HIT Standards Committee
FINAL
Summary of the November 13, 2013 Meeting

ATTENDANCE

The following members attended the meeting:

Dixie Baker
Steve Brown
Jeremy Delinsky
John Derr
Lorraine Doo
Floyd Eisenberg
Jamie Ferguson
Keith Figlioli
Lisa Gallagher
John Halamka
Leslie Kelly Hall
Stanley Huff
Elizabeth Johnson
Rebecca Kush
Anne LeMaistre
Arien Malec
David McCallie, Jr.
Kim Nolen
Jonathan Perlin
Wes Rishel
Eric Rose
Christopher Ross
Andrew Wiesenthal

The following members were absent:

Anne Castro
C. Martin Harris
Nancy Orvis
Charles Romine
Sharon Terry

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 52nd meeting of the Health Information Technology Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting with two opportunities for public comment (three-minute limit), and that a transcript will be posted on the ONC website. She called the roll and instructed members to identify themselves for the transcript before speaking.

Remarks

Acting National Coordinator Jacob Reider introduced himself. In addition to being a family physician with more than 20 years of involvement in HIT, he runs marathons. He said marathons are hard, painful, and the finish line is not in view, but they result in extraordinarily accomplishments, and are not unlike work on the HITSC. He said that he observed pain on members' faces. The committee's role goes beyond the incentive program. HITECH specifies that the HITSC will recommend to ONC the standards, specifications, and certification criteria for the use and exchange of electronic information, and involve a broad array of stakeholders in the establishment of a nationwide HIT infrastructure.

Review of the Agenda

Chairperson Jonathan Perlin thanked Reider. He noted the progress that had been made over 51 meetings. Exciting work is ahead. Perlin asked for approval of the summary of the September meeting as circulated. No objections were heard. Perlin declared the summary approved.

Action item #1: The summary of the September 2013 HITSC meeting was approved.

Comments

Vice Chairperson John Halamka commented on what makes an IT project successful—scope, time, and resources. The committee must set its priorities carefully. The discussion on the workplan will help to focus the committee's work. A reality check must be done since it is not possible to do everything. Committee members should offer feedback on scope, time, and resources.

ONC Policy Update

Jennifer King, ONC, showed slides and reported on the status of the certification program based on a vendor-level analysis. Eighty-four percent of EHs that attested to Stage 1 used a primary vendor that had any 2014 Edition products, which does not necessarily mean that the providers were using that version of a product. Rates varied by size and location of EH from 75 percent of CAHs to 86 percent of large EHs. Sixty-nine percent of EPs that attested to Stage 1 used a primary vendor that had any 2014 Edition product—55 percent of rural EPs and 56 percent of urban EPs with very little variation by specialty, except for the lower rate among radiologists. Seventy-three percent of hospitals have attested to meaningful use; only 5 percent are not participating. Eighty-three percent of Medicare discharges occurred in hospitals that have attested. Forty-seven percent of EPs have attested. The slides showed the findings of ONC's analysis by primary vendors with one or greater percent of penetration. Leaders were MEDITECH (20 percent), Cerner Corporation (14 percent), Epic Systems Corporation (14 percent), Computer Programs and Systems, Inc. (11 percent) and McKesson (10 percent).

Q&A

Arien Malec asked about the certification pipeline. King indicated that she is working on getting information from the certification bodies. Halamka interjected that some vendors do not have sufficient time to get their products ready for customers to meet the attestation deadline. He hears that some vendors intend to pull their products due to the impossible timeline. He is concerned with the effects on innovation among niche vendors. Wes Rishel observed that concern with innovation must be balanced with the goal of raising the bar over time. Not all innovative products are good ones. He talked about his concern that EPs and EHs may suffer financially because of the failure of their vendors. Vendor capability ranges broadly. Due to the tight timeline for Stage 2 attestation, average vendors will not be ready. He asked King how many providers will have to do a full year attestation without incurring penalties. Having this number would help to determine the impact of the deadline. This is the number of providers that will fail if their vendors do not provide updated products. Daniel said that for early adopters (those that attested the first year and must now move to Stage 2), the first year of Stage 2 reporting

