HIT Policy and Standards Committees
FINAL
Summary of the January 20, 2016, Joint Meeting

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) and Standards Committee (HITSC) joint meeting. She reminded the group that this was a Federal Advisory Committee Act meeting being conducted with two opportunities for public comment (limited to 3 minutes per person) and that a transcript will be posted on the ONC website. She told members to identify themselves for the transcript before speaking and thanked HITSC Vice Chairperson John Halamka, whose term on the HITSC ended with this meeting. Members introduced themselves.

Remarks and Announcements

National Coordinator Karen DeSalvo showed slides on delivery system reforms toward a health system that provides better care, spends dollars more wisely, and has healthier people, which is a priority for the administration. She referred to her blog of January 19. Regarding information, the goals are to bring electronic health information to the point of care for meaningful use, create transparency on cost and quality information, and support consumer and clinician decision making. The Interoperability Roadmap goals are as follows:

- 2015-2017: Send, receive, find and use priority data domains to improve health care quality and outcomes
- 2018-2020: Expand data sources and users in the interoperable health IT ecosystem to improve health and lower cost
- 2021-2024**:** Achieve nationwide interoperability to enable a learning health system, with the person at the center of a system that can continuously improve care, public health, and science through real-time data access

Commitments and calls to action include the following:

- Consumers easily and securely access their electronic health information in one place, and can direct it to any desired location
- Share individual's health information for care with other providers and their patients as much as permitted by law and refrain from blocking electronic health information
- Implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information and adopt best practices including those related to privacy and security

DeSalvo said that ONC will use more sub-regulatory guidance in the future. She announced the appointment of Principal National Deputy Coordinator Vindell Washington, MD, from Louisiana. He was Halamka's student. Members had no questions.

Review of Agenda

HITPC Vice Chairperson Paul Tang asked for a motion to approve the summary of the November 2015 meeting as circulated. A motion was made and seconded. The motion was approved unanimously by voice vote. A name change request was made by Elise Sweeney Anthony.

> **Action item #1: The summary of the November 10, 2015, HITPC meeting was approved unanimously by voice vote.**

Halamka asked for corrections or additions to the summary of the December 10, 2015, HITSC meeting. Hearing none, he declared them approved. He noted that his and several other members' terms are ending.

> **Action item #2: The summary of the December 10, 2015, HITSC meeting was declared approved by Halamka.**

Tang and Halamka mentioned the importance and timeliness of each of the items on the previously distributed agenda. Tang recognized Deputy National Coordinator P. Jon White, who was listed under the remarks and announcements agenda item but had been overlooked. White thanked the members, saying that he is grateful for their time and talents. 2015 was a busy year. 2016 will be exciting. The ONC team is a joy. Mike McCoy is leaving ONC after 1 year of service, during which he made many contributions.

Office for Civil Rights (OCR) Update

Marissa Gordon-Nguyen showed 29 slides and described the HIPAA) access guidance, which consists of the following components:

- Fact sheet
- Scope FAQs
- Form and format and manner of access FAQs
- Timeliness FAQs
- Other (clinical labs) FAQs

Gordon-Nguyen reviewed the general right to access, which consists of access to and copy of one's medical record upon request by the individual or personal representative. Designated record sets (DRS) are a group of records maintained by or for the covered entity (CE). The record is an item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a CE. The following are examples of information subject to access:

- EHR and/or paper medical record
- Other medical, billing, payment, enrollment, and claims records
- Clinical laboratory test reports
- X-rays and other images
- Wellness and disease management program information
- Clinical case notes
- Old or archived PHI

Regarding access to DRS held by business associate agreements (BAA), the CE is ultimately responsible to provide access, regardless of where DRS are maintained. The agreement can specify that the BA will fulfill requests and not just provide needed information to the CE. The request still must be fulfilled within specific time limits. For clinical laboratories, DRS include completed test reports, underlying data used to generate the reports, test orders, billing, and insurance.

