HIT Policy Committee
FINAL
Summary of the April 7, 2015 Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the Health Information Technology Policy Committee (HITPC) meeting. She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with opportunity for public comment (limited to 3 minutes per person), and that a transcript will be posted on the ONC website. She instructed members to identify themselves for the transcript before speaking. Members introduced themselves.

Remarks

In the absence of National Coordinator Karen DeSalvo, Chief Operating Officer Lisa Lewis acted as chairperson. She thanked everyone and said that the HIT Strategic Plan and Interoperability Roadmap will be finalized this summer. Jodi Daniel, ONC, previewed her presentation on the certification NPRM by saying that the rule proposes to leverage certification more broadly. She emphasized that HITECH gives ONC broad authority for certification beyond meaningful use.

Review of Agenda

Vice Chairperson Paul Tang noted the agenda items. The agenda was distributed in advance of the meeting. He asked for a motion to approve the summary of the March meeting as circulated. A motion was made and seconded. The motion was approved unanimously by voice vote.

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

Data Updates

Dawn Heisey-Grove, ONC, presented graphs. EP registration continues to increase. Registration is used as a marker of intent to participate. More Medicaid EPs have registered than originally estimated. 86% of Medicare-registered EPs have attested to meaningful use compared to 32% of Medicaid-registered EPs. Less than half of all Medicaid-registered EPs attested to meaningful use in the year immediately following AIU payment. Although 4 in 10 registered EPs were scheduled for stage 2 in 2014, progress to stage 2 differed between the two programs. 56% of all Medicare-registered EPs were scheduled for stage 2 in 2014 compared to 8% of Medicaid-registered. Over 90% of EPs scheduled for stage 2 in 2014 were participating in the Medicare arm of the program. Medicare data for the period are currently being analyzed and will be reported at a future meeting.

Q & A

Referring to the differences in Medicaid and Medicare participation, Paul Egerman observed that in addition to the question of insufficient financial incentives, smaller organizations have a less developed infrastructure with which to implement HIT and qualify for incentives. As a result, the program may contribute to rather than reduce inequality. Heisey-Grove acknowledged that smaller providers need technical assistance. The Regional Education Centers provide assistance to Medicaid providers. As a result, the organizations that received assistance were more likely to achieve meaningful use than like organizations that did not get assistance. Tang said that AIU payments are intended to assist small providers in this regard.

Chris Lehmann referred to recently-published papers (Pediatrics, December 29, 2014) on the disproportionate effects of the incentive program on pediatricians and their patients. Pediatricians primarily qualify for meaningful use under the Medicaid provisions. Some states have yet to include CHIP. There is state variation in reporting requirements. As a result of these and other policies, child Medicaid and CHIP beneficiaries are not being treated as effectively as are adults under meaningful use. According to Heisey-Grove, mechanisms other than meaningful use are available to resolve such disparities.

CMS Meaningful Use Stage 3 Update

Kate Goodrich, CMS, and Elisabeth Myers, CMS, gave an overview of the stage 3 NPRM. Goodwin said that CMS has invited private payers to participate in value based purchasing reforms. Goals include that by 2016 30% of payments are tied to alternative programs and 80% are tied in some way to quality measures. CMS has attempted to integrate and coordinate meaningful use with its other programs. To make the incentive program more flexible, CMS proposes: a single, aligned reporting period for all providers-entire calendar year (with Medicaid exception); the option to start stage 3 in either 2017 or 2018 (required in 2018); and more flexible measures under health information exchange, consumer engagement and public health reporting. The rule would reduce the number of objectives to 8. It includes a single set of measures slightly tailored for EPs and hospitals; removes redundant and widely adopted measures; realigns the reporting period into one for all providers with EHs to participate on a calendar instead of a fiscal year; aligns quality data reporting; and focuses on electronic submission. Via streamlining, the rule focuses on objectives that support advanced use of EHR technology. Providers would have more options to effectively coordinate patient care. She referred to one of the slides that delineated the reporting options. Starting in 2018, providers must use 2015 CEHRT and meet stage 3 requirements for the full year, with a limited exception for Medicaid providers demonstrating meaningful use for the first time. She emphasized that CMS has attempted to integrate the incentive program with its other efforts to improve quality and to implement value-based pay. The comment period is open until May 29, 2015. CMS announced January 29 its intent to engage in rulemaking this spring and is considering shortening the 2015 reporting period to 90 days and realigning hospital reporting to the calendar year.