requires a 90-day reporting period, beginning no later than July 1, 2014. Approximately 2,600 EHs fall into this group, according to staff, who said that more precise information can be provided at a later time. Jeremy Delinsky pointed out that without some special provision, providers that switch platforms will be trapped. Daniel acknowledged that may be the case. Rishel pressed for more data to assess the extent of the problem. As of July 1, 2014, 2,600 EHs must have a certified product, and that is about half of the early attesters. Elizabeth Johnson suggested that instead of members offering different opinions, staff should prepare a visual depiction of the timelines and the categories of providers affected. Leslie Kelly Hall observed that industry concentration is increasing and acquisitions must be taken into account; acquisitions typically require changing platforms. Dixie Baker pointed out that both complete and modular certification can meet the base requirement. She requested data on products by complete, modular and base certification. King agreed to supply that information. Perlin requested that staff provide a document that shows the effects of the 2014 Edition requirement, which will be in effect for both Stage 1 and 2 attesters. He acknowledged that resolution of these issues must be coordinated with the HITPC.

ONC Policy Update Continued

Jodi Daniel, ONC, reported on recent and upcoming activities of the HITPC. A hearing on accountable care to obtain an understanding of ACO HIT needs is planned for December 5. GAO appointed David Kotz, Devin Mann, and Troy Seagondollar to the HITPC. The Certification and Adoption Workgroup is considering voluntary certification for ineligibles, in particular long term and post-acute care (LTPAC) and behavioral health providers. HITSC members John Derr and Stan Huff are charged to coordinate with the workgroup. Final recommendations will be presented to both committees in March.

ONC contracted with MITRE for a feasibility assessment of establishing a public-private partnership to promote HIT safety and maximize the potential of HIT to improve patient safety. AHRQ is involved. The FDA report and recommendations for a risk-based regulatory framework for HIT will be submitted to Congress by January 2014, preceded by a public comment period. ONC is conducting an analysis of HIT-related adverse event data in PSO databases to identify types, frequencies, and underlying causes of HIT-related events in order to support public-private efforts to develop evidence-based measures for improving HIT patient safety. Initial findings are expected in March 2014. Under contract with ONC, the Joint Commission is conducting voluntary investigations of HIT-related events at provider sites. The Joint Commission will publish a research paper and develop educational materials. SAFER Guides, risk assessment tools based on the latest evidence of HIT patient safety, are being prepared.

Derr reported on the Certification and Adoption Workgroup discussion on voluntary certification of ineligibles. Forty-to-sixty percent of hospital discharges are to LTPAC. LTPAC providers want to play. Six vendors are already certified. Robust EMRs are available, but they have not necessarily been updated. They can generate CDAs or CCDAs. Although there is debate about more government control, LTPAC providers are already highly controlled.

Q&A

Malec commented that although by 2016 -2018 meaningful use may still be a tactical program, most providers will be participating in value-based payment programs. The HITPC should be 90 percent focused on value-based care and only 5 percent on attestation. In response to his question on the final FDA guidance and CDS, Daniel responded that only FDA representatives can comment on the guidance. Where CDS falls is under discussion.

Consumer Technology Workgroup Update

Chairperson Leslie Kelly Hall talked about the work and output of the workgroup to date. She showed slides to describe the process used by the workgroup and its scope, values, and discussion themes. She said that the workgroup concluded that PGHD is an opportunity to capture needed information for use

during care, with potential cost savings and improvements in quality, care coordination, and patient engagement. She gave the following reasons for PGHD value:

- Patient learning, self-monitoring, and self-management, enabling some activities to shift from provider-driven to patient-led
- Patient's family and other caregivers assistance in care
- Better coordination and information across multiple care team members
- More accurate information for providers (e.g., what is taken vs. what is prescribed, administrative, etc.)
- Providers' access to information for care decisions
- Avoidance of medical errors
- Reduction of data collection burden for providers

She reviewed criteria for technical specification for adoptability and maturity, and showed examples of their application. She went on to delineate several opportunities:

- Initiative to create needed collaborative care document structure to address versioning, expanded provenance, reconciliation, data governance and curation
- Consumer product and provider standards forum for alignment
- Blue Button+ API approach to accommodate PGHD
- Trust framework expanded for consumer/patient adoption in emerging technologies. (BB+)
- Consumer vocabularies considered for future
- ONC model for PGHD guidelines and policies (e.g. notice of privacy practice)

She showed a color-coded grid highlighting standards that are ready for meaningful use. She introduced Russ Leftwich, a member of the workgroup who worked on care planning, Lisa Nelson, and Chuck Parker, Continua, who helped with the modification of the CDA and device data respectively. Leftwich talked about the importance of the care team roster. The concept of a care team exists in the HL7 8800 but it is usually applied to a team of an organization, not a team involved with a patient. A unique ID is needed for all members and for specific roles. The composition of the care team is not typically known at first admission or initial encounter.

