HIT Policy Committee and Standards Committee
FINAL
Summary of the October 6, 2015, Joint 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) and Standards Committee (HITSC) joint meeting and called the roll. She reminded the group that this was a Federal Advisory Committee Act 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 and other participants introduced themselves. New members were recognized: Angela Kennedy, Patricia Sengstack, Richard Elmore, and Josh Mandel on the HITSC and Brian Burns, U.S. Department of Veterans Affairs, on the HITPC.

Remarks

National Coordinator Karen DeSalvo previewed each item on the agenda, which was distributed before the meeting. Each topic contributes to the U.S. Department of Health and Human Services (HHS) priority to build a person-centered health care system. Private and federal government partnerships are critical to accomplishing goals. She thanked the committee members.

Remarks and Review of Agenda

HITPC Vice Chairperson Paul Tang said that stage 3 of meaningful use will focus on outcomes and getting systems in place for reform. Tang referred to the summary of the September 2015 HITPC meeting. Paul Egerman moved to accept the summary. The motion was seconded and approved unanimously.

> **Action item #1: The summary of the September 2015 HITPC meeting was accepted as distributed.**

HITSC Vice Chairperson John Halamka welcomed the new members to the 75th meeting. He noted the importance of interoperability for the survival of health care systems. Deputy National Coordinator Jon White welcomed everyone. He recognized Jodi Daniel, who is leaving ONC, for her many years of service. Tang and DeSalvo also thanked Daniel for her extraordinary contributions.

Halamka asked whether there were any objections to the summary of the September 2015 meeting of the HITSC. Hearing none, he declared them approved.

> **Action item #2: The summary of the September 2015 HITSC meeting was accepted as distributed.**

Data Update

Elizabeth Holland, CMS, showed slides and gave the monthly report on the Medicare and Medicaid EHR Incentive Program. Through August 2015, nearly 546,000 EPs and EHs had registered. Due to proposed modifications for 2015, Medicare attestation data for EHR reporting periods in 2015 are not available. A short window opened in the summer to accommodate EHs and CAHs in their first year of participation. Attestation for 2015 will open on January 4, 2016 and run through February 29, 2016.

Q&A

None

Delivery System Reform Update

DeSalvo showed slides and described plans for system reform. The three focus areas are pay providers, deliver care, and distribute information. She reminded the members that in January 2015, HHS announced goals for value-based payments in Medicare FFS. The first goal is that 30% of Medicare payments are tied to alternative payment models built on FSS architecture and population-based payment by the end of fiscal year 2016 and 50% are by the end of 2018. The second goal is that 85% of Medicare FFS payments are tied to quality or efficiency of health care delivery, alternative payment models built on FSS architecture, and population-based payment by the end of 2016 and 90% are by the end of 2018. DeSalvo said that the available information indicates that these goals are realistic. A number of large private systems have indicated their movement in a similar direction.

HHS launched the Health Care Payment Learning and Action Network in March to help advance work across private and public sectors to increase the adoption of value-based payments and alternative payment models. Regarding care delivery, the Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation. Recently, $685 million was awarded to 39 national and regional health care networks and supporting organizations to help equip more than 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and reduce costs. Funding is going to practice transformation networks and support and alignment networks. Examples of Practice Transformation in Action grants follow:

- The American College of Emergency Physicians and the American College of Radiology will engage clinicians, patients, and families in reducing unnecessary testing. Working with member emergency department physicians and radiologists, they intend to avoid more than 1.1 million unnecessary diagnostic imaging tests and engage physicians in collaboratively selecting the most appropriate imaging exam, thus reducing unnecessary exposure to radiation and duplication of tests that inconvenience patients and increase costs.
- The National Rural Accountable Care Consortium will assess, educate, and provide onsite peer-supported education and training to more than 5,500 rural providers who may wish to transition into accountable care organizations.
- The American Board of Family Medicine will work with more than 25,000 family physicians serving 50 million or more patients to help clinicians and patients navigate the changing health care system, reduce disparities in health care, and move toward a wellness-based approach to managing care.
- The National Nursing Centers Consortium will work with more than 7,000 nurse practitioners who support 2.5 million patients to eliminate more than 14,000 unnecessary tests and to avoid more than 4,000 unnecessary hospital admissions.