These items are excluded:

- Quality assessment or improvement records
- Patient safety activity records
- Business planning
- Provider performance evaluations
- Psychotherapy notes
- Separately maintained information for civil, criminal, or administrative action or proceedings, although not the underlying PHI relied on in developing such records

Gordon-Nguyen described the reviewable and non-reviewable grounds for denial of access and the processes involved. She went on to say that the CE may require requests in writing, including writing on the CE's form, but must inform individuals of the requirement. The CE may offer an option of electronic request and cannot create a barrier to or unreasonably delay access. Reasonable steps to verify identity must be in place. Verification may be oral or written. Authentication controls may be required for electronic access. It is defined as unreasonable to require individuals to go to an office to obtain records or to go to a Web portal.

Regarding the right to an electronic copy, a scanned PDF version of PHI may be readily producible (but a CE is not required to purchase a scanner for this purpose), while a Word version of paper PHI may not be readily producible. The patient has the right to receive information in human-readable format; the electronic copy is expected to be in a machine-readable format to the extent possible, as is consistent with the request. The right includes x-rays or other images in the record. CEs are not required to purchase new software or other equipment to accommodate every possible individual request. But CEs must have the capability to provide some form of electronic copy if the DRS is maintained electronically, which may require some investments and cannot be charged to the individual. Whether the format is readily producible depends on capabilities, not willingness. Requested formats that may be readily producible are: MS Word; MS Excel; PDF; structured, machine readable data; other electronic format and particular technical standards such as RxNorm and LOINC.

Under the EHR incentive program, meaningful use includes providing patients the ability to view online, download, and transmit health information (VDT). VDT requirements are more exacting in some ways, but apply to a narrower range of data (e.g., access is limited to information in CEHRT, but must be provided in a much shorter time frame). If the CE uses CEHRT, electronic PHI is readily producible. CEs can use VDT mechanisms to fulfill access requests if the individual requests or accepts the form, format, or manner. The individual always retains right to access PHI in a DRS that is not available through CEHRT. The CE may provide a summary of PHI requested (in lieu of access) or explanation of PHI (along with access), if an individual chooses to receive and agrees to any applicable fees. They may be provided at a convenient time and place, by mail or e-mail (encrypted or unencrypted). The readily producible method of copy, transfer, or transmission depends on the capabilities and the level of risk to security of PHI on the CE's systems, based on Security Rule risk analysis. For example, if an individual requests PHI downloaded to portable media provided by the individual but the CE's risk analysis addresses potential use of external portable media and finds it to be an unacceptable level of risk, the individual may agree to purchase a portable device from the CE, or both may agree on an alternative form of electronic copy. For another example, when an individual requests that the CE provide access by establishing direct connection between the CE's system and the individual's app or device, if capable and consistent with security measures, the CE must provide access in this manner.

OCR expects that CEs have capability to transmit PHI by e-mail, without unacceptable security risks to the CEs' systems. A limited exception may be where diagnostic image file sizes are too large to transmit

via e-mail. Thus, a CE generally must agree to unsecure e-mail transmission but first must warn the individual of the risk that PHI could be read or accessed while in transit. The 2015 edition CEHRT is capable of sending unencrypted e-mail directly. A CE cannot require that an individual accept an unsecure method of transmission. The CE is not responsible for the following:

- Disclosures during unsecure transmission to the individual, provided warning was given and risks accepted
- Breach notification obligations
- Safeguarding information once delivered to the individual

The CE is responsible for reasonable safeguards in all other contexts and breach notification for unsecured transmissions and may be liable for impermissible disclosures that occur in transit. Gordon-Nguyen concluded with general information on permissible fees. Regarding the right to direct PHI to another person, the same requirements for providing access apply, except that the request must be in writing. State laws also apply, and some require access in a shorter time frame. Contrary laws are preempted by HIPAA unless an exemption exists.

Q&A

Tang reminded the members that the meeting was running behind schedule. Josh Mandel asked about the source of FAQs: How do new questions get on the list? What about a patient request that files be uploaded to a website? Gordon-Nguyen responded that uploading to a website would depend on the CE's security analysis and the risk to the CE but not the risk to the patient. A CE has the right to determine whether it has the capacity, and the request does not constitute a risk. New FAQs come from select e-mails. Staff categorize them and may use them in a later guidance. Enforcement activities in the regions also generate FAQs.