Discussion

David McCalllie asked whether the Consumer Technology Workgroup was requesting action on recommendations for specific standards. Kelly Hall replied that no recommendations have been made and no action from the committee is expected. But the workgroup wants feedback. Instead of use cases, the workgroup focused on the CCDA and structured questionnaires as a mechanism for obtaining PGHD. Other issues are the care team roster identification, expansion of Direct transport, and device data integration.

Floyd Eisenberg talked about the provenance of PGHD, the storage of those data in the EHR, and their use in CDS. He agreed that a taxonomy value set of care team roles is needed.

Wes Rishel noted that the workgroup seems to be trying to enable two kinds of patient engagement. One is engagement between the provider-based care processes and the patient, and the other is the engagement of the patient with her own health. Each presents a different set of challenges. He observed that the discussion is about standardizing information flows of practices that are not actually happening yet. The theory is that if there is a standard, the information will flow, as opposed to the alternative theory that if the information is flowing, standardization is needed. It is too early for standards requirements because innovation will be stifled. Someone will have to make specific recommendations as to what is required for care teams. He expressed concern that prescription of device standards and certification has not resulted in uptake. There is potential uptake in a model of vendor-based repositories. He encouraged the

use of specific standards at specific levels of the stack with a rollout in terms of voluntary use versus required use.

Kelly Hall acknowledged that the workgroup is concerned with innovation. Standards can stimulate innovation as less as retard it. A small company with very limited resources may want to spend those resources on core competencies. The innovation trade-off is relevant to the new player—the patient. When something is coming into an EHR, the rules must apply. When something is coming out of the EHR, it is open and up for grabs. The workgroup has not discounted voluntary use of standards.

Eric Rose said that he agreed with the list on slide 9. Nevertheless, strong evidence is required before its incorporation into policy and standards. One does not want to presume workflows that are not currently in operation or apply use cases that are not currently in existence. Somehow, the self-organizing networks and care by non-health care professionals for vulnerable individuals should be included in the care plan and team roster. He suggested thinking about standards for workflows or use cases in which the professional is not directly involved in the generation or use of data.

Kelly Hall said that much of the information used by the workgroup came from the 2012 hearing on PGHD. Also, ONC formed an expert panel process through the National e-Health collaborative and will publish a document on PGHD in December. The point at which PGHD are incorporated into the EHR, which is the property of the provider, is a natural and logical place for standards to be used. Unless these data are incorporated, the patient will continue to be left out. Perlin said the EHR technology is owned by the provider. The information belongs to the patient. Kelly Hall said that the workgroup had been asked to examine PGHD because the topic is being considered as an objective for Stage 3.

Mary Jo Deering, ONC, noted that the HITPC Consumer Empowerment Workgroup is trying to constrain the scope and use cases that might be applied in Stage 3. PGHD are not unfettered, unbridled streams of information. They will come via responses to structured questionnaires and the CCDA, not from mobile apps.

Delinsky said that discussions of patient engagement and analysis are most relevant for risk-based arrangements. Kelly Hall said that for both value-based and fee-for-service models, the patient is the only one who knows what drugs she is actually taking. PGHD are universal across all payment models. Delinsky said that inbound and outbound messaging and notes may be different and require careful consideration. Rules may not be appropriate.

Jamie Ferguson spoke about the importance of constraining any near term recommendations on specific use cases. He referred to a journal article on the 2013 proceedings of the International Medical Informatics Association and evidence around the use of consumer data in health care. A literature search of medical journals for articles published in 2012 on social media data and health care quality and outcomes found more than 300 articles. He said that he thinks there is some evidence that nontraditional data can be highly relevant to personalized care, quality, and care outcomes. Use cases should be constrained to things that are real and tangible, such as some remote monitoring devices.

Delinsky talked about existing vocabularies. SNOMED, LOINC and RxNorm probably were not intended to be patient friendly. Ambulatory providers are trying to push as much work as possible to the front end of the visit and hopefully having some of that work done in the home. But reconciliation should take place prior to the incorporation of those data into the EHR. It would be bad to require that all PGHD be expressed in the CCDA for consumption and incorporation into the record. Are there sufficient vocabularies for PGHD?

