HIT Standards Committee
Final
Summary of the June 24, 2015, Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator for Health Information Technology (ONC), welcomed participants to the meeting of the Health Information Technology Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee Act meeting with an opportunity for public comment (3-minute limit) 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

National Coordinator Karen DeSalvo thanked the HITSC members for their participation. She recognized the members whose terms expired with this meeting: Ann Castro, Dixie Baker, Martin Harris, David McCallie, Stan Huff, Liz Johnson, John Derr, John Perlin, Jeremy Delinsky, and Sharon Terry.

Review of Agenda

Vice Chairperson John Halamka reflected on the history of the HITSC and the progress made over the past 10 years in health information technology. The current task is to simplify standards. Halamka hopes that new members will build on the progress made to date and not reopen old issues. He spoke about the specific contributions of each retiring member. He noted the agenda items. The agenda had been circulated in advance of the meeting.

Deputy National Coordinator and Chairperson P. Jon White thanked everyone. Halamka asked whether there were corrections or additions to the summary of the May 2015 meeting. Hearing none, he declared them approved.

> **Action Item #1: The summary of the May 20, 2015, meeting was accepted as circulated in advance of the meeting.**

S & I Framework: Data Access Framework (DAF) Initiative Update

Initiative Coordinator John Feikema and Dragon Bashyam reported that DAF primarily focuses on enabling providers to access their patients' clinical information using modular and substitutable standards and profiles within their own local organization (Local DAF) and from a single targeted external organization (Targeted DAF). A future phase is expected to expand to multiple external organizations. The DAF scope is to develop an implementation guide using standards and profiles for specific use cases. The use cases deal with accessing both data elements (e.g., problems, medications, procedures) and documents (e.g., CCDA, C32). The following topics are currently out of scope:

- Trust establishment between organizations for Targeted Query

- Discovery of end points for Targeted Query
- Patient matching rules and algorithms that organizations may implement
- Policies that allow or disallow disclosure of patient data

Next, Bashyam showed a slide that depicted the query stacks and described their building blocks. He talked about various projects in collaboration with SDOs. The DAF S & I Initiative–IHE PCC collaboration published the DAF IHE White Paper in fall 2014. Existing IHE profiles that can be leveraged for document access were identified. Emerging FHIR-based profiles for document access were also identified as were gaps for discrete data element access.

The DAF S & I Initiative–HL7 Collaboration developed an implementation guide using the FHIR standard for data element access. The HL7 PSS was approved in fall 2014 and published for DSTU 2 in May 2015. It is currently under ballot reconciliation. A data element list based on stage 2 plus community input was published. The DAF S & I Initiative–IHE USA/IHE PCC Collaboration developed an implementation guide using the MHD Version 2 (FHIR-based) profile for document access and another implementation guidance for existing SOAP stack based on XCA. The guide was submitted to IHE for balloting.

Bashyam went on, listing other DAF-related projects. The Argonaut Project is led by industry in collaboration with HL7, with goals that include the following: development of CCDA to FHIR mappings, security guidance for FHIR, and FHIR implementation and DSTU publication. HEART is an MIT project supported by ONC as a committed member. The goal is to harmonize and develop a set of privacy and security specifications and profiles to enable individuals to control access to RESTful health-related resources by using Oauth, OpenId, and UMA. The plan is to develop open source reference implementations for the developed specifications and profiles. See http://openid.net/wg/heart/charter/. The DAF security layer could potentially reuse profiles and specifications developed by HEART. The report concluded with a slide on future phases and federated access.

Q & A

Halamka noted that the Argonaut Project is making every effort to coordinate with DAF. Arien Malec talked about the importance of making sure that foundational standards work stays close to implementation. An overly enthusiastic approach to innovation results in getting too far ahead of capacity to implement, an example being Blue Button Plus. A community of interest is essential. Malec advised finding a community of implementers before initiating additional work.

According to Baker, DAF is a good model for ONC's work with the private sector. She referred to PCORnet, which already has an information model. She wondered whether there are plans to change, replace, or harmonize the data model. Bashyam responded that staff has mapped the data model to the file model, but technical-level discussions have yet to take place to decide on an approach. Baker offered to confer with him about PCORnet.