Arien Malec observed that the guidance clarified the obligations for breach. He said that he interpreted the guidance as saying that CEs can offer patients general app access. If a patient's app is not on the CE's approved app list, is the CE obligated to open up to any app? Regarding fees, is it correct that the CE cannot charge more than the actual cost? Gordon-Nguyen replied that those and other questions will be answered in forthcoming FAQs. The charge cannot exceed cost, regardless of state law. Several months ago, ONC launched a website for app developers to ask questions. The questions generated will be covered in another guidance. ONC staff are currently working on questions pertaining to APIs.

Kim Schofield voiced concern about the rationale for the 30-day respond-to-request requirement, noting that with extensions and appeals, delays could be life threatening. The burden to respond should be placed on providers. According to Gordon-Nguyen, denials and appeals do not extend the 30-day obligation. OCR expects compliance as soon as possible. If a complaint is filed, an investigation would determine whether the provider should have acted faster. Everything depends on circumstances. In the future, the response time could be changed. Regarding areas in which provision of a record should be free to the patient, Gordon-Nguyen repeated her comment about cost and charge. This does not imply that the provider owns the PHI. The charge is for labor or devices, not for the information per se. This is not considered a cost of doing business.

Chris Lehmann asked about DRS components that are never seen by patients, such as sign-off tools. Gordon-Nguyen said that anything retained and used to make a decision about an individual is considered a part of the record set. CEs can explain what the set entails. Individuals can limit the extent of their requests. Regarding the requirement that a request by another individual be in writing, she clarified that it may be an electronic communique.

Lisa Gallagher said that the FAQs are very clear. She inquired about enforcement and redress when a patient encounters an uncooperative provider or when the provider does not have a process for responding to requests. Gordon-Nguyen responded that the patient should file a complaint of violation of the Privacy Rule. The OCR central intake unit may contact the provider and give TA. The next step is an investigation. OCR considers this a very important right. Civil monetary penalties can be imposed for violations. Regarding the inclusion of this issue in the 2016 audits, she said that she has not seen the audit protocols for this year. Gallagher said that a level set regarding providers is needed. It is difficult for patients to file these complaints, which are very common. ONC should do more to prevent non-compliance. Gordon-Nguyen promised to convey this suggestion to her colleagues.

Dixie Baker suggested that the guidance be more accessible on the website. Currently, it is posted under information for providers; it should be under patient information as well. Regarding the right of another person to request information, does this include a hospital or department or only an individual? Gordon-Nguyen said that the question will be addressed in the next guidance. The access guidance is now on the right side of the landing page. It is rather technical and written for providers. Gordon-Nguyen offered to speak to staff about its location.

David Kotz wondered how a patient would know what part of the DRS to request. Would the provider have a list? Gordon-Nguyen said that the patient can ask for a view of the DRS in order to narrow down the request. The patient can also ask the CE staff to help identify the relevant parts of the record. Typically, the patient will be able to describe what she is looking for. The patient can request an accounting of disclosures.

Troy Seagondollar referred to slide 28, wondering how this ties into opt-in and opt-out. If the patient is referred, does the patient give permission about which components of the DRS can be shared? Gordon-Nguyen reminded him that consent is not required to share information with providers for treatment purposes. In the case of an internal referral, the primary care provider would compile the relevant components. Opt-in and opt-out are not applicable. The CE is not required to share information with another CE or BA.

Eric Rose said that vendors are increasingly storing PHI in the cloud, and the provider will not always have access to the record. Vendor businesses can merge, be acquired, or go out of business; what happens to a patient's request then? Gordon-Nguyen said that OCR is working on guidance for the cloud and BAAs. The CE is responsible in contracting so that individual access requests are honored. Rose said that many providers may be unaware of this obligation, and it should be publicized more widely.