Q & A

Christine Bechtel asked about options for portals and OpenID, and multiple apps. She was concerned that too much would be left to providers rather than encouraging consumers' choice. According to Goodwin, the goal is flexibility. Myers described the three different use case options, saying that staff wants comments on the use cases. Daniel said that ONC is asking for comment on how to make this work. Bechtel declared that the Consumer Workgroup does not have sufficient information and technical expertise to comment. She requested assistance.

2015 Certification NPRM

Jodi Daniel, ONC, gave an overview. To advance interoperability, the rule proposes new and updated vocabulary and content standards for the structured recording and exchange of health information, including the Common Clinical Data Set. For transitions of care, both versions of the Consolidated CDA (Release 1.1 and Release 2.0) + Edge Protocol and rigorous testing for CCDA creation templates are proposed. The 2015 Base EHR Definition focuses on the functionalities that all users of certified Health IT should minimally possess consistent with the HITECH Act requirements. To enhance access, the Common Clinical Data Set includes key health data that should be exchanged using specified vocabulary standards and code sets as applicable. The 2015 Edition also proposes that the Common Clinical Data Set be available for additional use cases, including data portability, VDT and API. Several ways to increase user and market reliability are proposed. Privacy and security would be tied to specific functionalities, with the point being to transfer responsibility from the provider to the vendor. Safety enhanced design for a set of functionalities is proposed. The rule proposes in-the-field surveillance. Specific actions for transparency are proposed, such as disclosure of certain costs, contract restrictions, and posting on the CHPL. In order to better support the care continuum, the rule proposes a more accessible certification program that supports diverse health IT systems, including but not limited to EHR technology and health IT across the care continuum. Some optional criteria are: exchange of sensitive health information (data segmentation for privacy); record of social, psychological, and behavioral data; laboratory exchange; and care plan. She went on to name a few of the programs that currently use or propose to use the ONC Health IT Certification Program—Physician Self-Referral Law Exception and Anti-kickback Statute safe harbor for certain EHR donations, CMS chronic care management services, Department of Defense Healthcare Management System Modernization Program, and Joint Commission for participation as an ORYX vendor.

Q & A

Tang requested clarification questions only, reminding the members that the workgroups will be preparing detailed and formal comments on the NPRMs. Continuing with his concern for inequality, Egerman observed that the 1000 pages are nearly incomprehensible. How could an entrepreneur or small provider deal with such volume and complexity? He referred specifically to field testing by 15 customers. What about a vendor who does not have a sufficient number of customers? He also wondered about organizations not currently covered but could be covered at some time in the future. Daniel responded that any program that decided to include certification in the future would be required to engage in a notice of rulemaking. Egerman disagreed, saying that according to a SRG act, federal or state legislation could require certification without opportunity for public comment. Daniel pointed out that legislation is typically followed by rulemaking. Mike Lipinski, ONC, pointed out that the reference to 15 customers is a recommendation only. Comments are requested. Regarding smaller organizations and those targeting the underserved, ONC is already taking steps to assist them, such as working with SAMHSA and HRSA grantees, veterans and the accessibility community.

Tang reminded the members to ask clarification questions only. Another member who identified himself as an entrepreneur observed that CMS is shifting from the use of incentives to digitalize the U.S. health care system to the use of certification. Certification is being expanded to the post incentive payment period. Goodwin said that the elements of meaningful use are becoming the foundation of payment programs. Daniel noted that all ONC certification, although it may be required by other programs, is voluntary. When someone mentioned the lack of unique national identifiers as a fundamental barrier to interoperability, Daniel explained to the members, as she has done at many previous meetings, that HHS

appropriations legislation specifically prohibits that consideration. However, under transfer of care, criteria for patient matching are proposed.

