

**Health Information Technology Standards Committee
Final
Summary of the September 28, 2011, Meeting**

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 29th meeting of the Health Information Technology Standards Committee (HITSC). She reminded the participants that this was a Federal Advisory Committee meeting, with an opportunity for the public to make comments, and that a summary of the meeting would be available online. She conducted roll call, and turned the meeting over to HITSC Chair Jonathan Perlin.

2. Opening Remarks

Perlin announced that ONC's Judy Sparrow would soon be retiring from a lengthy federal government career. He said he has never in his federal experience seen a process so effectively championed by someone who assured the effectiveness of the process in terms of work being well coordinated, and the integrity of the spirit of the process in terms of public opinion. He recognized Sparrow on behalf of all of his ONC and White House colleagues and all members of the HITSC. Sparrow thanked the group, saying she has never seen such generosity of time from a group of people, such intellectual devotion to helping solve problems, and certainly never such civility in a group of people in helping make health IT better.

3. Review of the Agenda

Perlin noted that it is nearing the end of the federal fiscal year and the first year that hospitals have been able to test their meaningful use, and attest to it. HITSC Co-Chair John Halamka then reviewed the day's agenda. Halamka announced that after today's meeting, a reception has been arranged by the White House to thank the Committee and its workgroups for all of the work they have done.

Action Item #1: The Committee approved by consensus the minutes from the August 17, 2011 HITSC meeting.

4. Summer Camp Review

Doug Fridsma recognized all of the individuals who contributed to the efforts associated with the Summer Camp, team by team. He noted the short time frame in which they had to prepare for meaningful use Stage 2, identifying gaps and using the tools at their disposal to discover what was needed. They also needed to recommend revisions to already adopted certifications and criteria, and analyzed meaningful use working group draft specifications. There were six Summer Camp power teams, and a total of at least 39 public meetings and hearings. Fridsma

then briefly described each of the initiatives, and reviewed the completed work and summary recommendations of the various power teams.

Surveillance Implementation Guide Power Team

Taha Kass-Hout presented the work of the Surveillance Implementation Guide Power Team. He explained that the Team is recommending 17 core elements and 16 optional elements, vetted with syndromic surveillance practice and the community health field. The Power Team has a messaging guide based on these recommendations that is being revised to reflect stakeholder input received via public comment. Kass-Hout reported that health departments will be ready to receive these elements from providers starting November 15 of this year, using a service hosted on the cloud with local ownership and data control.

Doug Fridsma noted that some options that were previously required but could be left blank are now optional. These optional items generally relate to the treating facility, although the treating facility identifier itself is a required element.

Discussion

- Wes Rishel commented that typically when something is identified as “optional,” it is up to the receiver to define whether it is required or not. Unless a clear compliance statement indicates that all receivers must accept the message with any combination of optional fields not populated, a truly interoperable specification has not been created.
- Fridsma said he raised red flag on the optionality question and became persuaded that as a practical matter, the recipient here is public health, and virtually all public health organizations can accept this content, including the optional fields.
- Rishel expressed concern that there will be a public health department that could say, “it will cost us this much to change our system.” They could require anyone sending them data to include some of the pieces of optional data. He suggested that there be a conformance statement that gives providers something leverage in this scenario. Fridsma asserted that if an organization chooses to be non-conformant, then that is an issue that needs to be addressed through the appropriate channels. This implementation specification does introduce ambiguity.
- Kevin Hutchinson said that if it is optional, it must be required for all public health organizations to receive the information. Therefore, all of these elements are required from a public health entity, they are only optional for a sender. Rishel countered by saying that if a provider wants to send optional information, it should be fine for a public health department to receive the message but not store the optional information if they do not have a place for it.
- Carol Diamond expressed concern about optionality from a technical standpoint, commenting that organizations should collect only what they need.

- David McCallie pointed out that the information in some of these data fields is likely to become available on different timeframes: coded cause of injury could conceivably take days. Is the standard contemplated as to how timely the data must be captured and sent? Can the message be sent more than once as the data becomes available? Kass-Hout explained that empty elements can be backfilled later, since some information can take several days to collect. They Power Team took that into account, and the assumption is that the provider or institution might send more than one message. McCallie noted that this complicates the situation even more.

