

**Health Information Technology Standards Committee
Final
Summary of the January 12, 2011, Meeting**

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed members to the 21st meeting of the Health Information Technology Standards Committee (HITSC). She conducted roll call, noting that many Committee members were participating via teleconference due to inclement weather conditions. Before starting the meeting, she reminded participants that this was a Federal Advisory Committee Act (FACA) meeting, open to the public.

2. Opening Remarks and Review of the Agenda

HITSC Chair Jonathan Perlin introduced National Coordinator for HIT David Blumenthal, who commented on the significant amount of work that has been accomplished, founded on the efforts of this Committee and the HIT Policy Committee (HITPC) as well as the generous support of the community at large.

On January 3, the meaningful use registration program went active. At the end of last week, there were 4,000 registrants. Blumenthal reported that the standards and certification process is going extremely well: five temporary certification bodies have been approved and have certified more than over 230 electronic health records (EHRs) and modules, with that number increasing almost daily. The ONC has published permanent certification regulations, so certifying bodies can now begin to plan their applications. Some work must be done at ONC to choose an accrediting organization for certifying bodies—the Office will be working with the National Institute of Standards and Technology (NIST) and the National Laboratory Certifying Group to certify testing bodies.

There are a number of implementation programs moving at full speed. There are 62 regional extension centers (RECs), and by the end of this month 40,000 primary care providers who are interested in becoming meaningful users will have been enrolled. On the day following this meeting, the ONC will be releasing information at a hearing on progress in adoption with respect to primary care.

Fifty-six states and territories have planning grants for health information exchange (HIE). Twenty-two implementation grants have been approved, and Blumenthal noted that he hopes the remaining 34 will be approved by this spring. More than 3,000 students are enrolled in community college training programs that were created last summer by the ONC and 84 community colleges and multiple universities around the country, using model curricula developed with support from the Office. Four research centers also are at work. One of these research centers, at the University of Texas, has stood up a usability testing laboratory through which 18 vendors have received testing and feedback on their systems. Blumenthal pointed to this as an example of research being brought to bear on practice. The RECs will be following

that testing process, and will make the results widely available to their clients in the local communities around the country. All of this work was put in process 18 months ago, and the Office already is underway thinking about meaningful use stage 2. The ONC is in the midst of a 45-day comment period on the matrix for stage 2 meaningful use. This was initially a 30-day period, but the duration was extended at the request of the community. This matrix will be presented to the HITSC when it has been matured.

Yesterday, an NIH meeting about the role of imaging as an aspect of meaningful use raised a number of very important questions that the ONC will be tackling. If the ONC moves forward with an imaging component to meaningful use, it will be an issue for this Committee to consider.

Interoperability is a high priority for this year. In the rush for meaningful use stage 1, interoperability and high-level, robust exchange were not highly emphasized, due to the realization that the field was not yet ready to engage in robust exchange. A recent President's Council of Advisors on Science and Technology (PCAST) report emphasizes the importance of exchange and the role of standards in ensuring exchange. The ONC is thinking hard about the set of tasks that need to be undertaken in short order to make it possible in stage 2 of meaningful use to have more robust exchange of information. Topics to consider include privacy and security protections, governance of exchanges, and the assurance that the organizations involved in exchanging health information will meet the conditions of trust that the public is going to need.

HITSC Co-Chair John Halamka noted that he is in the middle of the hospital certification process for Beth Israel Deaconess Medical Center, and it is a substantial body of work. There is a clear need to make this as easy to implement as possible, and therefore good implementation guides are important. Two aspects of this are on the agenda for this meeting: a discussion of standards and interoperability frameworks, and the PCAST report.

Perlin asked for feedback on the minutes of the December meeting and, hearing no objections, approved them.

Action item #1: Minutes of the December HITSC meeting were declared approved by the Chair.

3. Overview and Priorities for the HIT Standards Committee

ONC Deputy Coordinator Farzad Mostashari spoke about ONC's programmatic and policy priorities for 2011, and their implications for the HITSC. Recently, what is hoped to be an annual grantee conference was convened. Extension center programs, health information exchange (HIE) grantees, and SHARP grantees all participated. It was a remarkable event, in that 1 year earlier none of this existed; it was also a humbling one, because it illustrated all of the challenges that remain.