Tang noted that the time allocated for discussion had expired. Troy Seagondollar observed that the CCDA is the current standard for sharing information. Regarding the sharing of relevant information from provider to provider, what is proposed as relevant data? He asked specifically about devices of which there are numerous variants. Daniel said that UDI refers to implantable devices. Lipinski said that the purpose is to capture certain information and test to ensure its capture. ONC did not specify any limitations. Comments are welcome. Seagondollar said that a CCDA cannot be reduced to less than 40 pages. Even in a digital environment, no clinician will read through that volume of information to integrate into another record. According to Myers, the purpose is for the provider to have the capability to send all data. Defining clinical relevancy is admittedly challenging; comments are expected. Tang asked for brevity.

In response to questions from Bechtel, Daniel affirmed that this is not the final stage of certification. Regarding options, areas such as psychological information are new territory. ONC negotiated with CMS staff who wished to limit the required objectives. Lipinsky pointed out that the optional aspects are not associated with the incentive program.

Pertaining to a question on intended links between payment reforms and enabling technology, Goodwin indicated that there was no explicit thinking about what tools might contribute to which aspects of payment reform. Interoperability is required for all of the new systems. Referring to Egerman's comment about the burden involved in understanding and commenting on the NPRMs, Lehmann inquired about a summary. Lipinsky said that various aids are in production. The upcoming HIMSS presentation will be available. Staff will design presentations for various audiences. Many requirements are in effect for legal documents. Staff plans to produce additional documents. After publication of the final rule, staff will publish another document with everything in one place. Daniel added joint CMS-ONC webinars to the list. She said that the preamble explains a lot.

Anjum Khurshid observed that there are many contradictions among the goals. He asked about the role of HIEs for data sharing. Goodwin replied that when she talked about flexibility, she was referring to the three measures for exchange. A provider must attest to all three and meet the thresholds of at least two of the three measures. Myers referred to the Roadmap as to how these could be achieved.

Gayle Harrell questioned the basis of authority for optional certification. Daniel explained again that ONC's certification authority is not limited to EHR technology and meaningful use. HIT is not limited to type. She assured Harrell that staff works closely with general counsel in formulating the NPRM. She offered to talk with Harrell offline. Harrell referred to the avoidance of bureaucratic creep.

Interoperability Roadmap Comments

ONC staff had assigned four of the workgroups specific sections of the Roadmap on which to comment. The workgroups gave their preliminary recommendations at the March HITPC meeting. In the interim, they completed their assignments. Each workgroup circulated final comments in advance of the meeting. The final comments included information previously submitted.

Interoperability and HIE Workgroup Chairperson Micky Tripathi presented general comments. The workgroup recognizes the importance of accurate identity matching and reliable resource location as roadmap categories. The workgroup raised many concerns. One concern is the aggregate number and complexity of the critical actions and the ability of the industry to accomplish actions in the 2015-2017 timeline. The 2015-2017 timeframe should focus on motivating use of requirements put in place in stage

1 and 2. New actions should be planned in 2015-2017 but not implemented until later. The Roadmap articulates an interoperability floor rather than a ceiling (i.e. matching should go beyond the minimum data matching elements). Half of the 2015-2017 critical actions rely on policy and operational functions driven by coordinated governance, which is not specifically defined. The workgroup declined to endorse or reject critical actions relying on coordinated governance. He continued. The Roadmap should include record location as a long-term goal based on identity matching and resource location capabilities. Private data sharing arrangements are already deploying such services today (CommonWell, MA HIway, etc). There is potential opportunity for CMS to launch Medicare-focused Record Location Services based on existing claims and HITECH data. Accurate individual data matching technical standards are necessary but not sufficient to establish accurate and reliable patient matching. There is value in communicating a best practice minimum set of standardized data elements for patient matching. However, such a set should not be required for patient-matching, nor should it be the basis for defining MU or EHR certification requirements. The 2015 Edition EHR Certification NPRM proposes requiring most of the Roadmap minimum data set recommendations. Best practice suggests using as many of the minimum data set elements as available and appropriate to the specific use case and/or data sharing arrangement. Co-chairperson Chris Lehmann interjected that the minimum data set refers to sex while the Roadmap uses the preferred term gender. Tripathi went on. Use of minimum set for patient matching is NOT mandatory due to high variation in data availability, data quality, and use case appropriateness. There is too much existing variation in data and use case circumstances to set top-down requirements. Locally driven data governance, such as data sharing arrangements as defined by the JASON Task Force, should be the prime motivators for use of the minimum data set and addressing technical and business requirements beyond the minimum set. Critical action item M2.1 should be moved from 2015-2017 to the 2018-2020 timeframe.