Regarding vocabularies, Kelly Hall said that maturity is necessary. The structured questionnaires would be constrained by the provider-initiated activity. LOINC has more patient usable expressions than other vocabularies. The workgroup plans to discuss consumer vocabularies next week. The market must be involved.

A member reported that the vocabulary donated by Kaiser Permanente to the National Library of Medicine includes about 2,500 patient-related comments. Lisa Nelson said that CDA can record narrative text.

Someone agreed that provenance should be a focus. A cost-benefit analysis is needed. PGHD are not currently supported and the CDA, which has no provenance data, is supported. More support for provenance data would mean that providers can use the data or not. If supports are available and valuable, new care models may develop. If sliders are put over to the right, specific workflows in each EHR would be required. There are safety-related issues. He advocated for a summary document that supports provenance and allows providers to figure out how to use that data as opposed to a slider that forces reconciliation of workflows. Secure messaging is a good tool and can be used for patient questionnaires. The responses can be incorporated and interpreted by the physician. Kelly Hall said that physicians do not want to have to review and incorporate free text messages.

Perlin noted that the committee should not do the work of the workgroup. Innovation, optionality, and workflow are important issues for consideration.

Dixie Baker referred to expanded provenance and a discussion of structured vocabulary at which it was said that provenance should reflect how the data were generated. Provenance should indicate the natural language processing. Provenance is interpreted in different ways by different people. Therefore, there may be a need to recommend a standard for provenance.

Someone reported that HL7 FHIR has adopted sort of the W3C standard for provenance, but there may be no single standard. People are making assumptions in different ways about what is included. Kelly Hall responded that the workgroup looked at the care team roster and the harmonization efforts around roles. Perlin put provenance on the parking lot, saying that its importance extends beyond the work on consumer technology.

McCallie asked about legal concerns about the use of PGHD. Kelly Hall said that relevant information is on the website.

Stan Huff returned to provenance. The primary vehicle for communication is the CDA, which is a snapshot in time and by design does not include provenance. There may be a need to think about ways to transmit these data that maintain provenance and attribution. Lisa Brown said that context is one of the six principles built into CDA R2. Many do not understand how to tap into this principle. Rebecca Kush asked how the discussion relates to the structured data capture initiative. PGHD aligns with clinical research.

Kelly Hall summarized that the workgroup will look at constraints to make sure that future value based-payment models are taken into account. Safety is a priority. Voluntary versus regulatory is an issue. Vocabulary should be reviewed in this context. Narrative is included. Provenance is a bigger-picture concern. Messaging has value and can be augmented by other types of data.

ONC Standards Update

Doug Fridsma, ONC, introduced Mary Troy and showed slides with the most recent operating outputs and participation data. He said that the stats indicate that people are paying attention and using the products. Then he talked about the slide that showed the status of the seven projects in his portfolio. Regarding structured data capture (SDC) (which may eventually be used to extend EHRs), two implementation guides are targeted for development based on REST/OAuth and SOAP/SAML. SOAP/SAML IG will be balloted through IHE as an SDC quality, research and public health (QRPH) content profile. REST/OAuth IG is planning on attempting a ballot through HL7 once FHIR resources are created.

The data access framework (DAF) participants have discussed the addition of the third user story on patient portability and began discussing data requirements. The local DAF use case is targeted to be

concluded with consensus by November 20. The DAF IHE brief proposal was accepted as a white paper into the patient care coordination (PCC) domain of IHE 10/09. The PCC technical meetings are taking place November 12-13. More information on the S&I Framework is at http://wiki.siframework.org/.

Q&A

Halamka observed that the framework is an enormous body of work. Prioritization is necessary.

Derr reported that he is advocating use of Blue Button among his colleagues. Kelly Hall asked about alignment of the framework and the work of the Consumer Technology Workgroup.

Delinsky asked about the DAF use case. Fridsma said that patients need to move their data from place to place in a computable way. Physicians also want to have easier access to their data. The innovation community wants a way to interface with EHRs.

McCallie plead for clarification on priorities as related to Stage 3. Much is involved in portability. Problems with portability are for vendors to solve, not regulation. Vendors need to know what to pay attention to. He favors FHIR. Which are priorities? Fridsma reminded the members that every item in the workplan came from a member's suggestion. Now FHIR has been added. Halamka talked about the importance of parsimony.