Mostashari outlined ONC's priorities for 2011. First, he discussed meaningful use. The ONC must do everything it can to assist all of the people and institutions who have indicated that they want to achieve meaningful use. The ecosystem is going to have to change in order for

meaningful use to be achieved, especially with regard to interoperability. The Office wants to encourage an environment in which pharmacies, labs, and public health agencies are all working to make sure they provide information structured for those who intend to become meaningful users. Also, consumers must be able to access their own information, and providers must be able to share information.

With regard to stage 2 of meaningful use, the intention is to increase the requirements around exchange and interoperability, and pay attention to what can be done to improve the security of health information through certification and standards.

Exchange can be examined in terms of governance, architecture, and framework. Significant progress has been made on enabling directed exchange in terms of policy, protocols, and structures, and work to support that must continue. The goal is to bring these efforts to the next level, with directories to support such exchange. Work must continue around the certificates, operational aspects and governance issues for intermediaries, and around policy issues that still need to be formalized. Directed messaging is not sufficient. The PCAST report highlighted the promise and challenges of creating a nationwide system that can support the more complex use cases for a learning health care system. Progress will be made on the issues relating to such a system: privacy and security, policies, standards and interoperability.

With regard to exchange, the ONC has a commitment to enabling consumer-mediated exchange. If consumers choose, they can be the medium for their own information's exchange. That requires progress around identity assurance in a scalable way. Hopefully, 2011 will be the year when this becomes possible. The goal is to connect the health care sector to the commercial sector around scalable identity assurance.

On the topic of adoption, Mostashari noted that encouraging news on the increase in rates of adoption of EHRs, in anticipation of the momentum of health IT would be presented on the day after this meeting. More work is needed on the usability of the systems, and particularly around bringing transparency to this usability. Objective measures are needed for usability, as well as systems for operationalizing that transparency and benchmarks for improving products. Progress also is needed on monitoring and intervening on adverse events associated with HIT, while recognizing that on the whole the country is much better off in terms of safety with EHRs than without them.

There is a need to monitor and consider all policy options for intervening should a digital divide emerge around HIT. The focus on health care outcomes associated with HIT also needs to be sharpened. It is a widely held belief that as the provisions of the Affordable Care Act are being laid down in regulation and practice, it becomes ever more important to link HIT to improvements in cost, care coordination, and quality, in the service of a transformed health care system.

On the topic of the Beacon Communities, Mostashari pointed to a renewed emphasis on decision support, moving it outside the rarified environment of a few benchmark institutions, and into the messy, chaotic real life of health care. The ONC and HITSC must learn how decision support is implemented and effectively used. Decision support, ineptly applied, can cause alert fatigue

and dissatisfaction, as much as appropriately applied decision support can help improve health care.

The ONC and HITSC must broaden and accelerate the move towards consumer e-health just as they have with clinical systems. There must be progress on giving patients access to their own health information, and all of the additional activities that will flow from that. Patients can get copies of their own EHRs. How can that information be used to improve the health of those Americans? How can the use of that information be facilitated across a range of applications? They must also pay attention to patient/provider communications, and the linkages between consumer and clinical information systems. Practicable solutions must be found for incorporating patient observations into clinical care systems, for quality measurement, and for quality of care purposes.

Also important is the notion of using the information that has been mobilized for clinical care to create a learning system. Privacy-protected methods of achieving population health goals, including standards, policies, and architectures for distributed queries, pop queries, and federated data models are needed.

Committee Discussion

Blumenthal noted that Mostashari's presentation included a long list of activities, and part of the ONC and HITSC role is to determine which are the "make-or-break" requirements. Every one of the items mentioned is important. In part, there is a sense of urgency because there is the fear that if the groundwork is not laid soon, there may not be the opportunity to do so in the future. This means having a robust policy around privacy and security—the Privacy and Security Tiger Team is working on this issue. It also means having standards in place to assure that willing providers can technically exchange information if they wish to do so. It means having the community and national resources, organizations, rules, regulations, and systems of governance in place that make it possible to solve problems when they arise. If this can be done in the next year, an enormous amount of work will have been carried out.

Halamka noted that if there are 56 HIEs all working on mechanisms for exchanging data in their local service areas, they will end up with 56 different directories, formats, and security standards, which may not allow transmission across state lines. Other Committee members concurred.