Regarding reliable resource location, Lehmann showed slides with detailed comments. He said that most of the reliable resource location critical action Items cannot be accomplished in the 2015-2017 timeframe and should be moved to 2018-2020 or beyond. Additionally, location should be focused on specific use cases since different use cases and problems will drive different technical and business requirements. Although the workgroup supports the various ONC initiatives contained in N2, members are concerned that ONC and CMS do not have the resources to undertake all of these critical action items in the 2015-2017 timeframe. The workgroup supports adding Direct addresses and ESI information to NPPES and making NPPES information openly available to support resource location and recommends that this be done in the spirit of an Open Data Initiative rather than as a provider directory service. Allow open access to the data via common industry data standards and let the market define services and uses.

Tang said that the comments would be approved by sections. There were no questions or objections to approval of the recommendations of the Interoperability and HIE Workgroup.

The Privacy and Security Workgroup made overarching comments and on sections H and G. The comments filled 19 slides. Chairperson Deven McGraw reported that ONC should clarify language regarding the relationship between basic choice and existing health or medical privacy laws that permit the sharing of health information for some purposes, such as among health care providers for treatment and care coordination, without the requirement to first obtain patient permission. ONC should make sure the final Roadmap clearly and unambiguously articulates the following national near-term goals:

- Exchange is permitted for certain purposes without an individual's permission;
- Basic choice, *if offered to individuals,* is offered in a technically standard way and individuals can more easily make choices electronically and online; and
- Harmonize categories and conditions legislatively defined under federal and state law (e.g., mental health).

With respect to exchange among providers, the Interoperability Roadmap should focus first on removing the roadblocks to exchange pursuant to existing laws, to achieve more consistent interpretations of these laws and assure greater interoperability. Regarding section H - consistent representation of authorization to access health information, comments responded to specific questions. ONC should gather information from a broad array of stakeholders trying to exchange, or facilitate the exchange of, health information to determine common obstacles with respect to demonstrating legal authority to access a record, particularly for treatment and care coordination purposes, and starting with circumstances where consent is not required. Clarification from state and federal regulators (ideally with specific examples) about what is acceptable for demonstrating legal authority to access information would be enormously helpful. Focus should be on specific, high impact use cases that achieve the interoperability goals of years 1-3 of ONC's 10-year vision. ONC should work with stakeholders to define these examples that might serve as a basis for additional regulatory guidance; achievement of meaningful use objectives and sharing within accountable care organizations pursuant to other alternative payment models are two suggestions. Suggested priority areas are: demonstrating the existence of a direct or indirect treatment relationship; requirements to share data for treatment or care coordination (both privacy and security); and the impact of consent or authorization of the patient to share information, both in circumstances where it is required and in circumstances where it is not. One example is the HITPC approved recommendations from the Tiger Team that included best practices for demonstrating legal authority to access a record in an environment governed by HIPAA. These and other approaches deemed acceptable should be broadly disseminated, if necessary in conjunction with the Office for Civil Rights (OCR) or other regulatory agencies. There is also confusion with respect to other federal laws (42 C.F.R. Part 2) as well as state laws, where even providers operating within states do not fully understand their own state laws with respect to authorized sharing of identifiable health information. ONC should focus on facilitating entity-to-entity exchange; who is permitted to access that information within the entity – role-based access – should be left to internal policies. Clarification that sending organizations are not legally responsible for how a receiving organization routes communication could help resolve uncertainty. The Interoperability Roadmap could reinforce the need for organizations to embrace best practices with regard to structuring these internal policies. Granular consent requirements may necessitate some role standardization. As ONC further explores harmonization of more granular consent laws, it should consider whether role standardization, at least a high level, would help resolve interoperability obstacles posed by granular consent requirements.