5. National Coordinator's Remarks

National Coordinator for Health Information Technology Farzad Mostashari, who joined the meeting at this point, reminded the group that an explicit expectation was that meaningful use Stage 2 would be more rigorous in terms of exchange and interoperability. As he talks to people around the country, he sees that there is an “under-recognition” of the progress that has already been made. Meaningful use Stage 1 set an important foundation for the work that is continuing. A lack of transport standards has meant that many groups have electronic health records (EHRs) that can produce clinical care documents (CCDs), but no exchange is taking place. Particularly in light of the fact that the HIT Policy Committee (HITPC) is recommending that Stage 1 be extended for an additional year, Mostashari commented that the field cannot afford a delay work on the exchange of information and on transport standards.

He asked, what to do in the face of no standards that are perfectly ready, none in which they have absolute confidence in maturity and adoptability, much less evidence of existing adoption? The Committee must gird itself to recognize that the standards may be imperfect. He urged the HITSC to push forward, commenting that not moving is a greater risk than moving forward on work that may be imperfect. The country cannot afford to wait another 5 years for exchange.

6. Summer Camp Review (Continued)

NwHIN Power Team

NwHIN Power Team Lead Dixie Baker reminded the Committee of the Team's charge and noted that the ONC has defined the Nationwide Health Information Network (NwHIN) as a set of standards, services, and policies to secure health information exchange over the Internet. In support of that definition, the Team was asked to help define the set of standards, services, and policies. The focus was on the national level, especially as it relates to scalability. Also, each standard was evaluated individually, not comparatively.

The ONC asked the NwHIN Power Team to recommend the standards that could be used at a national scale and to identify where further work is needed. Outputs from this work were intended to inform the ONC regarding investments for future NwHIN pilots and specification development. The ultimate goal is to facilitate exchange among federal, state, and private health care organizations. Baker presented the exchange and direct specifications included in the Team's analysis and described their methodology and evaluation criteria as well as the Team's conclusions and recommendations.

Discussion

- Wes Rishel commended the enormously powerful job of organizing and structuring this conversation. It is sometimes troubling that there is a perception that Exchange is about structured data and Direct is about e-mail. The HITSC does not make this assumption. Rishel pointed to the importance of recognizing that any rational set of standards should have sufficient modularity so that structured data can be sent by various transport means.
- Rishel commented that the standards and protocols developed for the NwHIN trial implementation include a number of elements that are both unproven and probably extremely difficult to implement at scale. Having a full role-based access control capability and a constrained patient look-up capability have created problems in terms of the ability to adopt.
- It was suggested that there is operational use of a different stack built out of many of the same protocols that are used in the NwHIN trial specification. It is a different statement of the use case, which avoids many of the policy issues that created the complexities in the NwHIN trial implementation profile, and there is a claim that it has been used by a number of vendors interoperating across their EHR systems. This should be given future consideration.
- The notion of trying to create more modular specifications is a challenge because implementations of specifications has, in many instances, added to the complexity in the tools that people use. This work is just getting started, and there are efforts underway to obtain public input to understand how to tease this apart into its component building blocks.
- Marc Overhage suggested that a process check be conducted. Based on the e-mail traffic and discussions, this topic will require a considerable amount of discussion, and a process will be needed to ensure complete Committee discussion.
- Mostashari commented that there appears to be some uncertainty about the facts and the extent to which there are various aspects of Web services that are being used or not being used. He said that the Committee does not need to push for consensus if there is none.
- Overhage indicated that he does not understand the patient query issue as it has been described. It is important to remember that the ability to draw data from a number of places is driven primarily by the day-to-day quality measure needs. A patient's data for a given quality measure does not live in one system, and probably never will.
- David McCallie said, at the risk of oversimplification, that there are two core exchange models: a "push" model and a "pull" model. The Power Team was given a push specification (Direct) and a pull specification (Exchange) and was asked to evaluate them. The question is whether the push model is good enough for meaningful use. If not, then the pull model needs to be examined in greater detail.
- Dixie Baker pointed out that Exchange and Direct were developed for entirely different use cases. The report from the President's Council of Advisors on Science and Technology

(PCAST) suggests “push,” “pull,” and analyze. Decisions are needed to identify parts of the network versus components of the health system. She proposed that the Committee agree on a definition of the term “network.” Are they using the term “NwHIN” as equivalent to the national health system?