Judy Murphy indicated that there is some confusion among people who want to participate as to who they should be connecting with. In terms of standards, they are hearing: "don't give us options, just give us the standard."

Wes Rishel said that there is a sense that private exchanges, not open exchanges, are more productive, and a recognition that participating in an exchange as a hospital is not free. It takes substantial resources from projects that might be doing other things. On one hand there is a notion of accountable care organizations, which seems to imply the first real, hard incentive and return on investment for having interoperability that has been seen. How will they deal with the difference between that incented and motivated interoperability, and the broader need for

interoperability across the country for patients that move in and out of accountable care organizations, or for research and other public use cases that tend not to be as well funded?

Blumenthal responded by noting that exchange for what purpose and how it is rewarded is the issue. There are a series of mechanisms to try to overcome parochialism, or sub-optimization. One is the meaningful use framework. They will continue to message and include criteria for meaningful use that will require robust exchange as a qualifying criterion. Stage 3 will have even a higher criteria associated with it. That will need to be reduced to practical application. What does robust interoperability actually mean? How can it be measured? The Department of Health and Human Services (HHS) is writing regulations about what constitutes an accountable care organization. Those regulations have the opportunity to speak to exchange. He suggested that if the incentives are right, they will not have to fight this battle for very long. Successful organizations are going to learn that if they really want to be accountable to their patients, they will have to be interoperable with other providers.

Kevin Hutchinson said that there is investment money ready to be spent, but there needs to be more clarity in the area of interoperability. A significant amount of funds are waiting to be poured into this space, but there is nervousness with respect to the role of private industry. Blumenthal acknowledged this, and said that there must be a lot of room for private sector innovation, but there must also be a central foundation for consumer protection. It is in the industry's best interest for the public to trust the framework.

Walter Suarez commented that the fundamental reason why information exchange happens within or across organizations is for care coordination and continuity of care. There is the risk of creating silo reporting of meaningful use metrics of organizations, so that each organization can say they are doing great within their populations. There is a need to begin to look at opportunities to measure meaningful use of HIT to improve community-level health, meaning not just health care by a particular organization within its own numerators/denominators.

Halamka pointed out that the HITSC has 11 meetings left, plus workgroup meetings. He expressed hope that they can develop a work plan before the next meeting and proposed that the Committee lay out how to address these issues in a timely fashion so that the ONC has all the guidance it needs.

4. PCAST Report Review

Mostashari informed the Committee about the newly formed PCAST Report Workgroup, which has been created to communicate to the health care community the contents of the PCAST report. The report comes from a perspective that is not within the traditional health care industry, and has applied its concepts to the HIT world. There is a significant amount of work remaining to create an understanding of what the report really means in the context of what has already happened in HIT.

He presented the list of PCAST Report Workgroup members, which includes Paul Egerman as Chair. The ONC has issued a Request for Information (RFI) with a series of questions. It is hoped that the Workgroup will synthesize information from those comments. Mostashari

presented the list of nine questions, including questions on what standards, certification criteria, and processes would be required to implement the specific recommendations from the PCAST report. They also asked about what processes would facilitate the rapid deployment and use of these standards, and what challenges there would be with transitioning to what the PCAST report recommends.

The Workgroup is going to examine the report carefully, synchronize it with the language and understanding of HIT standards, and review the comments received in response to the RFI. The Workgroup hopes to present a preliminary report to the HITSC in March, and a final report in April.

5. Direct Project Update and Standards and Interoperability (S&I) Framework

ONC's Arien Malec summarized progress on the Direct Project. Thanks to feedback from the HITSC and the Privacy and Security Workgroup, they have updated the specifications, and had a tremendous discussion on policy-oriented questions, expectations for receivers of data, and what kinds of data they need to receive. Three documents are going through the final stages of review, dealing with core specifications, a supplemental specification on how to use XDR and XTM, and an explanation of what it means to be a Direct client from the Direct Project's perspective. Those three documents will go through the consensus process in time for the next HITSC meeting.

There are seven or eight implementation geographies, and more in the planning stage. One is completely ready to go and is simply waiting for the provider to send the receiver, in this case, an immunization transaction. They expect to be at two to three operational exchanges by the end of the month, and three to five by the end of next month.