ONC Updates

Sweeney Anthony, Office of Policy, showed many slides. She began by announcing that CMS, in partnership with ONC, issued a Request for Information (RFI) on Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs, available at http://ww.federalregister.gov/articles/2015/12/31/2015-32931/agency-information-collection-activities-proposals-submissions-and-approvals-certification-frequency. CMS and ONC are requesting feedback on a number of topics, including how often to require recertification, the number of clinical quality measures to which a certified health IT module should be certified, and ways to improve testing of certified health IT modules. The comment period closes February 1, 2016.

ONC released a State Health IT Policy Levers Compendium in December 2015. It is intended to support state efforts to advance interoperability and can also be used in service of delivery system reform and includes the following:

- A Policy Lever Directory of 32 distinct policy levers and a description of how they can be used to promote health IT and to advance interoperability
- An Example Activities Catalogue with nearly 300 examples of actual or proposed uses of such levers
- A list of state points of contact who can be contacted for more information about the policy levers in their state

Sweeney Anthony described the Advance Interoperable Health IT Services to Support Health Information Exchange Program, which will leverage investments and lessons learned from the previous State HIE Program. Twelve 2-year awards totaling $29.6 million have been made. The Community Health Peer Learning Program (CHP) is a continuation of the Beacon Community Cooperative Agreement Program. CHP will recruit 15 communities on the path to interoperable health IT to identify data solutions and accelerate local progress around population health challenges. Academy Health will function as the CHP National Program Office to recruit the 15 communities. The Workforce Training Program awarded $6.7 million over the course of 2 years to update training materials from the original Workforce Curriculum Development program. The Workforce Training Program will also train 6,000 incumbent health care workers to use new health information technologies in a variety of settings.

Sweeney Anthony reminded them of the goals of the 2015 Edition Final Rule and described IT efforts toward those goals. She went on to say that In addition to the meaningful use programs under HITECH, a number of federal and other health programs currently point to certified health IT and/or the ONC Health IT Certification Program, including the following:

- Physician Self-Referral Law exception and Anti-kickback Statute safe harbor for certain EHR donations
- CMS chronic care management services (included in 2015 and 2016 Physician Fee Schedule rulemakings)
- Department of Defense Healthcare Management System Modernization Program
- The Joint Commission for performance measurement initiative ("ORYX vendor" – eCQMs for hospitals)

The Medicare Access and CHIP Reauthorization Act (MACRA), includes two key programs for Medicare providers: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Among other requirements, MACRA modifies participation and payment for meaningful use Medicare-eligible providers and requires participants to use certified health IT; 25% of the composite performance score under the MIPS must be determined based on performance in the meaningful use of certified EHR technology performance category. The Secretary has discretion to reduce the percentage weight for this performance category (but not below 15%) in any year in which the Secretary estimates that the proportion of eligible professionals who are meaningful EHR users is 75% or greater, resulting in an increase in the applicable percentage weights of the other performance categories. As per HITECH, the CMS EHR Incentive Program for Medicaid and Medicare's Eligible Hospital-based Medicare Meaningful Use program will continue. Staff are exploring ways to advance alignment goals.

HHS released a MACRA RFI in 2015 with a 60-day public comment period to obtain additional feedback about stage 3 going forward, in particular with MACRA. A MACRA NPRM is expected to be released in spring 2016.

Steve Posnack, Office of Standards and Technology, said that the 2016 Interoperability Standards Advisory comment period opened January 19. A HITSC task force will soon be convened to deliberate on interoperability. Interested persons may apply for membership. Staff are finalizing the 2015 Edition test

procedures. The Open Data CHPL is in the final stage of development. The HL7 cooperative agreement continues. ONC recently held a C-CDA implementation-a-thon and kicked off a C-CDA rendering tool challenge.