McCallie questioned the purpose of DAF. DAF is doing architectural work in the middle, which is not sufficient to do lower-level work and is not driven by a business model. It has a quasi-governmental imprint and is harmful. A number of things, such as trust for targeted query and matching, were left out. These elements are essential for scale. Argonaut participants have put money on the table because they see a business value. To invent something with the assumption that it will be used is not smart. McCallie indicated that he even questioned Direct Query.

White explained that the origin of the DAF project was affected by funding allocated in the Patient Protection and Affordable Care Act. Staff attempted to involve PCORnet participants, who said that they did not have time. Another attempt is being made. ONC wishes to involve others as well. McCallie

reiterated that ONC should not have to shop standards around. Halamka referred to his June 10 blog on interoperability. He said that an urgent need for a standard, combined with governance and an enabling infrastructure, was necessary. Building a standard in itself is not sufficient.

Wes Rishel summarized what he had learned about the complexity of achieving interoperability. Developers cannot get too far ahead of implementation. A standard interface will not work unless both sides of the interface have a business reason for making it work. Nothing works unless it meets a business objective. When a business objective is present, a way will be found even with bad standards. The establishment of meaningful use incentives without a broader business objective met with limited success. The potential for Argonaut comes from participants' common business interest. Rishel wondered how an agency such as ONC can function in the government world, then say, "Let Argonaut do it," and we will regulate it. He said that he wanted interoperability through economic dominance of the business leader without giving over ultimate control to a possible monopolist.

Malec said that he, Huff, and the S & I Task Force members make recommendations on initiatives at the request of ONC staff. One recommendation was that having a funder is not a sufficient reason for an initiative; others referred to priorities and having a community of interest. The recommendations were accepted by the HITSC and submitted, but no information has been provided on their status. The opinions being expressed during the meeting are similar to those set forth in the recommendations.

Steve Posnack, ONC, assured Malec that the recommendations are being taken seriously and reviewed, but they cannot be applied retroactively. Resources have been committed and cannot be pulled back. The recommendations are sound and staff is attempting to align them with ongoing work concerning patients and outcomes. Staff is trying to engage a community of interest.

Nancy Orvis said that the DAF work was helpful regarding continuity of care and providers that were not previously connected. The driver for providers' participation in HIEs is continuity of care and the avoidance of unnecessary retesting.

Halamka summarized that in hindsight it is obvious that the role of government in 2015 is different from a few years ago. The government has a role as convener of like business interests and less of a role in standards development. Standards development efforts have shifted to the private sector.

Interoperability Standards Advisory (ISA) Update

Chris Muir, ONC, reported that the intent of the advisory is to provide the industry with a single, public list of standards and implementation specifications to achieve a specific clinical health information interoperability purpose and to prompt debate among industry stakeholders when more than one standard or implementation specification could be listed as the best available. It is non-binding, although it may be adopted in regulation, required as part of a testing and certification program, or included as procurement conditions. Exactly 59 entities made public comments, 32 supportive and 8 not supportive. The remainder could not be categorized. Muir showed slides that categorized the comments. There was some support for expanding the scope of security standards. Commenters sought definitions for terms such as purposes, standards, and implementation specifications. Commenters expressed interest in the ISA update process, the criteria for the best available standard, guidance on the maturity of standards, and telegraphing future changes to standards or implementation specifications. Muir described the comments to specific questions. Comments on Question 5-1 were not consistent. Adding security standards was a consistent theme again in response to Question 5-2. In response to the question of what purposes are missing, the 23 responses were not consistent. Suggestions made in response to Question 5-4 were also inconsistent.

ONC staff has established the HITSC ISA Task Force, which will make recommendations to the HITSC August 26. In September, staff will update the ISA based on the HITSC recommendations, and a second round 60-day public comment will be opened. The ISA will be published in 2016. The Task Force is charged to make recommendations regarding revisions that ONC should consider as it creates a 2016 ISA. Public comments can be accessed at http://www.healthit.gov/policy-researchers-implementers/2015-interoperability-standards-advisory-public-comments.

Q and A

Halamka declared that some standards should go into regulations, some should never be used, and others may belong in an advisory. McCallie said that he considers the ISA harmful. The regulatory approach is to select standards. Standards are necessary but not sufficient. They follow business purposes. Consulting a list of standards is not the way to solve problems. Most of the standards in the current ISA list are not helpful. Just because there is a use case and an existing standard does not mean that it should be listed for sub-regulatory guidance. Some standards should be left out of the advisory, even though a gap may remain.