DeSalvo emphasized the importance of interoperability in achieving these ends.

Q & A

Eric Rose asked about the state of the art of quality measurement, referring to the adverse effects of past efforts in which some measures resulted in withholding care. DeSalvo talked about the responsibility to streamline and harmonize quality measurement across federal programs and assist Medicaid and private payers in doing the same. The goal is to establish e-clinical quality measures that do not require additional work flow. The Interoperability Standards Advisory provides an e-clinical data set as a building block. Measuring the right outcomes is important. DeSalvo referred to the IOM work on measures that matter. Measures should be simple, seamless, and straightforward. Kate Goodrich, CMS, added that an examination of performance on process measures found they had little effect on related outcome measures. CMS wants to move to more robust use of electronic data. Overtime, CMS has rebalanced its portfolio of measures, resulting in the removal of 50 measures.

Paul Egerman commended the removal of 50 measures. He asked how the model correlates with the Interoperability Roadmap. DeSalvo replied that representatives of ONC, CMS, and other HHS agencies meet frequency to coordinate their work. The key to coordination is alternative payment models and pulling as well as pushing data. Recommendations will be made to Medicaid programs on advancing value-based payments. The meaningful use program has provided rich data resources that will be used.

Wes Rishel referred to the dots shown on slide 6 and wondered about the overlay of Medicare Advantage: What will be the impact on Medicare Advantage? DeSalvo said that Medicare Advantage estimates are not sufficiently accurate to show on slides. However, many Medicare Advantage programs have already moved to value-based payments.

Arien Malec asked about efforts to encourage commercial payers to use value-based measures. Goodrich described a core measure collaborative to get payers and other relevant organizations to agree on aligned measures. When e-measures have been agreed on, CMS will implement them and private payers will incorporate them into their contracts. There is already consensus on some measures. CMS officials recognize the need to use electronic data for measures. However, these changes will take time.

Leslie Kelly Hall asked how appropriate care measures will include the patient's voice. Goodrich assured her that such measures will eventually be adopted. CMS recently began to require that actual patients (in addition to representatives of consumer advocacy organizations) be among the participants in planning groups on measure development. CMS staff has learned a lot from this new approach. However, they are still learning how to involve patients in measure development. DeSalvo said that ONC has launched an initiative on patient-generated health measures. Other efforts and use cases, such as PCOR, precision medicine, preparedness, and public health, are also relevant.

Andrew Wiesenthal said that the ICD-10 lesson is relevant. Delivery systems are looking for a clear path from FFS to value-based payments: Is there a plan for moving paths and targets? DeSalvo responded that the learning in action network will help to define paths. The downside risk to the transition must be minimized. There will be pain points for EPs. The grants referred to earlier will help to do that. CMS and HRSA have peer learning programs that can be used. Goodrich added that for physicians, the Medicare Access and CHIP Reauthorization Act (MACRA) is an opportunity to move to value-based payment. CMS will issue rules, establish policies, and provide tools to define the pathways. DeSalvo said that HHS must balance doing less and doing more.

Richard Elmore wondered about short-term HIT) priorities. Noting the afternoon agenda, DeSalvo said that unblocking the movement of data is important, including for private payers. Drivers can be created for shared APIs. The private sector can act before the final rule.

Dixie Baker inquired about the involvement of patients, noting that CMS is reducing the patient engagement measures: What are the alternative means and metrics? Goodrich said that the proposed rule includes use of APIs, which may be a better opportunity than portals for patients to engage. Baker observed that that pertains to certification. Goodrich pointed out that the proposed metric allows either portals or APIs.

David Lansky offered a suggestion for mapping the value-based payment model to the work of the HIT committees. The CMS proposed joint replacement comprehensive payment bundle could be a test case. The outcome measures have been specified with good patient-reported outcome measures. A set of risk adjustment variables would have to be captured from the clinical IT systems to interpret those outcome measures. There is mission appropriateness and potential overuse of bundles for which no measures are currently available. Patient-reported outcomes for which the standards have yet to be fully articulated will be used. The question of how to devise the standards, the IT infrastructure, the analytics, and feedback seem to be issues appropriate for a tiger team to work through. Goodrich said that the MACRA requires work to obtain robust stakeholder input. She agreed that such committee input would be helpful. Regarding the joint replacement model and patient-reported outcomes, data on patient-reported functional status will be required. Considerable work on the measures remains to be done.

