that should have been learned from Stage 1. He said that although he submitted eight comments, the questions were not appropriate for the solicitation of comments. Trust of the information captured, generated and transmitted is the main concern. The timing, sequence and provenance of the information are not available. He argued that the 27 items for the HITSC workplan should focus on the front-end providers' management of workflow and engagement with patients. The 27 items are mostly obscure items not having anything to do with patients. Robertson called time.

Health Information Exchange Hearing Report Out

Halamka said that several committee members participated in the recent HIE public hearing. The testimonies are available for review. He asked Robertson to send the link and recommended that members review the individual testimonies, which contain helpful information. He referred also to the summary on his blog. In particular, he recommended Micky Tripathi's excellent introductory presentation on the status of HIT in the United States today. He said that HIT was first a noun and now is a verb. For ACOs, HIT is a series of necessary business functions. Significant exchange is occurring today; e-prescribing is a major success. Panelists seemed to agree that business drivers should select the technology, not the other way around. Data collection needs to be integrated into the providers' workflow. Although the time is right to accelerate interoperability and exchange, work remains to be done. Cross-vendor exchange is a must in 2013. LTPAC and mental health providers need to be brought into exchange. Meaningful use has created a tipping point for patient engagement.

Q&A

John Derr reported that many attendees at the hearing told him they wanted to help exchange with LTPAC. Kelly Hall talked about patient-generated data. Halamka pointed out that a structured vocabulary must be developed. The co-mingling of patient-reported and provider-entered data requires standards.

Baker noted that the testimonies pointed out the need for better ways to identify patients. Digital signatures of downloaded and transmitted documents are needed for trust.

Suarez observed that in addition to the push and pull models, a third model – access and view – is important although no actual exchange occurs. He reported that not much was said about sustainability. The HIE cooperative agreements will soon end. Halamka added direct query to the three models called out by Suarez.

McCallie reported that his company had incorporated access-view. FHIR may be a counterpart to allow downloads. Kelly Hall said that access-view could be useful for "non-traditional" providers. McCallie declared that the approach may be useful to the Privacy and Security Tiger Team as it works on the simplification of privacy and security requirements to support query. Halamka reminded everyone that Surescripts allows a medical query as long as the requester asserts consent. SSA scans for XML metadata. The goal is a one-step process.

Malec noted that view is an opportunity for the use of basic standards. As reported in the testimony by the Epic representative, the majority of participants do not require explicit consent because trust was previously established.

Rishel told Halamka that typically in a query the doctor has to consider the time involved in a search for data in relationship to the expected payoff. He wondered in what circumstances view has been successful. Halamka described that in his state a doctor can click on a button which lets her know that information on a specific patient is available. There is no new consent or sign-on required. Users have established the

norm that it is bad form not to click for the information. The information comes up quickly. He offered to send the specs to Rishel. Knowing the PCP and the PCP's affiliation is required.

ONC Updates

Daniel reported that 12 new HITSC members will soon be announced and most likely seated at the March meeting. GAO is accepting nominations for two slots on the HITPC until February 22 (HITCommittee@gao.gov). Nominations for the Consumer Empowerment Workgroups have closed. Staff is getting confirmations. The announcement will be made next week. Staff will establish processes for cross-committee coordination. An HITPC ACO Workgroup will be formed. The HITPC workplan was finalized. (She circulated it via email later in the day.) On February 13th, a public hearing on documentation was held, followed by a joint meeting of the Meaningful Use Workgroup and the Certification and Adoption Workgroup. Recommendations are forthcoming. In addition to recommendations on reduction of burden and the importance of sharing information with team members to enhance accuracy, Paul Tang and staff are drafting a recommendation that documentation of clinical encounters be viewable with track changes and provenance. The recommendations submitted by the Certification and Adoption Workgroup were accepted by the HITPC in January. Recommendations for Stage 3 include implementation of a safety risk assessment as a menu item and voluntary reporting of HIT-related events to PSOs as EHR capability. Also recommended is the use of the surveillance subset of common format (expected Q3 2013) for EHR capture of events and unsafe conditions. She went on. ONC convened listening sessions on governance with 170 participants to assist in advancing governance goals. Themes were to increase interoperability, decrease cost and complexity of exchange and increase trust. ONC will host a governance summit and issue guidance. ONC is co-sponsoring an e-health equity summit February 21st. A summary of the proceedings will be available to the public.

Fridsma continued with his report on the workplan. He reported on the items on his to do list: gather more information on ESMD and FHIR; update the committee on the implementation and testing platform; train workgroups on the application of the NwHIN Power Team's standards readiness criteria; finalize workgroup assignments; and connect with the HITPC on strategic planning.

Q&A

Rishel spoke on balancing coordination of solutions with stackable solutions and acknowledged that there may be no right answer. Monolithic structures are characterized by obsolescence and problems of the use of different versions. There is a need to identify priorities and pieces of solutions or alternatives.

Walker made a distinction on usability of standards by vendors versus vendors making them usable for providers. A terrible standard is often continued because everyone understands it.

McCallie said that Walker is now a part of the vendor community. The NwHIN Power Team's work on the evaluation of standards brought out the multiple factors to be taken into account.

Fridsma observed that one of the challenges with standards is who shows up and works. He assured them that he had tried different things to involve vendors and was not always successful. Stakeholders are busy with other stuff. He requested help. He mentioned drive-by business models.

Recognizing that he was repeating himself, Malec said that Stage 2 established some basic functions. Stumbling blocks should be identified and assignments made to work on solutions so as to prevent surprises in the future. Stakeholders could prioritize the work. He reported that his company monitors S&I projects and he is confused about their purpose. In other industries, standards proceed via vendors solving problems for their customers; standards are driven by a business agenda.

Walker opined that the same thing is true for providers. Once they know the expectations, they marshal the resources for solutions. He repeated a previously-made suggestion. Instead of hearings, contracting for

a well-designed survey would be more efficient. Interviews to inform a structured survey would be less costly and yield more representative information.

Fridsma reported that federal agencies are very interested in structured data capture, which is a priority because it solves different problems. Ways are needed to get data out of the record. Distributed query may be beyond Stage 3.

Baker observed that the HIE hearing revealed the need to converge meaningful use and accountable care. The demands are overwhelming. Fridsma agreed that in building the infrastructure the broad goals of accountable care must be taken into account.

In closing, Perlin said that functional tasks must be considered in terms of the data model. In order to move, policy priorities must be clarified and make explicit. Some problems with the sharing of information occur because of the lack of corresponding policy; the clearer the trajectory, the better.

Public Comment

Thomas R. Bizzaro commented on the importance of including behavioral health workers and pharmacists in meaningful use, for instance, in med reconciliation.

SUMMARY OF ACTION ITEMS:

Action item #1: The summary of the January 2013 HITSC meeting was approved as circulated.

Action item #2: Arien Malec's proposal to recommend and develop a unified approach to a workplan in cooperation with the HITPC was agreed to by consensus.

Meeting Materials

Agenda
Summary of January 2013 meeting
Presentations and reports slides