In response to a question from Leslie Kelly Hall, Muir assured her that the staff is also considering comments on the Interoperability Roadmap. He said that although no consumer group commented on the ISA, there were a number of comments about consumers.

Floyd Eisenberg criticized the report, saying that it is not sufficient to note that responses were inconsistent. More analysis and substance are needed. Clem McDonald, who is not a committee member, sought to speak, but Halamka ruled that he must wait for public comment. Muir said that although the comments were scattered, more detail will be presented to the task force.

Baker said that many security standards are applicable beyond health care, although there are some health care-specific security standards, and there are health care-specific implementation guidances. Direct Query is an implementation guidance. She questioned the need for a task force.

Rishel referred to McCallie's comment on the value of the ISA, saying that sometimes these documents carry weight in internal government discussions. Therefore, the ISA should not be promiscuous. Rishel told Kelly Hall that some of the worst outcomes have been the result of efforts on behalf of patients. All providers recognize the importance of involving patients in their health care, but that awareness has not led to improvements in health. Providers acknowledge that they do not know how to engage patients in their data. There is no economic driver for doing so.

Lisa Gallagher said that the Transport and Security Workgroup had provided a list of basic security standards and comments. Lorraine Doo advised not to specific a version of a standard in regulations.

Kelly Hall responded to Rishel, saying that the issue is which standard to use. There are standards that do apply to patients. Consumer-friendly standards can be combined with other work on standards development. There is a moral obligation to include patients as equal participants in health care. Rishel said that he applauded Kelly Hall's work, but over a period of 6 years, the committee has tried to use standards to take on the challenge of consumer involvement, which is much broader than standards and sharing information. It has not worked, because it preceded a business objective.

2015 Certification NPRM Prioritization Recommendations

Content Standards Workgroup

Co-chairperson Rich Elmore showed and talked about two slides. One listed the standards that the workgroup recommended for adoption. They were as follows:

- Clinical Quality Measures: Health Quality Measure Format (eMeasure) DSTU, Release 2
- Common Clinical Data Set: Using SNOMED and Consolidated CDA standards as specified below.
- API Access to Common Clinical Data Set: FHIR
- Quality Reporting: HL7 Implementation Guide for CDA® R2: Quality Reporting Document Architecture — Category 1, DSTU Release 2 (U.S. Realm) and Errata (September 2014)
- September 2014 Release of the U.S. Edition of SNOMED-CT® and LOINC® Version 2.50
- Consolidated CDA: 2.1 if available in time for the final rule with backwards compatibility; only certify one version of Consolidated CDA — no interim period with two versions
- Refinement still needed for identification of food/substance-reactions/intolerances, labs, and med order entry
- Citation of standards should be done in a manner that allows maintenance updates to be published, perhaps just adding "or subsequent maintenance releases"

The workgroup recommended against adoption of the following standards at this time:

- Clinical Decision Support: HL7 Version 3 Standard: Clinical Decision Support Knowledge Artifact Specification, DSTU Release 1.2 (July 2014), Health eDecisions (HeD) Standard Release 1.2
- Data Segmentation for Privacy: HL7 Implementation Guide: Data Segmentation for Privacy (DS4P), Release 1
- Electronic Sending of Medical Document: Author of Record Level 1: Implementation Guide
- Virtual Medical Record: HL7 Implementation Guide for CDA® R2: Quality Reporting Document Architecture — Category 1 (QRDA), DSTU Release 2 (U.S. Realm)
- Quality Improvement and Clinical Knowledge Data Model
- Electronic Delivery of Service (eDOS): HL7 Version 2.5.1 Implementation Guide: S & I Framework Laboratory Test Compendium Framework, Release 2, Version 1.2 (eDOS)
- NCPDP Formulary and Benefit Standard (prefer real-time prescription benefit)

Discussion

Halamka noted an inconsistency on the slides: QRDA was listed both for and against adoption. Eisenberg (a member of the workgroup) pointed out that the slide was not correct. It should state QRDA Category 1, Release 3, which is now published on the HL7 website and corrects the errors in the previous release. In response to another question, he said that HQMF is directional. An upcoming ballot has been scheduled. Posnack assured everyone that the slides will be corrected, including removing an incorrect bullet on the second slide. According to Halamka, not all standards on the recommended adoption slide are actually ready at this time. Baker agreed that FHIR is not ready for national adoption.