Next, Malec turned to the S&I framework. Using a series of slides provided in the meeting materials, he defined the framework and discussed the initiatives that were just launched. The purpose of using the S&I framework is to solve point problems in the context for those solutions to be used in a wide context. There is a focus on value and outcomes throughout the framework. The point of the S&I framework is not to be a standards development organization (SDO). Rather, it is to harmonize existing standards in the context of health care. For the needs of national e-health priorities including meaningful use, those standards need to be harmonized in order to create a strong package of standards specifications.

The participation of the community in the S&I framework is critical. Success is predicated on the ability to communicate with all the other actors in the larger ecosystem. The way they will put work through the framework is not to solve all problems through a central, harmonized framework, but rather to develop the specifications through specific health interoperability initiatives. Each initiative requires calls for participation from the larger community. The participation of SDOs, federal partners, and the broader HIT community will be needed. For each initiative they have put together a call for participation, and this work is being conducted in an open and transparent manner.

An initial take on priorities and a prioritization framework was posted online. A total of 31 comments were received—they addressed broad themes of prioritization. They heard that there is a need to simplify the prioritization framework and that there is a need to be transparent about weighting and scoring. There also is a need to include cost/benefits, including specific cost information. A great deal of feedback was received on the proposed initiatives, and the two initiatives that were launched after the information on priorities and the prioritization framework was posted online were refined and informed by these comments.

Currently, the ONC has updated the descriptions for the two initiatives that are being launched. The Office has recalled the prioritization framework to refine it in order to reflect this feedback.

Malec then discussed the following S&I initiatives at greater length: (1) transitions of care, (2) lab interface improvement, and (3) consolidation project. ONC's next steps are to continue to measure the launched initiatives, launch additional initiatives, and refine the framework to evaluate the feedback it has received.

Committee Discussion

In response to a question from David Blumenthal, Malec explained that the S&I framework is driving to improved care for individuals, improved health for populations, and cost reduction for improved quality. The expectation is that providers can meet their meaningful use obligations and meet the broader set of quality improvement obligations that are tied to meaningful use. The lab results project is an example: it is work around a process measure, and a broader quality measure. They will see quality improvement because of better lab data access, better public health reporting, improved transitions in care, and better patient care across multiple settings. With regard to the project that involves transitions of care, the focus is on improving the care of the patient across all care settings, and making sure that the care of the patient is improved holistically.

Doug Fridsma noted that the consolidation project is unique in that two standards organizations are coming together, and one of the intended values of the project has to do with making work simpler. The focus is on reducing complexity and giving people advice about what they can do to enable the functions that providers need.

Hutchinson noted that he is thrilled with the priorities that have been set because they will probably have the most visible benefit in the areas of care management and coordination. He explained that the Committee discusses examining this as a quality of care issue, but he thinks it may also have effect on a patient's psyche. The "hassle" factor of going from one place to another and trying to coordinate care makes people noncompliant with their care orders. So quality of care is a great measurement, but they could also look at the impact on patients' being more compliant with those care orders because it is a more coordinated environment.

Hutchinson also referred to the notion of combining templates into a single library. If they could get to a place where there is just a single document that can be used many times, versus a library of templates that can be used a few times, they will have larger success in getting this implemented at the industry level.

Jamie Ferguson discussed the lab effort. He was involved in both of the specification development efforts that are potentially being merged. There are two different specifications because they were intended for different purposes. For example, the e-links use case is intended for a single EHR and a single lab. By design, that specification does not include public health reporting, patient visit information, or provider details, because commercial labs do not want to carry that extra data. The interoperability specification is intended by design to include reuse of the information for public health, population care, and other reporting purposes, and is intended to be used across multiple providers. It is not a question of harmonizing; rather, it is a question of finding the right use case.

Judy Murphy voiced concern about disseminating the work appropriately. Part of the solution will be getting broad dissemination of these three use cases, and showing these as examples of what can be done today, in stage 1. Malec explained that they attempted to get the initial invitation out through various mailing lists. They tried to the extent possible to get a broad publication of the S&I initiative. He hopes this meeting will also help, and asked the Committee to get the word out as well. Murphy suggested using the RECs or the state HIEs to spread the word. She has not heard much about harmonization in those efforts.

Malec noted that they are starting to see good alignment in the efforts of some state HIEs and RECs, which are working together on such specific projects as electronic reporting of labs in North Carolina.