Responses to questions asked in section G (consistent representation of permission to collect, share and use identifiable health information) were presented.

> G1. Are states ready to collaborate on the issue of permission? Why or why not? We agree collaboration would be helpful and hope there is a willingness on the part of the states to come to the table, but states are addressing many issues and there may be limited bandwidth to take this on, particularly given its complexity. There will need to be a federal "convener" to support this effort. An early focus could be on developing standard definitions, so that consent can be more consistently represented. As the imperatives to exchange grow stronger (due to payment reform and increased adoption of telemedicine, for example), the distress levels felt by

providers who are unable to exchange due to lack of understanding of legal requirements and lack of technical mechanisms for achieving compliance will increase. This may help bring people to the table. States could consider whether the framework recommended by the National Committee on Vital and Health Statistics (NCVHS), which established specific, defined categories for granular consent, would help them achieve some consensus on how to harmonize. Consider also whether the Uniform Law Commissioners could help in drafting harmonized approaches. The development of standards on granular choice should focus on circumstances where a patient's consent is required by law to improve provider confidence that they are exchanging data in compliance with law, and therefore to remove barriers to interoperable exchange.

G2. What other methodologies, including technical solutions, should also be considered to address this concern? ONC should evaluate the work done by the Social Security Administration (SSA) in formulating a universal authorization to share data that has enabled them to access data across states for consideration in disability determinations. ONC should also investigate the successful nationwide implementation of simple consumer preferences (akin to basic choice) through the FTC's Do Not Call Registry. ONC should also look at successful existing exchange models to explore whether their approaches can be scaled. Use of consent repositories is another approach worth considering. Achieving technical ability to persist consent or authorization is desirable – but likely only in those circumstances where there is either a legal obligation for consent to be persisted and honored across settings, or in the circumstance of data shared directly by, or at the request of, the patient. At a minimum, consents need to be clearly communicated in circumstances where law or policy requires consent for sharing. In our work on query for patient records, as well as on granular consent and data segmentation, we have repeatedly recommended having a standard way of communicating consent to share where such consent is required. There is concern that in the absence of a legal obligation to obtain the consent of the patient, it may not be possible for that consent to be honored downstream. Individuals providing that consent need to understand this. Does persistence of a consent trigger an obligation (either in reality or perception) that the consent must be honored? In addition, if we require consent to be persisted, do we risk creating an environment where consent becomes a de facto requirement because the absence of consent communicates that such sharing is not permitted?

ONC should make sure it also focuses on assuring that exchange can occur in circumstances governed by HIPAA (where choice is not necessarily required), in addition to focusing on choice circumstances. For example, ONC should look at the recommendations on directed exchange adopted by the HITPC in August 2010. ONC should also consider how to enable patients – such as through basic choice – to require that their data be shared for treatment purposes; in other words, ONC and applicable regulators could clarify whether a provider is permitted to refuse to exchange data when a patient requests exchange. This should be a fundamental use case for the Interoperability Roadmap and an example for which additional regulatory guidance could be promulgated. Basic choice has been implemented in one form or another by a number of HIEs and other exchange settings. Achieving exchange among HIEs is a desirable near-term goal, which bolsters the argument for early focus on basic choice. Because granular choice harmonization requires some significant work on the policy front, and work with multiple states, efforts to bring states together to begin the dialogue could be launched even while the standards focus is on enabling basic choice. ONC can consider whether there are intermediate options between basic and granular, because granular is typically defined as applying to types of data. ONC can consider enabling choice at the level of provider or provider organization, and enabling patients to make more global choices (for example, all treating providers vs. being required to specifically name them). Success

metrics should be linked to Interoperability goals, and, as noted above, focused on removal of obstacles to achieving high impact use cases. Examples were given.

In response to a question about role-based rules being an impediment to exchange, McGraw said that HIPAA requires organizations to formulate role-based access policies, but does not say what they should be. While ONC should focus on entity-to-entity exchange, staff should be aware of the possibility of role-based rules posing barriers in some situations.