Malec asked about the context for recommending HQMF. Eisenberg said that HQMF is recommended for expressing measures, and adoption of HeD for CDS is not recommended. Malec asked for clarification on the certification criterion. Halamka said that the two may be decoupled.

Posnack clarified that it is integrated into the QRDA Category 1. The September 2014 errata reflect updates to Implementation Security Category 1 consistent with HQMF Measures Release 2.1. But there was not a separate proposal in the NPRM.

Halamka asked for differentiation between standards that are currently ready for adoption and those that could be ready at a later time. He called for objections to moving forward. None were stated. Halamka called the recommendations approved pending corrections.

> **Action Item #2: The recommendations of the Content Standards Workgroup were approved, pending distinguishing of those standards that are approved but not yet ready from those that are ready.**

Semantic Standards Workgroup

In the absence of the chairperson and co-chairperson, Mitra Rocca, an ex officio workgroup member representing FDA, reported on the workgroup's rating of the standards assigned to it. Members used the readiness criteria previously approved by the HITSC (see http://jamia.oxfordjournals.org/content/jaminfo/early/2014/12/17/amiajnl-2014-002802.full.pdf?%2520ijkey=8oAq1ZTZyQ6edqC&keytype=ref\). She said that standards still under development or in draft stage (DSTU) by definition cannot be high maturity (e.g., FHIR profiles, application access APIs, others). With evidence of successful pilots, maturity, and adoptability generally are medium. When rating adoptability, the relationship between the target or desired level of adoption and the current level and other barriers to adoption (e.g., associated infrastructure) were considered. There are items that may not meet criteria for national standards but may still be valuable or necessary to designate. ICD-10-CM and ICD-10-PCS are not in use but are specified in HIPAA rules. UCUM is not widely adopted but is the only choice to standardize units. Items may be acceptable in isolation, but when considered in combination or in a broader context, they may be problematic. For example, LOINC for laboratory CPOE has been successful in isolated instances, but there are still major barriers to broad adoption. In using the criteria and definition of attributes, standards not listed as high/high should not qualify for designation as national standards, except as noted.

Halamka stopped the presentation to say that the slides did not make sense, were incorrect, and should be sent back to the workgroup. It does not make sense to say that a standard is mature in one context and not in another when the only difference is the wrapper. If the vocabulary standard is widely adopted and familiar, who cares about the package?

Baker said that suitability for use was confused with readiness. Orvis said that message format and content are often confused in her organization. Huff, a member of the workgroup, explained that the context of use was used in the ratings of maturity. McCallie said that the workgroup seemed to rate the context not the vocabulary.

Malec said that context is important is system-to-system interoperability. He questioned the ratings. Baker talked about the difference between certification criteria and standards. Standards may be mature and ready for use but not ready to be used for certification criteria. Many of these standards are ready for use as standards but not for certification.

Halamka declared that the report should be sent back to the workgroup. Huff argued that context should be taken into consideration for adoption. For example, LOINC is ready for lab results but not genetics. Halamka said that the slides mixed and confused context, content and semantics. Posnack suggested that they summarize the discussion for the transmittal letter.

Rocca continued through the 26 slides showing rankings of high (H), medium (M) or low (L) on maturity and adoptability. The ranking were as follows:

CDT dental procedures:

- § 170.315(b)(1) — Transitions of care: H H
- § 170.315(b)(6) — Data portability: H H
- § 170.315(e)(1) — View, download, and transmit to third party: H H
- § 170.315(g)(6) — Consolidated CDA creation performance: H H
- § 170.315(g)(7) — Application access to common clinical data set* L L

CPT-4

- § 170.315(b)(1) — Transitions of care: H H

- § 170.315(b)(6) — Data portability: H H
- § 170.315(e)(1) — View, download, and transmit to third party: H H
- § 170.315(g)(6) — Consolidated CDA creation performance: H H
- § 170.315(g)(7) — Application access to common clinical data set: L L

ICD-10-PCS

- § 170.315(b)(1) — Transitions of care: L L
- § 170.315(b)(6) — Data portability: L L
- § 170.314(e)(1) — View, download, and transmit to third party: L L
- § 170.315(g)(6) — Consolidated CDA creation performance: L L
- § 170.315(g)(7) — Application access to common clinical data set: L L