In response to a question from Josh Mandel, Goodrich confirmed that the 30% goal applies to payment dollars. Chris Lehmann observed that quality is specialty specific. Four states are not ready for ICD-10, which will affect pediatric populations. Although 25% of patients are children, in 2012, only 8% of pediatricians had pediatric functionality built into EHRs. If one wants to report on quality and drive value driven care, EHRs to support that care and allow documentation are required. ONC should examine EHR certification requirements for subspecialties. DeSalvo said that certification rules were changed to focus on functions. As the certification program matures, ONC will look for new ways to tailor functionalities.

Sengstack reminded the members that the nation's 3.4 million nurses do the majority of documentation for payments. In her organization, a student counted 537 clicks to fill out the required nursing assessment for one patient; much of the documentation was considered irrelevant to patient care. She asked about goals or roadmaps to shrink the number of unnecessary clicks. DeSalvo introduced Rebecca Freeman, the new ONC chief nursing officer. Documentation burden should be considered in relation to outcomes. DeSalvo is currently working on a response to a related question from Senator Lamar Alexander. The documentation burden has a negative effect on accuracy. DeSalvo indicated that she would appreciate input from the committees. Goodrich reported that the proposed rule reduces documentation. She agreed that setting targets for reduction could be helpful. Regarding quality measures, she acknowledged that CMS could have done better in stages 1 and 2 by gathering information from and involving frontline workers. Nevertheless, CMS is currently working with frontline workers.

Gayle Harrell said that the expertise of frontline workers should be sought for development of specialty measures. She questioned the achievability of the goal of 90% by 2018 given the status of interoperability. DeSalvo agreed that more engagement of frontline workers is needed. The goal for Medicare payments is on target. Harrell also expressed concern about the capacity of rural providers for interoperability. DeSalvo said that ONC is working with CAHs; she agreed that they are facing significant problems.

DeSalvo acknowledged that all of this will be hard. The reward system will drive changes in behavior. Advanced decision support will play a part. Intermountain Healthcare is a good model. Based on her experience in New Orleans after Katrina, DeSalvo believes that change can happen quickly.

Medicare Access and CHIP Reauthorization Act (MACRA) Request for Information (RFI)

Goodrich showed many slides. MACRA will change how Medicare pays physicians. MACRA replaces the sustainable growth rate (SGR) methodology, which has caused physician payment uncertainty for more than a decade. MACRA is more predictable than SGR. It will increase the number of physicians participating in alternative payment models that encourage quality and efficiency. Physicians in high-quality, efficient practices may benefit financially from MACRA. CMS is starting to develop proposals that implement MACRA's key elements. Goodrich went on to describe these proposals. The Merit-based Incentive Payment System (MIPS) includes consolidated aspects of the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare EHR Incentive Program. It includes incentive payments for certain EPs who participate in alternative payment models (APM) and encourages the creation of physician-focused payment models (PFPM). The paths for EPs include the following:

- EPs can participate in MIPS or meet requirements to be a qualifying APM participant (QP).
- EPs in MIPS can receive a positive, negative, or neutral payment adjustment.
- EPs who are determined to be QPs for a year will be excluded from MIPS and receive a 5% lump sum incentive payment for that year.
- MIPS payment adjustments and APM incentive payments will begin in 2019.
- The APM incentive payment will be available from 2019 through 2024. Beginning in 2026, services furnished by QPs will receive a 0.75% fee schedule update, and all other services will receive a 0.25% fee schedule update.

MIPS consolidates aspects of the three programs with a single composite performance score. Payment adjustments will increase from +/- 4% in 2019 to +/- 9% in 2022 and later. It is budget neutral unless an exception applies. Additional funding for positive adjustments for exceptional performance for the period 2019–2024 will be instituted. Goodrich described the MIPS Composite Performance Score, which is based on weights in four categories. The weights may be adjusted if there are not sufficient measures and activities applicable for each type of EP, including assigning a scoring weight of 0 for a performance category. EHR weighting can be decreased and shifted to other categories if the HHS Secretary estimates that the proportion of physicians who are meaningful EHR users is 75% or greater (statutory floor for EHR weight is 15%). The performance threshold will be established based on the mean or median of the composite performance scores during a prior period. The composite performance score will range from 0 to 100. The score will assess achievement and improvement when data are available.