Egerman expressed concern regarding the consistent requirements for sharing data: Are there exceptions? Is this only for treatment purposes? McGraw explained that under HIPAA the patient has a right to obtain and have data sent to another provider. There are a few very narrow exceptions such as expected harm to a patient. The workgroup was thinking primarily about a patient wanting data for treatment or research purposes, which would trump a provider's preference for use of the information. The patient has the right to have her data sent to any entity or destination, including apps. Egerman brought up potential provider concerns about burden, cost or security risk. McGraw referred to provisions about unreasonable burden and requests. Lucia Savage, ONC, interjected that ONC wants to have a better fit between patient and provider understanding about transfer and disclosure. The question posed was on a need for clarity; the discussion demonstrates that there is indeed such a need. Egerman pointed out that providers must be allowed to protect their systems against denial of service attacks. McGraw noted that the recommendation is that ONC consider how to do this. She indicated that the workgroup could say more. She seemed to be willing to add Egerman's point allowing providers to protect their systems by giving information in alternative ways.

Advanced Health Models and Meaningful Use Workgroup Chairperson Paul Tang reviewed the workgroup's assignment—to develop a repeatable process to identify priority use cases with high impact on the triple aim and apply the process to the set of use cases complied in Appendix H of the Roadmap. At the March meeting, Tang had described the prioritization process based on pass-fail triple aim impact, programmatic needs, market and industry readiness for phasing, and beneficiary net impact. HITPC members expressed no objections to that framework as described. As a result of scoring the impact criterion, 56 use cases were reduced to 15. The slides and a document circulated prior to the meeting explained the scoring criteria and rating process. In conjunction with the formulation of five vision statements, which were stated on slides, the following high priority use cases were then selected:

- A health care professional accesses and imports elements of a common clinical dataset on an individual she is treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings
- A health care professional accesses and imports elements of a common clinical dataset on an individual she is treating from the EHRs of other providers who have cared for the same patient, in order to improve coordination of care across settings
- An individual queries for a common clinical dataset from all of her health care providers and receives these data as a single aggregated record to support better self-management
- An individual (or family member/personal caregiver) sends person-generated data automatically from home-based medical devices (e.g., BP cuffs, glucometers and scales) to the individual's health record
- A health professional's system automatically sends reminders to a patient for preventative screenings, care and medication regimens based on the individual's own care history, to increase adherence to recommended preventive care
- A primary care provider sends a specialist a basic set of patient information consisting of structured data and free electronic text to support more effective care coordination
- A specialist sends a primary care provider a basic set of patient information consisting of structured data and free electronic text, including the findings of a consultation or determination that no consult is needed, to support more effective care coordination
- A payer links clinical quality data from providers with administrative cost data to support more accurate assessment of value in value-based payment models
- Providers automatically send syndromic surveillance data (including de-identified data) to public health departments to improve public health monitoring

Tang concluded that federal agencies can leverage and use this process to identify and reach consensus on top use cases with consideration for respective programmatic needs. States can use this in combination with or as their own use case prioritization process as part of their own roadmap activities. Beneficiaries can leverage the process for delineating use case gaps and net impact across types (consumer, community, provider, public health, research, and payer). Tang said that this two-stage prioritization process separates technical considerations from programmatic and strategic needs to inform policy decisions. The workgroup found the attributes appropriate and their assessment straight-forward. Nevertheless, additional work on inter-rater variability and a Delphi approach would be useful. This matrix provides a global view to identify gaps and address programmatic needs. Members made no comments.

Consumer Workgroup Chairperson Christine Bechtel submitted comments in a 20-page letter and a 24-slide deck. The workgroup was assigned sections C and D, and it also made overarching comments. The overarching comments include the following:

- Partnerships among clinicians, patients and family caregivers should be an essential building block in the Learning Health System (LHS); Building block B already states "a supportive business and regulatory environment that encourages interoperability."
- Consider merging sections C and D to support the partnership and streamlining of the overall effort of achieving a LHS
- Rapidly changing role of the consumer and evolution of technology are not well reflected in the overall plan. EHRs appear to be the central focus
- Replace others with authorized family members and other authorized caregivers throughout the roadmap
- Replace care plan with person centered plan because health care is a piece of the plan but includes other areas such as community services and long term care services.
- Provide a realistic vision of what interoperability will or should look like in 2024. In a truly patient-centric model, the patient will be the dominant curator of health information
- Section D should be revised to better emphasize the clinical-patient–family partnership. Section D is very provider focused, even in sections where consumers and families have an important role to play (example: governance). Section D is potentially overwhelming; providers report being overwhelmed with requirements today (MU, PQRS, ICD 10, etc.). Overall we suggest focusing more on outcomes and less on process. Combining this with Section C could also help

The workgroup also made comments on a number of the specific calls to actions as embedded in the presentation slides.