Chief Medical Information Officer Andrew Gettinger, Office of Clinical Quality and Safety, reviewed accomplishments in safety-enhanced design. Design criteria were incorporated in the 2015 EHR certification criteria. However, safety requires much more than certification. Plans are underway for a non-regulatory Health IT Safety Collaborative. Toward that end, ONC contracted with the National Quality Forum (NQF) for prioritization and identification of patient safety measures in the following three levels:

- Level 1 – Safe Health IT: Addressing Safety Concerns
- Level 2 – Using Health IT Safely: Ensuring the Safe Use of Technology and Avoiding Unintended Consequences
- Level 3 – Using Health IT to Make Care Safer

Aspects of the Interoperability Roadmap are being tested under contract with RTI, Inc. RTI will identify specific opportunities and solutions to improve usability related to medication management. A workgroup of volunteer stakeholders has been convened. Evidence to inform solutions is being acquired and examined, and collaboratively developed solutions will be disseminated. Gettinger mentioned several private-sector initiatives, including the following:

- ECRI Institute: Partnership for Health IT Patient Safety
- Copy and Paste Workgroup
- Patient Identification Workgroup
- Pew Charitable Trusts Medical Device Initiative
- EHR Usability Meeting
- American Medical Association-MedStar Health Partnership Developed
- EHR User-Centered Design Evaluation Framework
- CHIME National Patient ID Challenge (HeroX, $1 million prize)

Q&A

Floyd Eisenberg said that getting data from EHRs to measure quality is a continuing challenge: What is the approach for measuring safety? Gettinger talked about avoiding more reporting burden on the clinical community. It is difficult to devise e-measures. ONC is collaborating with NQF, CMS, and AHRQ. ONC is proposing a collaborative of IT vendors with statutory protection similar to hospitals' protection for discovery of safety issues. Gettinger talked about ongoing research on patient identity management.

Malec summarized that meaningful use requirements are still in place, and ONC and CMS want to reconcile and harmonize reporting and outcomes across various programs.

Patricia Sengstack referred to the many agencies and initiatives working on HIT safety. She wondered about duplicate efforts and creation of different standards. Gettinger said that ONC staff participate in all of these efforts. Often the same people are involved in the different groups. Duplication will be prevented by the individuals involved. The proposed ONC collaborative will be hosted by an organization already working on safety.

Baker acknowledged that she had not read the reports. What about denial-of-service attacks, threat reporting, and similar events that have safety implications? Gettinger responded that parts of the Security Rule have safety implications. The planned collaborative will use different work streams based on the selection of the most significant perceived risks. Medication management was selected, because

it is the number one safety issue according to several studies and reports. Baker reminded him that data integrity affects safety.

Jitin Asnaani referred to Anthony's slide 10 and target areas, saying that $30 million will not accomplish the expansion goal. ONC needs to coordinate with others who have the skills and ongoing community efforts. He observed that it is difficult to keep track of and build on everything going on at ONC. Anthony indicated that she will share his comment with her colleagues. Staff intend to report frequently to the committees and other stakeholders.

Richard Elmore applauded any opportunity to simplify requirements for providers. He wondered how best to bring national interoperability to scale. Posnack responded that the Interoperability Roadmap delineates priorities and timelines. Where there is opportunity for one more round of testing to get to scale, the opportunity will be used. Getting to scale requires a big resource commitment and payment and regulatory levers. Also, grants and procurements will be used. Lorraine Doo interjected that CMS, the national standards group, and ONC have the opportunity with payments to push interoperability to scale. Regarding collaboration, everyone must be at the table in testing for usability. Posnack said that interoperability is expected to have many effects on business interests, clinical care, usable data, and others. ONC participates in Argonaut and many other activities to work toward interoperability.

Public Comment

Jeff Smith, American Medical Informatics Association (AMIA), read a statement on behalf of his organization, saying that the HIPAA access guidance is an opportunity for providers and developers. Computable data will enable better data liquidity. Data liquidity and computable data are essential for a learning health system. Providers can switch vendors more easily, among other benefits. In the longer term, AMIA wants certification requirements to enable the provision of granular, computable structured and unstructured data.