Standards Update Continued – Demonstration of MUSICO

Fridsma demonstrated MUSICO. MUSICO is a graphical tool that allows a user to explore existing relationships among roles (patient, primary care provider, etc.) based on initiatives and their associated standards and meaningful use requirements. MUSICO can also be used for gap analysis, i.e., where standards that address interoperability are needed in the health IT infrastructure. After selecting a pair of actors (e.g., patient and ambulatory care setting), MUSICO displays the associated initiatives and applicable meaningful use alignment and standards. He asked members to review the web-based tool at ONC-musico.gov and to provide feedback to him.

Public Comment

Asif A. Syed, MD, American Medical Association, reported that the AMA has consumer-friendly CPT procedures code available along with CPT files to licensees.

HITSC Workplan

Prior to the presentation of the workplan, Daniel verified that providers that started Stage 1 in 2011 or 2012 must go to Stage 2 in 2014; approximately 2,600 EHs are in that situation. Both those providers beginning Stage 1 and those moving to Stage 2 in 2014 must use a 2014 Edition product. They must begin reporting for the 90-day period no later than July 1, 2014. Rishel asked about the possibility of receiving both an incentive and a penalty for starting in July. Daniel offered to check with CMS and report back.

Halamka referred to the FY 2013 workplan. Fridsma talked through slides that categorized workplan "topics" into high, medium, and low priority. The categorization was based on e-mail responses from members. (Although the response rate was not mentioned, subsequent discussion indicated that some members had waited until the meeting to express their opinions.) Fridsma noted that prioritization did not take into account issues beyond meaningful use. At a result of comments during the meeting, new topics, such as vocabulary, may be added. All items originated from members' input. The workplan has been under discussion for many months. From a total of 21 topics, six were rated high priority and one was low priority. Halamka reminded the members again that possibly not all of the items on the workplan could be done. Resources must be taken into account. Regarding image exchange, the Clinical Operations

Workgroup will present preliminary recommendations next month. The NwHIN completed recommendations on data transport.

Discussion

Discussion commenced with the high priority items. Regarding securing data at rest, Baker said that the topic was actually data at rest for consumer downloads, which, per HIPAA, is out of scope. Andy Wiesenthal commented that in moving to value-based payment based on quality measures, quality reporting and measurement is a high priority. Fridsma said that something on outcomes may be needed in CDAs.

Rishel said that as providers switch platforms, the data access framework will become more important. Changes in EMRs are difficult. Fridsma differentiated patient data portability and practice data portability. Rishel talked about upgrade decisions not being made lightly; there is always some loss in fidelity of information. McCallie agreed that patient migration and provider migration are different. Vendor switch is more complex. They are different use cases.

Delinsky spoke in favor of image exchange and reporting as high priorities. Reporting is more urgent than measurement. How are reporting and measurement split? Fridsma talked about two separate suites of standards, QRDA and HQMF.

Eisenberg referred to quality reporting and measurement. The issue is really quality improvement, which is affected by CDS. Harmonization is important. Outcomes as part of care plans are important. Outcomes should not be a separate effort.

Eric Rose talked about the difference between a provider measuring patients and measuring an aggregate population, which may involve multiple providers. EHR-centric approaches should not be the model. The system perspective should be emphasized. In the shift from claims-centric to quality-centric measures, perhaps SNOMED should be used for everything. Data access is required for a patient-centered approach and multiple settings. Halamka said that it is challenging to hard code numerators and denominators for quality measures. McCallie referred to quality measures and CDS and advocated for a focus on unambiguous definitions.

Rishel commented on economic benefits and recommended looking at what standards people are using. He wants to look at things that are working the hard way, such as organizations making up their own standards, and make them easier.

Moving to the medium priority items, Wiesenthal argued for APIs as higher priority. APIs would increase opportunities for innovations. The presentation layer is the most valuable for the end user.

McCallie said a SMART platform can be used to embed user experience into EHRs. FHIR may be a promising standard to focus on profiles for specific use cases.

Eisenberg pointed out that provenance is an issue that crosses several of the listed topics. It should be called out for attention and not ignored.

Keith Figlioli observed that work on APIs could be foundational. Most vendors have APIs, but they are not published. He said that this is why he participates and why his organization is interested in the committee. Downstream all of this should be published. Fridsma responded that standards are in five categories—meaning, structure, transport, security, and services. A service could be an API. It is one of the five building blocks. It has not received sufficient attention and it could solve some of the larger functional problems. Figlioli said that in other industries API platforms are being created and contracted. He agreed that he would call it high priority; he admitted that he had failed to vote on priorities.