LOINC

- § 170.315(a)(2) — Computerized provider order entry — laboratory*: L L
- § 170.315(a)(6) — Vital signs, body mass index, and growth charts: H M
- § 170.315(a)(21) — Social, psychological, and behavioral data**: M L
- § 170.315(b)(1) — Transitions of care: H H
- § 170.315(b)(4) — Incorporate laboratory tests and values/results: H H
- § 170.315(b)(5) — Transmission of laboratory test reports: H M
- § 170.315(b)(6) — Data portability: H H
- § 170.315(e)(1) — View, download, and transmit to third party: H H
- § 170.315(f)(3) — Transmission to public health agencies — reportable laboratory tests and values/results: M M
- § 170.315(f)(4) — Transmission to cancer registries: M M
- § 170.315(g)(6) — Consolidated CDA creation performance: H H
- § 170.315(g)(7) — Application access to common clinical data set: L L

Race and ethnicity

- § 170.315(a)(5) — Demographics: H M
- § 170.315(b)(1) — Transitions of care: H M
- § 170.315(b)(6) — Data portability: H M
- § 170.315(c)(4) — Clinical quality measures — filter: H M
- § 170.315(e)(1) — View, download, and transmit to third party: H M
- § 170.315(g)(6) — Consolidated CDA creation performance: H M
- § 170.315(g)(7) — Application access to common clinical data set: L L

OMB race and ethnicity

- § 170.315(a)(5) — Demographics: H M
- § 170.315(b)(1) — Transitions of care: H M
- § 170.315(b)(6) — Data portability: H M
- § 170.315(e)(1) — View, download, and transmit to third party: H M
- § 170.315(g)(6) — Consolidated CDA creation performance: H M
- § 170.315(g)(7) — Application access to common clinical data set: L L

Birth sex must be coded in accordance with HL7 Version 3 attributed as follows: (i) Male. M; (ii) Female. F; (iii) Unknown. UNK

- § 170.315(a)(5) — Demographics: M M

- § 170.315(a)(6) — Vital signs, body mass index, and growth charts: M M
- § 170.315(a)(21) — Social, psychological, and behavioral data: M M
- § 170.315(b)(1) — Transitions of care: M M
- § 170.315(b)(6) — Data portability: M M
- § 170.315(c)(4) — Clinical quality measures — filter: M M
- § 170.315(e)(1) — View, download, and transmit to third party: M M
- § 170.315(g)(6) — Consolidated CDA creation performance: M M
- § 170.315(g)(7) — Application access to common clinical data set: L L

HL7 Version 3

- § 170.315(a)(21) — Social, psychological, and behavioral data: H L

UCUM

- § 170.315(a)(6) — Vital signs, body mass index, and growth charts: H M
- § 170.315(a)(21) — Social, psychological, and behavioral data: H M
- § 170.315(b)(1) — Transitions of care: H M
- § 170.315(b)(6) — Data portability: H M
- § 170.315(e)(1) — View, download, and transmit to third party: H M
- § 170.315(g)(6) — Consolidated CDA creation performance: H M
- § 170.315(g)(7) — Application access to common clinical data set: L L

HL7 Version 3

- § 170.315(a)(15) — Family health history — pedigree: L L

SNOMED-CT

- § 170.315(a)(7) — Problem list: H H
- § 170.315(a)(12) — Smoking status: H M
- § 170.315(a)(14) — Family health history: H H
- § 170.315(a)(21) — Social, psychological, and behavioral data: H H
- § 170.315(b)(1) — Transitions of care: H H
- § 170.315(b)(2) — Clinical information reconciliation and incorporation: H L
- § 170.315(b)(6) — Data portability: H H
- § 170.315(c)(4) — Clinical quality measures — filter: M M
- § 170.315(e)(1) — View, download, and transmit to third party: H H
- § 170.315(f)(3) — Transmission to public health agencies – reportable laboratory tests and values/results: M M
- § 170.315(f)(4) — Transmission to cancer registries: M M
- § 170.315(g)(6) — Consolidated CDA creation performance: H H
- § 170.315(g)(7) — Application access to common clinical data set: L L

NCPDP

- § 170.315(a)(11) — Drug formulary and preferred drug list checks: H M
- Consolidated CDA
- § 170.315(b)(1) — Transitions of care: M H
- § 170.315(b)(2) — Clinical information reconciliation and incorporation: M L
- § 170.315(b)(6) — Data portability: M H
- § 170.315(b)(7) — Data segmentation for privacy — send: L L