- With regard to the patient query, Team member Tim Cromwell explained that patient discovery is a “show-stopper” in that right now the U.S. Department of Veterans Affairs (VA) is interoperable with 11 health information organizations (HIOs). In each of those, they must make sure they have securely and correctly identified the right veteran. That process of patient discovery is not scalable when next year there may be 50 members of the NwHIN. McCallie noted that this addresses the question of administrative scalability. Overhage noted that the VA and DoD healthcare systems are highly complex; the complexity experienced seems more in the policy requirements than the technology. By design in the Direct discussions, the debate is whether to require a national provider identifier (NPI) that spans both systems that use Direct. The group said “no,” because that would make it unusable. Most messages arrive without a structured identifier and an office identifier. This is very scalable. Direct is an attempt to make that process better—it is trying to improve upon what is happening now with faxes and other current methods of communication. Members agreed that the policy aspects of patient query will require further work regardless of what specification is utilized.
- Cris Ross noted that transport is not at the level of other issues such as vocabulary; this is still a pioneering space in almost every respect. Also, the exercise was artificially constrained. The Power Team was asked only to assess NHIN, Direct, and Exchange. They tried to broaden that slightly to look at other patterns of health care that have been used successfully, and inserted that where they could. The Team was not asked to come up with a set of recommendations for Meaningful Use Stage 2 requirements. Their work was intended to support a broader range of potential industry activities.
- Ross continued that they are now at the point where there is an immature set of specifications, and an industry that has not put them in use. He suggested that there are three choices for action: (1) force fit a specification by more analysis and more precision; (2) constrain the problem set (focusing on push); or (3) put the specification in use to force rapid iteration. What is the right process for iterating correct transport? He wondered if there is any way within the regulatory environment that meaningful use Stage 2 and 3 specifications around transport could focus on behavior and outcome, rather than a specific use of technology.
- In terms of Ross’ third suggested approach, Mostashari asked whether it matters if most of the exchanges are local or national. If most of the exchanges that people will be pushing themselves to do are local, then there is more of a concern that the ways those exchanges are done may lead to national progress, as opposed to a one-off proprietary patch and other non-scalable approaches.
- Jamie Ferguson said that his organization has been in production status using Exchange specifications for over 2 years. Of the 19 production participants today, only three or four

are federal users. Millions of non-federal patients are affected by this. He noted that the Team did not hear testimony from any non-federal players, and that the coordinating committee that governs Exchange was not consulted. Baker pointed out that input was received from Ferguson's organization, though not formally, and that Avinash Shanbhag worked with the coordinating committee at the outset. Ferguson said that unfortunately, input that the Team received was skewed and not really representative of the experience of the majority of the participants of the Exchange.

- Chris Chute said that Mayo had implemented Exchange specifications in their Beacon Community and he thought it was not burdensome.
- McCallie suggested that it is a mistake to declare only push or pull. Perhaps pull locally and push on a larger scale would be most effective, or pull locally and push to the consumer, and then the consumer uses push nationally.
- Rishel commented that there appears to be significant observable use of some group of specifications that strongly resembles the NwHIN trial implementation specifications. It is clear that they have not fully explored the possibility that there is something resembling a pull option—if there is time, he suggested that the group examine the information from the Beacon grants and the 12 other implementations. The goal should be to determine how to do pull in the next round of regulations, rather than figure out a way not to.
- James Walker reflected on the Team's recommendations as a communication tool for the industry. He observed that there is field evidence indicating that recommendation three is overstated.
- Perlin characterized the report and the discussion as an eloquent and explicit framework in which to evaluate. There is a set of building blocks, containing elements that are usable today; the Committee does not wish to constrain organizations that are doing important work. There is clearly a need for more data on implementation, from Exchange participants and vendors. In the spirit of this conversation as well as the compelling need to support the ONC and its fundamental charge, the Committee will transmit with comment the evaluation framework and communication of this Summer Camp activity. The Committee's role is not to make the determination; rather it has raised many policy questions and raised points for further work.