Egerman referred to the Consumer Workgroup membership roster and asked about the absence of EHR vendors. Bechtel replied that ONC selects the membership. Egerman opined that vendor participation could be helpful. He agreed that metrics should focus on outcomes, not interoperability per se.

Charles Kennedy emphasized that the industry supports quality measures. Bechtel explained that in referring to the absence of a business case, the workgroup was focusing on development of measures such as patient-reported functional improvement over time. Seagondollar indicated his approval of the references to PGHD and devices. More than collection and acquisition are required. The market is pushing the use of many devices. There is a need to validate, calibrate, and evaluate the quality of the data and measures. Furthermore, there may be legal responsibility issues to consider.

McGraw referred to privacy and security, and providing access to the patient's own behavioral health data. The data segmentation standard reviewed by the Privacy and Security Tiger Team and proposed for certification is for read only access in order to prevent re-disclosure. Bechtel said that the comment is intended to allow patients to make decisions about disclosure broadly. The comment does not refer to data segmentation in that context. She said that McGraw's comment can be added to the letter. In response to a question by Khurshid on transparency, Bechtel indicated that the timeline as proposed was adequate.

Tang said that action on the Roadmap was required. He summarized that a comment on data segmentation will be added to the Consumer Workgroup's report. A reference to security attacks and denial of service will be added to the recommendations of the Privacy and Security Workgroup. There were no additions to the recommendations of the Interoperability and HIE Workgroup and the Advanced Health Models and Meaningful Use Workgroup. Tang asked for a motion to that effect. The motion was made, seconded and unanimously approved by voice vote. The amended recommendations will be submitted to ONC.

Action item #2: The recommendations on the Interoperability Roadmap were accepted as presented with additions to the Consumer Workgroup's and Privacy and Security Workgroup's recommendations respectively.

Tang and Consolazio announced that the following members' terms are expiring: Kennedy, David Bates, Marc Probst, and Bechtel.

Public Comment: None

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the March 2015 HITPC meeting was approved unanimously by voice vote.

Action item #2: The recommendations on the Interoperability Roadmap were accepted as presented with additions to the Consumer Workgroup and Privacy and Security Workgroup respectively.

Meeting Materials

- Agenda
- Summary of March 2015 meeting
- Presentations and reports slides

Meeting Attendance							
Name	04/07/15	03/10/15	02/10/15	02/10/15	01/13/15	12/09/14	11/04/14
Alicia Staley		X				X	
Anjum Khurshid	X	X	X	X	X	X	
Aury Nagy						X	
Charles Kennedy	X		X	X	X		
Chesley Richards	X	X			X		
Christine Bechtel	X	X	X	X	X	X	
Christoph U. Lehmann	X	X			X		
David Kotz	X	X	X	X	X		
David Lansky	X	X	X	X	X	X	
David W Bates		X	X	X			
Deven McGraw	X	X	X	X	X	X	
Devin Mann		X	X	X	X	X	
Gayle B. Harrell	X	X	X	X	X	X	
Karen DeSalvo	X	X	X	X	X	X	

Kim Schofield	X		X	X	X	X	
Madhulika Agarwal	X						
Marc Probst	X	X	X	X	X	X	
Neal Patterson	X		X	X		X	
Patrick Conway							
Paul Egerman	X	X	X	X	X		
Paul Tang	X	X	X	X	X	X	
Scott Gottlieb	X		X	X			
Thomas W. Greig	X	X			X		
Troy Seagondollar	X	X	X	X	X	X	
Total Attendees	**19**	**17**	**17**	**17**	**17**	**14**	**0**