- § 170.315(b)(9) — Care plan: M H
- § 170.315(e)(1) — View, download, and transmit to third party: M H
- § 170.315(g)(6) — Consolidated CDA creation performance: M H
- § 170.315(g)(7) — Application access to common clinical data set: L L
- § 170.315(i)(1) — Electronic submission of medical documentation: M L

ICD-10-CM

- § 170.315(b)(1) — Transitions of care: L L
- § 170.315(b)(6) —Data portability: L L

SCRIP

- § 170.315(b)(3) —Electronic prescribing: H H

RxNORM

- § 170.315(b)(1) — Transitions of care: M M
- § 170.315(b)(2) — Clinical information reconciliation and incorporation: M L
- § 170.315(b)(3) — Electronic prescribing: M H
- § 170.315(b)(6) — Data portability: M M
- § 170.315(e)(1) — View, download, and transmit to third party: M M
- § 170.315(g)(6) — Consolidated CDA creation performance: M M
- § 170.315(g)(7) — Application access to common clinical data set**: L L
- HL7 Standard Code Set CVX — vaccines
- § 170.315(b)(1) — Transitions of care: H H
- § 170.315(b)(6) — Data portability: H H
- § 170.315(e)(1) —View, download, and transmit to third party: H H
- § 170.315(f)(1) — Transmission to immunization registries: H M
- § 170.315(g)(6) — Consolidated CDA creation performance: M M
- § 170.315(g)(7) — Application access to common clinical data set: L L

National Drug Code Directory — Vaccine Codes

- § 170.315(b)(1) — Transitions of care: M M
- § 170.315(b)(6) — Data portability: M M
- § 170.315(e)(1) — View, download, and transmit to third party: M M
- § 170.315(f)(1) — Transmission to immunization registries: M M
- § 170.315(g)(6) — Consolidated CDA creation performance: M M
- § 170.315(g)(7) — Application access to common clinical data set: L L

PHIN Messaging Guide

- § 170.315(f)(2) — Transmission to public health agencies – syndromic surveillance: M M

HL7 Version 2.5.1

- § 170.315(f)(3) — Transmission to public health agencies — reportable laboratory tests and values/results: M M
- § 170.315(f)(4) — Transmission to cancer registries: M M

IHE Quality, Research, and Public Health Technical Framework

- § 170.315(f)(5) — Transmission to public health agencies – case reporting: M M

HL7 Implementation Guide for CDA

- § 170.315(f)(6) — Transmission to public health agencies — antimicrobial use and resistance reporting: M M
- § 170.315(f)(7) — Transmission to public health agencies — health care surveys: M M

Discussion

Halamka observed that there were too many issues, qualifications, and objections to describe in a transmittal letter. Malec recalled that medium maturity was intended to be used for limited-scale production use. Therefore, many of the medium ratings were not correct. McCallie suggested another category: not yet relevant. Members continued to make comments about specific ratings until Consolazio intervened to say that action would not be taken. Staff will work with the co-chairpersons to rework the recommendations. Revised recommendations will be circulated for an e-mail vote.

Architecture, Services and APIs Workgroup

Architecture, Services, and APIs Workgroup Co-chairpersons McCallie and Malec reported on standard readiness. Malec noted that a transmittal letter had been approved at the May meeting. He summarized that HL7 FHIR is not yet ready to be a national standard. Healthcare Provider Directory is not ready for a national standard and should be removed from the NPRM. There is general agreement with XDM Package Processing. Continuity of Care Document (CCD) is limited to CCD for Data Portability. CAQH CORE should not be in the NPRM.

The group went on to recommend convening of a task force on orchestration patterns to consider peer-to-peer and peer-to-peer with delegated authority, publish/subscribe, general pattern notification of an event, and CDS as a service, as well as more generalized orchestration patterns.

Discussion

Kelly Hall talked about managing HeD, which has not worked well. Malec said that the recommended approach would make CDS more broadly applicable. Kelly Hall expressed her eagerness to help with a task force on orchestration.

Halamka declared that he heard no objections to acceptance of the recommendations.