Delinsky referred to digital signatures as important, but a reconsideration of how to approach the problem is needed.

Malec talked about orderable catalogs and digital ordering. Insurance information for lab tests can be tricky. There is no universal list of insurers and EHs need patient registration information for lab orders. Regarding APIs, he talked about innovation. Ability to incorporate secure messaging can be inhibited by lack of APIs. FHIR provides an opportunity. Fridsma told McCallie and Malec to take this case up for homework. He wants to know how to accelerate FHIE in view of the lack of pilots and resources. He wants to know how to get vendors involved in a use case. FHIR is apparently not ready at this time.

Kelly Hall noted that advance directives could be a use case for newer technologies. A problem is how to find the most recent directive, a menu item in Stage 2. Someone asked about the term advance directive. She acknowledged confusion across several terms and documents. It is really patient-directed care planning. There are also POLST and MOLST. Regarding a glide path and the next step, she said that a link to a document or contact is difficult. Computable data would be useful, but a conversation between provider and patient is the first and most important step. Regulation around standards may be premature. She agreed that the area is one of high value.

Rishel referred to FHIR and opined that HITSC and government involvement, and the resulting increase in complexity, could be the death of FHIR as happened with another standard that he did not name. FHIR can best be enabled by pilot studies and use cases. By requiring APIs, vendors are increasingly put on the line for usability and safety. Interfaces around the edge of products are more important than restructuring them. Regarding the five fundamentals listed by Fridsma, he suggested that the term security be replaced with trust and scale.

Baker reported that the Privacy and Security Workgroup had talked about digital signatures with CMS staff, but ONC staff had not clearly instructed the workgroup as to what it should do. Digital signatures should have high priority. Standards for signing transmissions to consumers and third parties are needed immediately. She suggested that the workplan separate digital signature from CMS use cases. Fridsma declared that he would take action in consultation with Joy Pritts to provide direction to the workgroup.

Halamka asked about CDS and Health e-Decisions. Fridsma said that having the ability to share information even though it is not computable and actionable is important. Another use case is CDS as a service. The two use cases serve different purposes. CDS fits into quality improvement. McCallie commented that the third use case is pluggable user experience for CDS service in the cloud. Many CDS use case problems could be solved. This may be the most important use case. Fridsma directed McCallie and Malec to include this case in their homework. Malec said that he is hearing about the need to plug knowledge of patients into the EHRs. This use case overlaps with the plan of care.

Reider asked about knowing whether one has all the data. He asked McCallie to include clarification of the specification for use case 3 in his homework. Eisenberg said that use case 1 is the most important.

They moved to the next slide. Halamka explained how Harvard-affiliated hospitals do defect reporting. The challenge is whether EHRs have the technology to detect defects. A member asked about defects caused by the EHRs and how to gather this information.

Regarding registry reports, Halamka noted that every registry has some subset of esoteric data elements that are difficult to generalize. Rose commented said the cancer registry requirement may offer a natural experiment from which to get information to answer questions.

Halamka reported on consent management in his state. Standards were invented. Malec spoke about segmentation for privacy; there is a standard with uncertain policy requirements. There must be policy that is actionable by vendors. McCallie agreed that the current paper-world policy cannot be applied to the digital environment. Fridsma said that clarification of policy is needed.

Someone spoke about documentation for new payment models. There are issues around ICD 10 documentation support. Halamka explained that reengineering is required along with a multifactorial approach. The available products do not link SNOMED, ICD-10, and workflow.

Having talked about all of the items on the workplan list, Halamka said that staff will reorder the priorities and further develop the workplan. He said that there was agreement on the high priority items. Some of the items in the medium category were determined foundational and others may be medium-high. Some priorities have to do with foundational work in addition to meaningful use. Fridsma announced that members who had not submitted votes as requested could do so now.

In closing, Reider talked about standards and certification as lego blocks. The parts are available, but the system has yet to be built. The HITSC is expected to design a strategic vision.

Public Comment

None

SUMMARY OF ACTION ITEMS:

Action item #1: The summary of the September 2013 HITSC meeting was approved.

Meeting Materials

Agenda
Summary of September 2013 meeting
Meeting presentation slides and reports