Regarding the RFI, CMS seeks public comment on questions related to the following topics:

- MIPS EP identifier and exclusions
- Virtual groups
- Quality performance category
- Resource use performance category
- Clinical practice improvement activities performance category
- Meaningful use of certified EHR technology (CEHRT) performance category
- Other measures
- Development of performance standards
- Flexibility in weighting performance categories
- MIPS composite performance score and performance threshold
- Public reporting and feedback reports

The MACRA specifies that the measures and activities for the meaningful use of certified EHR technology performance category under the MIPS are the requirements established under HITECH for determining whether an EP is a meaningful user of CEHRT. Under MACRA, 25% of the composite MIPS performance score must be determined based on performance in the category of meaningful use of CEHRT. MACRA gives the HHS Secretary 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 EPs who are meaningful EHR users is 75% or greater), resulting in an increase in the applicable percentage weights of the other performance categories. Goodrich reported that the RFI delineates the following questions pertaining to meaningful use of CEHRT:

- Should the performance score for this category be based solely on full achievement of meaningful use?
- Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive Program's meaningful use objectives and measures?
- How should such a methodology be developed?
- Should scoring in this category be based on an EP's under- or overperformance relative to the required thresholds of the objectives and measures, or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?
- What alternate methodologies should CMS consider for this performance category?
- How should hardship exemptions be treated?

Goodrich went on to define an eligible APM entity as having the following characteristics:

- Requires participants to use certified EHR technology
- Provides payment for covered professional services based on quality measures comparable to MIPS quality measures
- Either requires participants to bear financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home model expanded under section 1115A(c)

A small minority of providers will qualify for the APM incentive payment in the early years. For the period 2019–2024, there are two options, one for Medicare thresholds and another for all-payer thresholds. A Technical Advisory Committee (TAC) will be named to allow stakeholders to propose PFPMs. The TAC will review and provide recommendations to the Secretary based on criteria established through rulemaking. HHS and CMS will review and prioritize recommendations against existing factors, which are described at http://innovation.cms.gov/Files/x/rfi-websitepreamble.pdf. Technical assistance will be available to practices in Health Professional Shortage Areas. MACRA requires the HHS Secretary to enter contracts or agreements with appropriate entities, such as quality improvement organizations, regional extension centers, or regional health collaboratives. These entities will offer guidance and assistance to MIPS EPs with respect to the performance categories or in transitioning to the implementation of and participation in an APM. The RFI was published September 2015. Webinars are planned for October. The proposed rule is expected to be published in March 2016 with final regulation publication expected October 2016. The Health Care Payment Learning and Action Network was established to increase the adoption of value-based payments and alternative payment models through a learning collaborative. Interested persons are encouraged to sign up at http://innovationgov.force.com/hcplan. Daniel encouraged members to submit individual comments. ONC is not asking for committee feedback due to the short comment period.

Q&A

Neal Patterson wondered whether these changes will replace the current procedures coding system required for physicians. Goodrich admitted that the proposed system does not change current procedures for coding and billing. The MIPS is based on the way medicine is practiced and billed for today, however onerous. Devin Mann pointed out that nothing about these programs changes what providers have to do in terms of coding and billing for services. Goodrich said that CMS understands the burden of reporting. The law is clear regarding the intent to move to registry and EHR-based submissions of data. New programs for interfacing with CMS are needed. This law provides for more flexibility. What would be most helpful to CMS is for members to think about how to achieve an ideal state. Mann observed that regulations should be explicit and based in part on time studies and should require that new procedures demonstrate value without drag. The work burden should not be increased. DeSalvo said that some of FFS makes sense for specialists. The comment period is an opportunity for dialogue and to learn from what is already working: How would a better model look? Tang suggested that the paperwork reduction act be updated to apply to click reduction.