> **Action Item #3: The recommendations of the Architecture, Services, and APIs Workgroup were accepted.**

Implementation, Certification, and Testing Workgroup

Co-chairperson Liz Johnson reported that the following are recommended for adoption: gap certification eligibility table, common clinical data set definition, and the ONC HIT Certification Program and HIT Module. The workgroup was generally supportive of Open Data Certified HIT Product List, retesting and certification, design and performance, and removal of the meaningful use measurement certification requirements. For various reasons, adoption was not recommended for the following: unique device identifier (UDI), immunizations mapped to NDC codes, CCDA creation performance, requiring all the document templates to be mandatory (list of document types), base EHR definitions, safety-enhanced design, Web content accessibility guidelines, required summative testing, encounter diagnoses, medication dosing, implantable device list, pharmacogenomic data standards, data portability, and automated numerator recording and calculation. In addition to the rationales and qualifications summarized on the slides, Johnson said that a report accompanied the recommendations.

Discussion

Kelly Hall expressed concern about the recommendation not to adopt UDIs, saying that they are being used with increasing frequency, and patients want to know about their implanted devices. Johnson said that ambulatory services are not yet ready for the use of UDIs. Providers are diligent about informing patients, when they can locate them, about implanted devices when FDA or other warnings are received.

Halamka said that he heard no objections to approving the recommendations.

> **Action Item #4: The recommendations of the Implementation, Certification, and Testing Workgroup were accepted as presented.**

Public Comment:

McDonald referred to the recommendations of the Semantic Standards Workgroup. He pointed out that unless there is a consistent standard, there is no point in requiring CPOE. He explained that there were LOINC copyright issues related to the social psychological variables. However, except for stress, they have been resolved and are ready for use. These codes are not in SNOMED. The entire report needs more homework.

Lindsey Hoggla, Academy of Nutrition and Dietetics, read a long statement on behalf of her organization. Content for nutrition care across all settings and conditions should be represented. Medication allergies should include food allergies terminology as is now available in SNOMED-CT. This is essential for patient safety.

Closing

Consolazio thanked the members of the workgroups, which are being sunset in favor of short-term task forces on select topics. She invited everyone to apply to join one of the task forces. The HITSC will not meet in July.

SUMMARY OF ACTION ITEMS:

> **Action Item #1: The summary of the May 20, 2015, meeting was accepted as circulated.**
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> **Action Item #2: The recommendations of the Content Standards Workgroup were approved, pending distinguishing those standards that are approved but not yet ready from those that are ready.**
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> **Action Item #3: The recommendations of the Architecture, Services, and APIs Workgroup were accepted.**
>
> **Action Item #4: The recommendations of the Implementation, Certification, and Testing Workgroup were accepted as presented.**

Meeting Materials:

- Agenda
- Summary of May 2015 meeting
- Meeting presentation slides and reports

Meeting Attendance								
Name	**06/24/15**	**05/20/15**	**04/22/15**	**03/18/15**	**01/27/15**	**12/10/14**	**11/18/14**	**10/15/14**
Andrew Wiesenthal		X	X	X	X	X		X
Anne Castro	X	X		X	X	X	X	X
Anne LeMaistre	X	X	X	X	X	X	X	X
Arien Malec	X	X	X	X	X	X	X	X
C. Martin Harris	X		X	X	X	X	X	
Charles H. Romine		X	X	X	X			X
Christopher Ross	X	X	X	X	X			X
David McCallie, Jr.	X	X	X	X	X	X	X	X
Dixie B. Baker	X	X	X	X	X	X	X	X
Elizabeth Johnson	X		X	X	X	X	X	X
Eric Rose		X	X	X	X	X	X	X
Floyd Eisenberg	X	X		X	X	X	X	X
James Ferguson		X	X	X	X	X		X
John Halamka	X	X	X	X	X	X	X	X
John F. Derr	X		X	X	X	X	X	X
Jon White	X	X	X	X	X	X		
Jonathan B. Perlin				X				
Keith J. Figlioli	X	X		X		X		X
Kim Nolen	X	X	X	X	X	X	X	X
Leslie Kelly Hall	X	X	X	X	X	X	X	X

Lisa Gallagher	X	X	X	X	X	X	X	X
Lorraine Doo	X		X	X	X	X	X	
Nancy J. Orvis	X		X	X	X			X
Rebecca D. Kush		X			X		X	X
Sharon F. Terry			X					X
Stanley M. Huff	X	X		X	X	X	X	X
Steve Brown	X		X			X		
Wes Rishel	X	X	X	X	X	X	X	X
Total Attendees	**21**	**21**	**22**	**26**	**25**	**22**	**20**	**25**