Action Item #2: The NwHIN Power Team report was forwarded to ONC, with comments, by consensus.

E-prescribing of Discharge Medications Power Team

Team Lead Jamie Ferguson reminded the group that the Power Team is revisiting an issue from their report to the Committee during its July meeting. The Team's previous recommendation was to align with Medicare Part D. The Committee asked the Team to be more explicit on the HL7 messaging to achieve the level of specificity needed for the specification, as the Part D language is very vague. The Team worked with the National Institute of Standards and

Technology (NIST), and Ken Gephart in particular, to interpret and understand how NIST would interpret the specification to create certification test scripts.

The analysis came back with any valid HL7 version 2 prescription message meeting the requirements of Medicare Part D. Certification is not a significant technical challenge, Ferguson said.

If they wanted to recommend a single standard, and not the whole range of 2.2 through 2.5.1, it might make future hospital integration easier, but that would put the standards out of sync with Medicare regulations, and would jeopardize the compliance of hospitals that are currently in compliance. The Team proposes to modify the draft transmittal letter to add the specificity.

Discussion

- It was noted that with regard to Medicare Part D, there can be an amendment to reflect backward compatibility of future versions of this standard. This will expand the ability to use that particular standard.
- Steve Posnak asked whether, for meaningful use certification, an entity would certify that they always can generate an electronic prescription. Would they have to specify for internal use, or only for external? Judy Murphy suggested that the question is how to define internal versus external—this has yet to be vetted. There are many vendors who do e-prescribing who have never thought about using HL7. Internally, many hospitals would choose to use National Council for Prescription Drug Programs (NCPDP) because the software is currently configured for it. With certification, is it one, the other, or both?
- Ferguson explained that for Part D e-prescribers, the use of HL7 or NCPDP script is required. If he were only sending all discharge prescriptions to a retail pharmacy, he would use script. It depends on what capability the product has. Rishel suggested that they will have to do both, indicating that use of the word “or” will be interpreted as “and.”

Action Item #3: The E-prescribing of Discharge Medications Power Team report was forwarded to ONC, with comments, by consensus.

7. Clinical Quality Workgroup and Vocabulary Task Force: Transition Plans

Vocabulary Task Force Chair Jamie Ferguson reminded the Committee that last month, six different quality data set areas were identified for which transitions would be required to reach the long-term vocabulary improvements that the Task Force recommended. His report to the Committee focused on managing those transitions to the standardized vocabularies.

The Task Force sought to balance the need for standardization with flexibility and needs of implementers. The recommendations are not intended to apply beyond the quality measure reporting. He recognized that was some discussion last month about the potential of using the problem list, for example, for other requirements, but this discussion is limited to the transition

from interim or alternative to long-term standards of vocabulary for the purposes of quality measures.

The Team examined the effects on stakeholders, those being Certified Quality Manager (CQM) developers, HIT developers and certifiers, care-delivery organizations, Center for Medicare and Medicaid Services (CMS)—who would be required to accept them all—and non-CMS players.

Ferguson said the Team discussed acceptable transition vocabularies for the six quality data management (QDM) elements to consider, then looked at the various factors that would go into determining dates for transitions, including laws or regulations that require specific dates, and how soon value sets could be developed for transitions. Ferguson then walked through each of these considerations by transition vocabulary. He noted that the ONC needs to track and revise the final dates according to changes affecting meaningful use timeframes, etc. A central point of authority does not yet exist to do that.

Discussion

- Marjorie Rollins suggested that 1 year after the effective date, they may want to think about adding additional language about this being contingent upon the experience, because they do not know what the experience will be.
- Perlin noted that the group cannot tread into Policy Committee work regarding timing, but there must be an issue with the mapping that would be helpful in terms of clarification. Ferguson concurred, pointing to the need to understand the timing for the existence of the cross-maps and how long they need to be supported.
- McCallie asked whether developers should come up with a complete list of codes for which cross-maps should be created.
- Betsy Humphreys said that the selection of value sets from a vocabulary to represent a particular set of meanings for a measure needs to be an activity in which the experts in the content from the point of view of the measure and from the point of view of the vocabulary and code set both have their place and must work together.
- Rollins commented that any of those mappings should be rule-spaced for a particular use case, and localized per user.