Rose requested clarification: Is it correct that the payment adjustments for Medicare meaningful use nonparticipation that started in 2015 are going to go away and be replaced by the MIPS payment adjustments that do not go into effect until 2019? Is it correct that the PQRS paper reporting program is being replaced with true pay for performance in which payments are based on the results of the quality measures not just reporting the results? Goodrich repeated that three programs are affected: PQRS, VM, and meaningful use. Sunset will occur December 31, 2018. On January 1, 2019, payment adjustment will be down or neutral, the MIPS program will go into effect, or an incentive payment of 5% for being part of an eligible APM will be available. The adjustments under the HITECH Act will not go away.

Stan Huff, a former committee member, observed that these new provisions perpetuate the use of certified EHR technology. The current certification process has had a negative effect on innovation and usability. Certification criteria should focus exclusively on interoperability functions.

Liz Johnson commented on excessive clicks and quality measures. She offered to share the results of an analysis of quality measures conducted for her employer that identifies inconsistencies in definitions and measures. She expressed concern that EPs and EHs are asked to do different things, which make it difficult for hospitals to enforce procedures for reducing penalties with physicians. Goodrich said that the legislation changes payment adjustments. She said that she wants concordance in requirements. She requested specific information on how to correct these inconsistencies.

Public Comment

None

Formation of New Task Forces

Staff added this item to the published agenda. Consolazio announced the formation of three new joint committee task forces in addition to the Transitional Vocabulary Task Force, for which the first meeting is scheduled for October 14. The Certified Technology Comparison Task Force is charged to assist with the MACRA provision that by April 16, 2016 the HHS Secretary must issue a report to examine the feasibility of establishing one or more mechanisms to help providers in selecting certified EHR technology products. The task force will recommend the most feasible and public-private approaches that could be used to create and maintain such a mechanism. The Interoperability Experience Task Force, for which meetings will be scheduled later this month, is charged with providing recommendations on policy, technical, and public-private approaches that could be implemented to

improve the interoperability experience for providers and patients. The API Task Force, which is due to kick off in November, will identify perceived security concerns and real security risks that are barriers to the widespread adoption of open APIs and identify priority areas for ONC to address so that consumers and providers are confident that information is appropriately private and secure. Interested persons are invited to apply for task force memberships.

Halamka commented on the importance of understanding interoperability experiences. He reported that representatives from major vendor companies, many of whom are represented on the committees, recently met under the auspices of KLAS to talk about measuring interoperability and increasing transparency.

Interoperability Roadmap

Erica Galvez, ONC, and Steve Posnack, ONC, reported on the Final Version 1.0 of the Interoperability Roadmap, which ONC has been working on for 9 months. During the period, the committees had been briefed and gave feedback three times. DeSalvo reminded the members that the focus areas are incentives, care delivery, and electronic information. She said that the administration is making the following commitments:

- Commitment 1: Help consumers easily and securely access their electronic health information, direct it to any desired location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community.
- Commitment 2: Help providers share individuals' health information for care with other providers and their patients as much as permitted by law, and refrain from blocking electronic health information (defined as knowingly and unreasonably interfering with information sharing).
- Commitment 3: 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.

Galvez defined interoperability as the ability of a system to exchange electronic health information with and use electronic health information from other systems without special effort on the part of the user. All individuals, their families, and health care providers should be able to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable to support the health and wellness of individuals through informed, shared decision-making. Interoperability is critical to achieving health care reform. She noted that although exchange of information has increased, only 23% of U.S. hospitals are finding, sending, receiving and using data electronically. The roadmap establishes the following goals:

- 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 HIT 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.

The main driver is value-based payments for care consistent with the goals presented by Goodrich. Posnack went through slides that outlined the technology. He explained that calls for action include the

private sector and that commitments pertain to the federal government. Examples of calls to action for consistent data semantics follow:

- HIT users should provide feedback to SDOs and other stakeholders, including government, regarding additional data elements and/or data domains that should be prioritized for semantic alignment.
- NLM, FDA, CDC, CMS and other stakeholders should collaborate regarding approaches to promoting laboratory information exchange (especially through the use of LOINC, SNOMED-CT, UCUM and UDIs) between in vitro diagnostic devices and database systems, including laboratory information systems and EHRs.

Posnack showed slides that listed milestones, calls to action, and commitments for consistent data formats; consistent, secure transport techniques; secure, standard services; and industry-wide testing and certification infrastructure.