Certified Technology Comparison Task Force Recommendations

Task force Co-Chairpersons Anita Somplasky and Cris Ross explained that in MACRA, Congress requested that the HHS Secretary conduct a feasibility study regarding the need for a certified HIT comparison tool. As part of that study, ONC convened the task force to solicit stakeholder input. The task force was charged with providing recommendations on the benefits of and resources needed to develop and maintain a certified HIT comparison tool. Two virtual public hearings were convened. Output of the hearings indicated that there are ongoing needs for comparison tools for providers who are making their first purchase of HIT products, considering modular component purchase to meet new HIT needs or replace existing HIT products, or developing an ongoing IT strategy to determine what products are on the market and assess future purchase needs. Existing tools are well-respected, have brand recognition, are based on extensive market research, and have developed robust comparison platforms that meet the specific needs of their customers. Nevertheless, current tools may not meet the needs of all providers, particularly providers in small, rural, or specialty practices or other providers that lack technical support. Most tools lack the following:

- Empirical sources of comparison for quality reporting
- Objective usability information
- Comparative product costs
- Information about products' ability to integrate with other health IT

In addition, the cost of the tool may be prohibitive to smaller or under-resourced practices. Testimony indicated that comparison tools have a number of benefits. Ross showed slides that categorized tool

information needs and recommendations on filling those needs by ONC or the private sector. Finally, the task force recommended that ONC should do the following (in order of importance):

1. Advance data sources like CHPL as an information resource for private sector tools (although CHPL is not in itself a tool)
2. Contract with one or more tool vendors to ensure tools are accessible to, and meet the needs of, specialty and small practice providers
3. Communicate about comparison tool availability to health care providers
4. Make recommendations for private sector consideration

ONC should not do the following:

1. Develop and maintain a comparison tool or expand CHPL to serve as a comparison tool.
2. Endorse one or more tool vendors.

Somplasky went through the appendix slides, which listed the attributes of an ideal tool.

Discussion

Halamka referred to KLAS Research's work on interoperability, wondering whether the publication of numerators and denominators of meaningful users is at all useful. He argued for the inclusion of subjective data on a few elements, which would be a Yelp-like function.

Rose referred to gag laws, saying that ONC should get statutory authority for safe haven. The elimination of vendor influence on reviews is a major concern. Ross said that the task force focused on the selection tool. The influence of the reviewed on the reviewer is definitely an issue and has been covered in press reports. Purchase of IT is a complex procurement. Ross deferred to ONC on the safe harbor question. Somplasky said that practices have not been allowed to share information on cost; this needs to change.

Leslie Kelly Hall opined that slide 14 should be amplified. She wondered about attributes for consumer health products within HIT. What about standards to implement the attributes? Ross indicated that the recommendation would apply to features that consumers use. Somplasky added that although APM is largely unknown, any tool will have to take new models into account.

Andrew Wiesenthal talked about the unique needs of small and specialty practices: Should some kind of subscription service be available to conduct evaluations for these practices for a small fee in lieu of contracting with tools? Somplasky talked about her experience with extension centers. To do something similar with every practice is too expensive. She agreed that these providers may need more than a tool.

Tang referred to a missing link: What would motivate the private sector to do this, and what if it does not? Ross told him that, according to testimony at the hearings, recommendation tools are growing in the market. There is no simple solution to designing comparisons. Vendors could not point to specific actions to take toward a tool. Tang wondered why private tool makers cannot do a better job. Ross said that the exact matching of objective attributes and measurement may not be possible.

Lehmann talked about the special needs of pediatricians and others serving vulnerable populations. In 2012, only 8% of pediatricians used full EHR features. What will be done to make specialty needs a priority? Somplasky said that any tool would have to have filter and search capabilities. In the future, specialties may use multiple models and registries. Lehmann said that specialists should be involved in any tool selection development efforts.

Baker objected to the cloud versus hosted attribute listed on slide 14, saying that it seemed an odd characterization. A provider would likely care more about installation and on-site maintenance or

whether a subscription is available. Price and maintenance are probably the most important considerations. Ross agreed, saying that cloud is often used as a proxy for software service. He agreed to change the expression. Baker referred to her work with a HITSC task force on criteria for evaluating the maturity of standards, saying that those recommendations would be a helpful addition to information on EHR selection. Ross responded that the suggestion is a good one. The information could be collectable by CPHL and is measurable and verifiable. Halamka mentioned distinctions between software service, platform service, and outcome service.