8. Framework Follow-up Discussion

ONC's Doug Fridsma reviewed the activities associated with the Standards and Interoperability (S&I) Framework to date. The overarching questions are how to achieve interoperable health care systems and how to enable stakeholders; curate a portfolio of standards, services, and policies; and enforce compliance. He discussed the key questions guiding the current S&I Framework initiative, as follows:

- Although not perfect, does it represent the best we have so far?

- Does it point us in the right direction?
- Is it the next step in an incremental approach to refining the standards and implementation guides?
- Does it support our policy objectives?
- Can we update it as needed through the SDO community?
- Is this a “path of least regret?”

He presented a diagram showing how the S&I Framework complements other standards initiatives, and described the modular specification project, which was discussed earlier in the meeting in the context of the Summer Camp activities.

Fridsma then walked the group through a diagram that uses some of the work of the NwHIN Power Team to relate the extensibility and flexibility with ease of implementation and degree of interoperability of CCD, CDA, C32, CCR, and Templated CDA. He showed a slide dealing with the potential for Green CDA, explaining that they are incrementally moving toward more domain-expert friendly tags applied to those standards, in order to be responsive to criticisms of C32. He then reviewed the initiatives and summarized findings in the following areas:

- Transitions of care. There is significant convergence around consolidated CDA templates. Recommendations include using the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates standard currently in ballot reconciliation in HL7.
- Lab Results interface. There is broad agreement on usage of the new LRI IG and required vocabularies. It is recommended to use HL7 Version 2.5.1 Implementation Guide: Laboratory Results Interface, currently in the HL7 ballot process, with required vocabularies (LOINC, SNOMED). Pilots of optional vocabularies should be encouraged and monitored—these include UCUM, OIDs, and SNOMED CT (for specimen information)—for future inclusion in implementation guidance.
- Provider directories. There is consensus that a DNS-with-failover-to-LDAP solution allows a greater number of implementers to effectively enable certificate discovery and management. This suggests pilots as the next step. There also is agreement that standards to query provider directories need broader real-world usage.

Fridsma noted that at a future meeting, the Committee will be presented with information on other S&I Framework initiatives, including the Certificate Interoperability Initiative, Query Health Initiative, Data Segmentation Initiative, and Electronic Submission of Medical Documentation.

Discussion

- In response to a comment from Wes Rishel, Fridsma agreed that Green CDA is difficult to use “over the wire” because there is no consistent normative standard about what a Green CDA is supposed to resemble. John Halamka commented that it is an interesting detail that has not yet converged to consensus. Simplifying by using Green CDA sounds plausible, but there are many who are not using simplified versions.

- Rishel suggested that if they want a quick monetary fix, they should implement a Health Insurance Portability and Accountability Act (HIPAA) claims attachment. This work is going on independently of work on HIPAA claims attachments, even though they are both varieties of the CDA. The scope of the work that was done on claims attachments was to allow the same package to contain both unstructured and structured data.
- David McCallie said that if it isn't simple on the wire it isn't worth doing, because otherwise it's just another layer of complexity to fail.
- Dixie Baker noted that when the Committee had a discussion about provider directories, their conclusion was that a national-level lightweight directory access protocol (LDAP) directory was not going to be the solution, and that it should be much more simple. The Committee encouraged the ONC to look at the use of microdata, which does not require the development of a complete data model. She asked about what happened as a result of these discussions. Fridsma reported that a microdata initiative was launched, but did not have enough participation to move forward.
- Chris Chute commented that LDAP has severe technical restrictions and performance issues, and would not scale—these points were made at the August Committee meeting. He asked about the S&I Framework process, noting that it is unrealistic to expect that a schema that would ultimately be owned by the ONC would be created by an outside entity. He suggested that they re-examine the enthusiasm and interest to see if microdata could be considered as an alternative.
- Kevin Hutchinson questioned whether the S&I Framework is getting feedback from providers or patients to measure whether they are impacting the care process as they hope they are. Fridsma explained that such feedback comes indirectly through the pilots, and more broadly across the ONC there are groups charged with understanding what is happening in the community.
- Stan Huff explained that Green CDA is a medical-specific extensible markup language (XML), providing a language for describing content, but it has lots of variability. Even if the issue of translating from Green CDA to the wire format is solved, there is still an underlying question of whether the model of data is consistent, and also the connection for the model to the vocabularies. Fridsma noted that the recommendation was to use Consolidated CDA, and agreed with Huff's comments. They will not necessarily solve that problem within the S&I Framework. The only way Green CDA on the wire will be successful is if the medical terms are consistent, which will require consistent mapping and vocabulary use.
- Fridsma noted that it be helpful to understand whether the S&I Framework is directionally going where it needs to go. Are there things that need to change? Perlin suggested that this topic be discussed at the next HITSC meeting.