Marc Overhage noted that it feels like this is the “nth” iteration that this country is going through in trying to create implementation guides to meet providers’ needs. He has heard the sentiment that people do not know where to go. He is concerned that the message is that there are not enough frameworks and implementation guides. He described what he sees as two schools of thought. First is the “magical thinking” school, which says that with the right standards, everything could simply plug together and work. This is not a reality because there are operating systems that must be managed and massaged no matter what the vehicle is. Between 5 and 15 years of heavy lifting are going to be required to get things to work together. The second school of thought is, “quit confusing us, quit asking a new set of questions, because then we stop doing the heavy lifting while we figure out whether the next thing is the perfect solution.” He asked, what problem are they trying to solve? They have tried this before, and what makes this different?

Malec responded, explaining that the landscape is different now. In many HIT contracts these days, service—one particular example is putting together the lab interface—is a core part of the contract that is sold. Economic incentives are harmonizing interest. Also, there is a critical mass now in that enough providers are using EHRs that standards have a place to hook in. There is a set of changed circumstances that does make the situation different, and a whole set of people are looking for answers around specific domains. Pursuant to the discussion in the Implementation Workgroup, Malec is hearing that there needs to be one obvious solution around each of the major interoperability problems.

Fridsma acknowledged that there have been a lot of initiatives previous to this one, but he said that the focus here is on attempting to organize existing work, and coordinating all the parts

required. Overhage agreed with Fridsma's assessment about organizing. The disconnect for him is how this activity drives that.

Wes Rishel pointed out that sending lab data is the most widely solved problem, other than e-prescribing, in terms of standards. What they are really saying with regards to the lab is not that they cannot do it now, but that the cost is too high for the interface, for example. This has a little to do with format, and a lot to do with compendium. The process they are going through is not going around in circles; it is spiraling upwards. This current initiative is responsive to one of the biggest lessons learned by the Healthcare Information Technology Standards Panel (HITSP), which is the fact that one needed 14 fingers on each hand to hold all the relevant places in a book of specifications.

Rishel went on to say that Ferguson's description of two different specifications being needed for two different situations, and there being a problem with that, relates to the cost of operating a lab. Absent the recognition that there will be different cases based on the business conditions surrounding the use of a standard, he is not sure they will get to useful standards. He suggested that an option to consider through the S&I framework is to not only have a single document where the specification is written, but also to have a triaging document for standards and variants. If they find the business implications of a standard would drive the cost of daily operations up, then they need to consider these options.

Steve Anders suggested that there are two broad categories to consider: provider exchanges and those that are consumer aggregated. They must look at the consumer side, and see how that is reusable by the providers that the consumers patronize.

Dixie Baker asked about how the fact that standards are always evolving will be handled. Fridsma acknowledged this, and said that one hope is that by creating some consistency in how the information is represented, others who are developing complementary standards will use this consistency, which will make it easier to use tooling to update where relevant. Also, they need to identify those organizations or groups that can be considered stewards of those value sets or those vocabularies and terminologies, and then create a mechanism for incorporating this into the documentation and templates. They do not have the exact solution, but they recognize it as an issue that needs to be addressed.

Carol Diamond made the point that more and better standards specifications almost never creates incentives to share information, but the imperative to share information creates a demand for the standards. The more that the ONC can forge alliances to create that imperative, the more likely it is that this and other standards work will increase.

6. Information Exchange Workgroup—Directory Standards

Information Exchange Workgroup Chair Micky Tripathi introduced the Committee to the general charge of the Workgroup and the Provider Directory Task Force, offering background information on provider directory delineations: entity level and individual level. Tripathi also presented the policy recommendations on entity-level provider directories (ELPDs) that the HITPC has endorsed, which included some specific directions for the HITSC. Many policy issues are not recognizable until the implementation work begins. State level programs, in

particular, have been given strong encouragement from the ONC to use grant funds to work on provider directory projects. Guidance in this area is being sought.

Tripathi reviewed the Provider Directory Task Force policy objective and problem statement, along with a list of Task Force members and a roadmap showing where they are in the workflow. He is concerned that there could be missed opportunities to align projects to take advantage of such multiple funding streams from places like Medicaid and public health agencies, which are allocating funds that could be used to develop provider directories.