Q&A

Halamka said that use cases may require different architectures. He believes that designating architecture may not be the best approach. Posnack said that the roadmap attempts to balance the advantages and disadvantages of specificity. Galvez pointed out that the roadmap does not use the term architecture.

Lorraine Doo said that CMS worked with ONC on the roadmap, except with administrative standards for payment. The method used for transfer of funds should be added to payment reform.

Referring to slide 7, Mann commented that the capture of data elements cannot replace a narrative for usefulness. The narrative is what physicians care about. Posnack referred him to a call for action described in the roadmap.

Malec said that although he applauds the direction of the roadmap, some sections imply excessive emphasis on process measures and compliance. He objected to the reference to federally recognized standards, saying that he prefers nationally recognized standards. He wondered about the management of innovation. Posnack replied that the roadmap is not regulatory. Not everyone will agree with the entire content. However, they can try to agree on succeeding levels.

A member inquired about interdependencies in calls to action: What are the expected results in 3 years? Posnack talked about the multidimensional characteristics of the roadmap. At the end of 2017, the goal may be to agree on priorities. Other goals may be full implementation. Staff wants to conduct a stepwise analysis along with an incremental approach to cycles.

Kelly Hall asked that the patient use cases have priority. Galvez reminded her of the tradeoff in building from existing HIT, which is not patient centered. Staff is committed to a patient-centered approach.

Lehmann observed that the numbers presented may exaggerate the actual use of information by clinicians. He supports the establishment of a task force on interoperability experience. He called attention to the influence of special interests both in the committees and on the outside. Many interests want to maintain the status quo. He believes that this is the time for bold decisions and appreciates the work on the roadmap.

Jamie Ferguson questioned the measurement of progress, referring to a measure based on the number of emails. Measures based on the comprehensiveness and usefulness of information exchanged should be developed. Galvez agreed that the same point was prevalent in the public comments. Staff want to be able to analyze the correlation between process and outcome variables. Posnack said that he hopes

to make progress on the measurement of outcomes. Ferguson talked about allowing innovation in patient-centered information.

Referring to usefulness and comprehensiveness, Wiesenthal said that from the patient perspective, nothing about "me" without "me" applies. From a clinician perspective, the number of decisions made in which information is missing can be measured. Wiesenthal thinks that survey data can be collected if necessary. He observed that discussions of standards are often based on theology, not science. Halamka said that interoperability should be measured by the availability of information at the point in time that it is needed. Galvez said that the roadmap reflects the tension between getting standards implemented consistently and the desire to innovate. The public comments revealed great disagreement in the industry on the balance for that tension. Use cases are not included in the roadmap.

Egerman pointed out that the roadmap does not define the success of interoperability. He suggested that consistent progress would be a good definition. He asked staff what success would look like. Galvez responded that having the right information at the right time is subjective and that there is no way to measure it.

Rishel talked about innovation in delivery and innovation in sharing data among organizations. Organizations find ways to share information when they need to. If there is innovation in delivery, they will find ways to share data. Progress should be measured in terms of what problems one is trying to solve. The industry does its best at making standards when it is solving for best practices. Standards should be based on demonstrated maturity.

Huff suggested thinking about life cycle testing. Interoperability is different in different situations. The easiest part of interoperability is changing syntax; format is more difficult. He wants to think about the difference between defining interoperability and implementing interoperability. DeSalvo reminded them that this is a roadmap, not the final answer.

Interoperability Roadmap Continued

Galvez continued with the presentation slides, describing the revisions based upon public comments, milestones, calls to action, and commitments for accurate individual data matching; health care directories and resource location; ubiquitous, secure network infrastructure; verifiable identity and authentication of all participants; consistent representation of authorization to access electronic health information; and consistent understanding and technical representation of permission to collect, share and use identifiable electronic health information.

Q&A

Lisa Gallagher said that algorithms for patient matching are being evaluated and that the findings should be included in the roadmap. Regarding privacy and consent, terms such as granular consent and computable consent are not widely understood. ONC has committed to issuing a guidance on granular consent. The legal and regulatory basis of terms for information sharing must be considered.

Halamka observed that a great deal of information was presented by the staff. He requested that time be allocated for discussion at the next HITSC meeting. A lot is going on with the strategic plan, the roadmap, and the release of new rules. Members need more time to understand and comment on these important topics.