9. Implementation Workgroup Update

Implementation Workgroup Co-Chair Judy Murphy reviewed the group's recent activities. ONC's Steve Posnak said that he and the Implementation Workgroup have been working to get

as far as they can with draft certification criteria for meaningful use Stage 2. After that, there will be a period open for public comment.

Workgroup Co-Chair Liz Johnson presented a grid showing the Implementation Workgroup's recommendations for certification criteria, standards, and implementation specifications to support meaningful use Stage 2 objectives. The grid contains 54 rows—each row includes a column that includes: a meaningful use criterion or other item that needs to be addressed, adopted certification criterion, recommended new or revised certification criterion, and recommended standard(s) and/or implementation specification(s). Johnson encouraged the Committee to review the grid in detail and provide input.

Discussion

- Committee members discussed the challenge with quality reporting document architecture (QRDA), with one member saying he heard the sentiment that they should “get something out there that has some capability, and get it used.” Having a decision is better from the quality measures standpoint, because as they look at measures being specified, always thinking in terms of what the report out is going to be, they end up putting things in the measure that belong in the report. He noted that only category one was approved as a draft standard for trial use (DSTU). Categories two and three were not validated. Perlin suggested that part of the recommendation might be a determination of what belongs in the measure and what belongs in the reporting. Carol Diamond said that it only helps to have something if it actually works. She recommends that they note this as a gap that they have identified, and a group should come together to decide whether an existing standard accommodates this kind of report, or a QRDA, or other.
- Murphy said that one way to drive the effort is to declare it as the standard, so that work is put into it.
- Johnson directed Committee members' attention to row 18, which addresses a new requirement for meaningful use on electronic notes. They provided a draft definition of an electronic note that deals with eligible hospital days. The Workgroup needs to hear back with a final definition.
- In measuring computerized physician order entry (CPOE), emergency department patients were a great source of discussion and controversy. Some physicians want to know if these patient would be included for electronic notes, and whether a per-visit measure for a hospital day would be used? Should they be included in the construct around electronic notes or not? Johnson said the consensus from the Workgroup is that they should be included, on a per-visit measurement.
- Row 23 was discussed—the entire concept of a patient and how they are going to act with their personal health record (PHR) was a difficult one for the Workgroup . There was much discussion as to whether or not there had to be a portal and/or a PHR. Steve Posnak said they are looking for some guidance around whether, in addition to providers, third parties (like PHRs) should also be responsible for being certified to provide view and download

technology. With this approach, providers potentially could use PHRs as a way to provide this service for their patients.