Jonah Frohlich and Walter Suarez serve as Co-Chairs of the Provider Directory Task Force. Suarez explained that provider directories are electronic searchable resources that list all information exchange participants. He likened them to a yellow pages and a white pages. The entity-level provider directory is like the yellow pages, and the individual-level provider directory is similar to the white pages. They created a framework that they first applied to the entity-level directory, and then to the individual-level directory.

Suarez then shared the Task Force's recommendations that were approved by the HITPC. The recommendations addressed the following areas: (1) users and uses, (2) functions, (3) content, and (4) operating requirements/business model. He then presented three additional policy recommendations, one of which specifically addresses the HITSC:

- The HITSC should be directed to identify technology, vocabulary, and content standards that will create an ELPD with multiple registrars and a single, nationwide registry.
- The federal government should use the strongest available levers to require registration in, and encourage use of, the nationwide ELPD.
- State-level HIE and Beacon programs should be required to enable the use of a national registry in addressing their constituents' provider directory needs.

The individual-level provider directory work plan was then discussed, as was a proposed timeline for future work.

Committee Discussion

Halamka said that as a result of this presentation, the Committee must start thinking about functions such as add, change, delete, and query. It is less about the schemas of the directory, and more about figuring out how the ecosystem of various repositories will interact, and how to ensure that each individual HIE has a common mechanism for interacting. The question for discussion offline is, where does this work take place? Is that part of the Clinical Operations Workgroup's purview? Should a new workgroup dive into directory structures?

Suarez noted that part of this deals with standards, and it is helpful that there are a number of standards already in existence, including HITSP T64, ISO standards, and the IHE provider directory profile. He suggested that perhaps the work could be taken on by the Privacy and Security Workgroup, as an extension to their recommendations related to digital certification. Perhaps that group could be expanded to include infrastructure issues.

Jodi Daniel suggested that consideration be given to forming a workgroup that could focus on this and on the work around ONC priorities that was presented earlier in the meeting.

David McCallie noted that the real advance in this area is on the identity-proofing aspects of who gets to be included in the directory, and then the management of the PKI infrastructure. Suarez concurred, and added a third area, which is the discoverability of information exchange capabilities. McCallie therefore urged the group to pay attention to the things that have been learned with the Direct Connect project, where they wrestled with such issues for months.

Wes Rishel confirmed that this is a recommendation to create a singular, government-provided directory, rather than a set of principles by which people might build directory systems. He asked if there was any estimate of the cost. Suarez responded that there was not.

7. Implementation Workgroup—Hearing Review

Implementation Workgroup Co-Chair Judy Murphy discussed the group's recent 2-day hearing. Two panels were held on January 10, and three on January 11, dealing with RECs, the certification process, and HIE, as well as two panels of eligible providers discussing their experiences as early adopters, and two panels of early adopter hospitals.

She shared with the Committee the questions that the panelists addressed and noted that the panelists represented different geographic areas, small and large providers, variable vendors, hospitals who are early adopters and those who have decided for specific reasons to wait, and also included representatives from the Centers for Medicare and Medicaid Services (CMS) and ONC to provide reactions.

Co-Chair Liz Johnson said that the overarching message they heard at the hearing is that this is something people want to occur and believe in. They have concerns, but the hearing was full of people who want this to work. She emphasized that the Implementation will present more specific information at a future Committee meeting, and provided some general themes learned at the hearing:

- RECs received mixed reviews. There are significant variations in the way the centers work from region to region in terms of cost, customer makeup, and business model. There are at least four different models for how the centers might work. The best practices and the right way to run a REC are unclear.
- With regard to certification, they heard consistent and positive feedback that once the certifying body's process starts, that process works very well. This feedback came from both the vendors and the users of those bodies.
- From a vendor perspective, there are a number of challenges. There is a great deal of interest in and desire for further definitions in the area of modular certification. People are asking, if a certified vendor has a list of products that together create certification, do they have to buy them all? This leads to the question of what is a complete HER? How can products be mixed and matched to achieve meaningful use?