Mandel referred to actions that the government could take, one of which is the publication of data captured during testing and certification. Somplasky acknowledged that providers wonder why their certified products do not produce as expected. Mandel said that the CHPL could link to a YouTube video demonstrating the test. The testing process materials could be required to be posted on CHPL. Ross referred to time limitations that restricted the extent to which details could be included in recommendations. However, the general recommendation to expand CHPL to make it more useful and to include consumer comments applies. Halamka interjected that at a recent meeting of Boston area CIOs not one admitted to having a gag order imposed.

Kathleen Blake talked about the importance of quality measures and the longitudinal record, as well as registry data. Registries need comparable data. The problem of the validity of reviews in the area of merchandise has been widely reported. There must be a way to qualify a commenter. Halamka referred to Amazon and validated purchasers. Rational criteria are needed. Ross agreed, saying that another issue is who is allowed to comment on behalf of an organization.

Tang said that the HITPC had made a recommendation on usability certification, similar to Mandel's suggestion. He asked that it be incorporated into the recommendations on comparisons. Ross said that task force members would have to be polled. He did not want to cherry-pick data items. Consolazio said that the task force could be reconvened to deliberate on these suggestions. Dawn Heisey-Grove, ONC, reminded the members that ONC is conducting a feasibility study on the comparison selection tool. She offered to add these comments to the tables in the slides. Ross said that the task force did not gather information on cost and feasibility. Somplasky said that much of what is collected in meaningful use is not meaningful. Tang said that he was not suggesting the collection of new data, just transparency for data already captured at no cost. Ross and Halamka questioned the advisability of mandating publication of the videos of the certification process. Elmore said that there are intellectual property issues that should be considered before taking action. Halamka said that the recommendations presented by the task force could stand with a few changes in wording. Explanations could be expanded in the transmittal letter. Ross said that suggestions for studying the feasibility of adding to CHPL could be highlighted. In response to a question from Malec, Ross stated that the recommendation was to contract with vendors (#2). Discussion ensued about adding another recommendation, deferring action, or modifying recommendation #1. Consolazio and Tang advised that a vote be taken on a new recommendation. Halamka said that recommendation #1 could be amended to the effect that the advancement of CHPL would be informed by a feasibility study to be conducted by ONC. Hearing no objections, Halamka declared the recommendations so approved.

> **Action item #3: The recommendations of the Certified Technology Comparison Task Force were approved with the addition of a reference to the results of a feasibility study.**

Closing Remarks and Thoughts of Appreciation

DeSalvo thanked Halamka for his 10 years of extraordinary service, personal time, and intellectual capital. Halamka said that this was an important transition. With the retirement of several members, the composition of the HITSC will change significantly. The work of Baker and others will live on. White

recognized each of the retiring members by listing the numerous workgroups and task forces on which each had participated during his or her tenure. In addition to Vice Chairperson Halamka, the terms of the following members have expired: Baker, Keith Figlioli, Rebecca Kush, Jamie Ferguson, Ross, and Wes Rishel.

Halamka said that, since 2005, he had attended 200 meetings, many more than he had expected when he joined the American Health Information Community. He recalled discussions of topics such as CCR, CCD, SNOMED, and whose XML is better (all of these things are now in production), as well as the transition from a public-private effort to a federal advisory committee. In 2015, FHIR and Open ID were topics. HIT has moved a long way. Halamka acknowledged that he is weary of regulations and would like to make the proverbial water better in lieu of leading or forcing the horse to water. He identified patient identification as the most important issue for standards and recommended that every patient and provider have an API. He passed the baton to the new HITSC co-chairpersons, Gallagher and Malec, saying that from now on, everything that they say and write will be deemed influential. He ended by saying that it had been an honor to serve.

Public Comment

Three comments were received via the Web meeting chat.

Sherry Reynolds wrote, "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?"

Sherry Reynolds wrote again, "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/"

Mbanks wrote, "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."

SUMMARY OF ACTION ITEMS

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Action item #2: The summary of the December 10, 2015, HITSC meeting was declared approved by Halamka.

Action item #3: The recommendations of the Certified Technology Comparison Task Force were approved with the addition of a reference to the results of a feasibility study.

Meeting Materials

- Agenda
- Summary of November HITPC meeting
- Summary of December HITSC meeting
- Presentations and reports slides