Kelly Hall said that the privacy and consent components are insufficiently addressed from the perspective of the patient. Lucia Savage, ONC, said that staff is working with other HHS staff on HIPAA issues in addition to the roadmap. The first priority is to get data moving with the patient. Kelly Hall

referred to a Surescripts study finding that in 40% of transfers of information the patients themselves carried their data to the next provider.

Malec said that more discussion is necessary. Implementation of the NIST security framework will shock most systems. Regarding computable consent, representation of the purpose and context of use is required for interoperability. ONC could take and build on the work already done by others. Savage said that ONC staff wants people to take advantage of the permissions that they already have.

More on the Interoperability Roadmap

Galvez reported and showed slides on the outcome section. She talked about milestones, calls for actions, and commitments for individuals and providers. An example of a commitment in the provider category is that ONC, federal agencies, and the industry will identify additional best practices for the incorporation of patient-generated health data in health care delivery and research. Moving to the tracking progress and measuring success section, she explained the milestones, calls to action, and commitments.

Q&A

Tang reflected on the potential consumption of the roadmap by intended users. He suggested taking a stakeholder view. Galvez assured him that staff are already working on such a document. She said that a supplementary document is available at the website as well. Posnack added that a separate introduction will be available. Kelly Hall referred to a reference to reconciliation and advised against the use of that word.

White thanked everyone. He said that he will be responsible for tracking progress on the roadmap. Daniel reminded the members that this was her last committee meeting. She thanked Consolazio for the application of her organizational skills to the committee work and went on to say that a great deal of progress has been made during her tenure. She thanked the committee members.

Public Comment

None

SUMMARY OF ACTION ITEMS

> **Action item #1: The summary of the September 2015 HITPC meeting was accepted as distributed.**

> **Action item #2: The summary of the September 2015 HITSC meeting was accepted as distributed.**

Meeting Materials

- Agenda
- Presentations and reports slides

Meeting Attendance								
HITPC Name	10/06/15	09/09/15	08/11/15	06/30/15	05/22/15	05/12/15	04/07/15	03/10/15
Alicia Staley	X							X
Anjum Khurshid		X	X	X	X	X	X	X
Aury Nagy								
Brent Snyder		X	X	X	X	X		
Brian Burns	X							
Chesley Richards			X				X	X
Christoph U. Lehmann	X	X	X			X	X	X
David Kotz	X	X	X	X			X	X
David Lansky	X	X	X	X	X	X	X	X
Devin Mann	X	X						X
Donna Cryer		X	X	X	X	X		
Gayle B. Harrell	X	X	X		X	X	X	X
Karen DeSalvo	X	X	X	X	X	X		X
Kathleen Blake		X	X	X	X	X		
Kim Schofield		X	X	X	X		X	
Neal Patterson	X	X					X	X
Paul Egerman	X	X			X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Scott Gottlieb	X	X			X		X	
Thomas W. Greig				X			X	X

Troy Seagondollar	X	X	X	X	X	X	X	X

HITSC Name	10/06/15	09/22/15	08/26/15	06/24/15	05/20/15	04/22/15	03/18/15	01/27/15
Andrew Wiesenthal	X	X	X		X	X	X	X
Angela Kennedy	X	X						
Anne Castro	X			X	X		X	X
Anne LeMaistre	X	X	X	X	X	X	X	X
Arien Malec	X		X	X	X	X	X	X
Charles H. Romine					X	X	X	X
Christopher Ross	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
Eric Rose	X	X	X		X	X	X	X
Floyd Eisenberg		X	X	X	X		X	X
James Ferguson	X	X	X		X	X	X	X
Jitin Asnaani		X						
John Halamka	X	X	X	X	X	X	X	X
John F. Derr	X	X		X		X	X	X
Jon White	X	X	X	X	X	X	X	X
Josh Mandel	X	X						
Keith J. Figlioli			X	X	X		X	
Kim Nolen		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
Patricia P. Sengstack	X	X						
Rebecca D. Kush	X	X	X		X			X
Richard Elmore	X	X						
Steve Brown		X		X		X		
Wes Rishel	X	X		X	X	X	X	X