- On the subject of HIE, the message is that clear, concise interoperability specifications are needed now. The sustainability and value proposition related to HIE is unclear. The question is, how will these things keep going when the money goes away? Also, there is a conflict between public and private sectors, and between national and local needs. People are unsure when, where, and how to sign up, as well as what to sign up for.
- There are timing issues. Vendor software changes are still being made, and upgrades and patches are still coming. As people prepare for attestation and meet the intent of meaningful use rules, the software is still in movement. If products are still coming out, then the certification of those products has to follow, which is a timing problem.
- With regard to communication, people want prompt responses, and they are saying that the FAQs can be confusing and contradictory. They want a help desk with rapid responses, and they want clear and concise information. Also, the documentation needs to be reliable, clear, complete, and in one place. CMS and ONC need to be working together on this issue.
- Quality measures are difficult to understand, and there is the potential to report on different aspects of quality measures for different agencies in different ways.
- One group wanted to know what was coming in 3-5 years—not in absolute detail, but as a general roadmap. For example, if they understand that at the end of the day 95% of all computerized physician order entries (CPOEs) are going to need to be electronic, they want to know that now.

The Workgroup's next steps were presented, included a re-evaluation of progress with regard to the recommendations that they have been working with that date back to the implementation hearings in October of 2009. They will work with the HITPC Adoption and Certification Workgroup chairs to divide the work.

Committee Discussion

Anne Castro emphasized that the communications issue must be highlighted. Her one source of information is John Halamka's blog. If he did not put together that information, she does not know what she would do to understand some of these big-picture items.

Suarez commented that measures to help evaluate progress in care coordination are going to be needed.

John Derr explained that the ONC purposely gave out different models to different groups to see which would come out with the right model. It is going to be difficult for providers to support all these different models. Also, some vendors are being a little greedy on what they are charging. One vendor was going to charge each nursing home \$2,000 per month to be part of this, making it outrageously expensive to participate.

Judy Murphy noted that a repetitive theme at the hearing was that "a bad standard is better than no standard at all." Liz Johnson added that they are receiving feedback from those likely in the

top 25 percent in the industry. They were talking to early adopters, and yet they saw concern. If there is concern at that level, then there is going to be far greater concern from those who are not the early adopters.

Marty Harris noted that they are starting to see workflow challenges that highlight inconsistencies between the spirit and the letter of the law. For example, in almost all visits to pain management specialties, there will be pain medication use. They are using the formulary properly, but law requires that all narcotic prescriptions must be printed out. So, rather than sending non-narcotic prescriptions electronically and printing out just the narcotic ones, they are printing all of them out. Doing otherwise would split the workflow, and would not make sense. So on a scorecard basis, they are not going to pass the test of meaningful use. But from a spirit point of view, they have accomplished the greater goal of using the formulary to deliver the best care to patients. He wondered if other examples like this have come up, and what the process will be to handle them.

Jonathan Perlin explained that additional comments and questions should be directed to Liz Johnson and Judy Murphy, so that they become part of the FACA record.

8. Clinical Operations Workgroup—Device Standards Update

Clinical Operations Workgroup Chair Jamie Ferguson reported that there has been no Clinical Operations Workgroup meeting since the last HITSC meeting, but two are planned before the next HITSC meeting.

He discussed an upcoming Workgroup hearing. Its purpose is to identify barriers and enablers for device interoperability. There will be three themes: (1) interoperability requirements for a variety of different use cases in different care settings, (2) device security, and (3) the unique identification of devices. Coordination with the U.S. Food and Drug Administration (FDA) with respect to the latter will be important.

9. Privacy and Security Workgroup—Digital Certificate Standards

Privacy and Security Workgroup Chair Dixie Baker noted that at its last meeting, the Workgroup took on an HITPC assignment to develop digital certificates that are used to authenticate organizations, software, servers, and individual people. They are focusing on directed exchanges, which are those exchanges of clinical information between provider organizations. This is complementary to the work on enterprise-level directories. The work on digital certificates will maintain synchronicity with this directory work.

She also reported that several members of the Workgroup are continuing to serve on the Policy Committee's Privacy and Security Tiger Team. The Tiger Team is completing its recommendations regarding patient matching.

Finally, Baker announced that Walter Suarez will be the new Co-Chair of the Privacy and Security Workgroup. She thanked outgoing Co-Chair Steve Finley for his efforts.

10. Public Comment

Carol Bickford from the American Nurses Association brought to the Committee's attention the fact that significant work has been done in the development of a disaster registry.

SUMMARY OF ACTION ITEMS

Action Item #1: Minutes of the December meeting were approved by the Chair.