- Diamond noted that the “view” component was already included in meaningful use Stage 1, so now they are only addressing downloading information that the patient was already able to view. Presumably to view, there was some kind of secure log-in. The advantage of view/download is it does not require a patient to join some kind of service, be it a PHR or whatever. They may want to do nothing more than that. If there is no certification criteria that enables view and download at a minimum, then they are saying that a patient may need to join some service to get their information—that is not ideal. With a secure log-in, if the patient wants to use a third party to help them manage their information, they can and the same doorway could be used. However, PHRS should not be a required function of qualified technology.
- Dixie Baker explained that the term “portal” is defined differently even within the technical community. She suggests avoiding use of the term completely. Also, she noted that rows 46 through 50 of the grid are security and privacy requirements that came out of the Tiger Team, all relating to patient access to information. She suggested that all of this information be moved up to row 23. View and download should not be separate from the security requirements around it.
- It was noted that the technology Diamond described could be many things, not necessarily just an EHR. Are they talking here about certifying Microsoft Health Vault? That is a statutory problem; there is a need to solve this nomenclature issue. Another Committee member said that certified EHR technology is whatever structure is certified. Murphy said that the intent is that the health care organization has an accountability to help market this capability and to show patients how important it is for their health care.
- McCallie said that the mere provisioning of a secure log-in is a sufficient step for a patient to create a Direct account. He can imagine a scenario in which a patient who wants to download their information could be directed to create a Direct account. He is anxious to make sure to define an outcome, which is that the patient can easily get a copy of their record. The download could be a standard protocol like Direct, if they choose. In the long run, everyone is better served if the patient has their files in a secure, organized place.
- Kevin Hutchinson commented that because the measurement is on number of views, they should recommend that a download is a view, because there is no measurement in the definition on downloads. The 10 percent requirement is on the viewing and the ability to download. Rishel pointed out that the more different ways a patient can download the data, the harder it is to count views. The ability to count the views through third party technology needs to be included.
- Baker noted that the Privacy and Security Workgroup will offer feedback on patient secure messaging by the next HITSC meeting.

- Johnson noted that in row 29's far column, the Workgroup left open the recommended standards to be inclusive. Are they moving to a single standard between CCD and CCR? That topic continued to come up in the Workgroup meetings, and this has been discussed within the S&I Framework effort. She asked, at what point do they harmonize with the S&I Framework? Fridsma said that they would eventually like to see a convergence occur and asked for any directional recommendations from the Committee.
- Jim Walker noted that a transition period and a roadmap for industry would be beneficial. Very few organizations support CCR, and if a roadmap could be provided with some indication about the direction this work is moving in the next 18 months or 2 years, that could be extremely useful.
- The Committee discussed attestation around immunization registries, found in row 31. There is a question of whether the capabilities should be split in two—one would be to record, modify, and retrieve immunization data, and the other would be to submit the data. The survey data that the Workgroup has indicates that there are modules that are sold to carry out these activities independently. Rishel said that "record, modify, and retrieve" sounds like it applies to an EHR, versus what would go to the state registry or other source. Clarity is needed.
- Baker pointed out that row 52 does not address security. Rather, it relates to amending data elements in a record.

10. Public Comment

John Valutkevich (sp?) from Meditech Enterprise EMR spoke about row 23 of the Implementation Workgroup's grid. He said that the number of downloads should be electronically downloaded or tracked, and he presumed that would be the certification. The legal ramifications of that is that patients who view and download that information are going to take that on to some other place for clinical decision or support. Where will a copy be kept of what was downloaded? For certification criterion, if this is for the patient to view and download, he certainly understands the readable format. However, it also has to display and be codified with all the standards next to it, with CCD and/or CCR. If a human-readable format includes all that, he is worried that usefulness will be an issue..

Carol Bickford from the American Nurses Association thanked Judy Sparrow for her years of service.

Mark Siegel from GE Healthcare thanked the group for its NwHIN discussion. He asked that the Standards Committee and ONC look carefully at the detailed comments that the EHR Association made earlier this week on the Power Team findings. Clearly, there are a few issues with the analysis, but he pointed to issues especially with the conclusion as finalized in today's document, which seemed imbalanced towards Exchange as opposed to Direct. He agrees with Mostashari that both are necessary. What the Standards Committee and the ONC recommend will be critical signals to the market. Broader uptake and investment has been constrained by uncertain federal signals around transport. What is defined as appropriate from the NwHIN has

broader implications for the HIE infrastructure and for meaningful use certification, especially where it references such things as Direct that have local and national ramifications.

SUMMARY OF ACTION ITEMS

Action Item #1: The Committee approved by consensus the minutes from the August 17, 2011 HITSC meeting.

Action Item #2: The NwHIN Power Team report was forwarded to the ONC, with comments, by consensus.

Action Item #3: The E-prescribing of Discharge Medications Power Team report was forwarded to the ONC, with comments, by consensus.