HIT Standards Committee
DRAFT
Summary of the June 19, 2013 Meeting

ATTENDANCE

The following members attended the meeting:

- Jonathan Perlin
- John Halamka
- Dixie Baker
- Jeremy Delinsky
- John Derr
- Floyd Eisenberg
- Jamie Ferguson
- Keith Figlioli
- Lisa Gallagher
- Leslie Kelly Hall
- Stanley Huff
- Elizabeth Johnson
- Rebecca Kush
- Anne LeMaistre
- Arien Malec
- David McCallie, Jr.
- Wes Rishel
- Eric Rose
- Sharon Terry
- Andrew Wiesenthal
- Tim Cromwell
- Nancy Orvis
- Kamie Roberts for Charles Romine

The following members were absent:

- Anne Castro
- Lorraine Doo
- C. Martin Harris
- Kim Nolen
- Christopher Ross

KEY TOPICS

Call to Order

MacKenzie Robertson, Office of the National Coordinator (ONC), welcomed participants to the 48th meeting of the Health Information Technology Standards Committee (HITSC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting with an opportunity for public comment. Robertson called roll and asked Committee members to identify themselves before making comments, reminding them that the meeting was being transcribed. She then turned the meeting over to Judy Murphy of ONC.

Welcome and Introductory Remarks

Murphy noted that the ONC is at a critical juncture in terms of its programs, industry, and progress towards implementation. At the time of this meeting, the 50 percent mark has been passed in the payments to providers for either the Medicare or the Medicaid incentives, and the 75 percent mark has been achieved for hospitals. She reminded the committee that this work is not just about getting electronic health records (EHRs) into wide use; this work is about health care transformation, changing the habits, clinical workflows, care delivery, and modes of payment in health care. The challenge ahead involves the tools and using them as the platform or using them to enable the clinical and financial changes that must be made. Following these comments, Murphy turned the meeting over to Committee Chair Jonathan Perlin for a review of the agenda.

Review of the Agenda

Perlin noted that the Nationwide Health Information Network (NwHIN) Power Team will present HITSC with recommendations for consideration and approval in the broader sense of standards to support consumer exchange for Stage 3 meaningful use. The HITSC will also receive updates from the Consumer Technology Workgroup, the Clinical Operations Workgroup, and the ONC. He then asked for any changes to the summary of the April 2013 HITSC meeting. Hearing none, he announced acceptance of the April 2013 meeting summary as circulated.

Action item #1: The summary of the April 2013 HITSC meeting was approved as circulated.

HITSC Vice Chair John Halamka expressed excitement regarding the presentation by the NwHIN Power Team, noting that someday interoperability will not be an innovation, but an expectation.

NwHIN Power Team Update

NwHIN Power Team Lead Dixie Baker indicated that the Nationwide Health Information Network (NwHIN) Power Team update primarily consisted of a presentation on preliminary recommendations related to transport standards for consumer exchanges. These recommendations must still be approved by the Consumer Workgroup and the Privacy and Security Workgroup. She reminded HITSC members of the task assigned to the NwHIN Power Team: to make recommendations for additional standards to support transport of data to and from patients. The goal is to recommend whether the ONC should consider other transport standards in addition to or in lieu of those that have already been recommended. The team was asked to look specifically at Blue Button+ (formerly known as the Automated Blue Button Initiative, or ABBI), HL7 Fast Healthcare Interoperability Resources (FIHR), the RESTful Healthcare Exchange (RHEx), and the standards that they use. The team also looked at the language from the Health Information Technology for Economic and Clinical Health (HITECH) Act requiring that a patient be able to download or pull their own data from their EHR or for a provider to push it to them and for a consumer to request that their EHR data be sent to a third-party or made available to a third-party.

The team noticed several commonalities among Blue Button+, FHIR, and RHEx. All three use secured RESTful transport. One way to view this is as a standard that enables single sign-on, which would allow a patient or provider to visit multiple websites without ultimately having to re-authenticate at every single one. OAuth2, a protocol that enables a consumer to authorize another application such as a personal health record (PHR) or smart phone application to pull their data from EHR held by their doctor, was another common factor across the initiatives. An examination of these commonalities provided insight into two types of standards that seemed to exist. Lower-level (“building block”) protocols were used to create other protocols. The higher-level (“composite”) protocols were composed of lower-level standards.

Baker continued the presentation with an overview of some lower-level protocols. OAuth2 is a flexible standard that has been widely adopted by social media and networking sites as well as the RHEx demonstration and the Blue Button+ pull capability. OpenID Connect is used for remote authentications, and allows an authenticated identity to be shared with another Web site so that an individual does not have to sign-on multiple times. Another standard used for single sign-on is SAML, which is mostly used in the traditional kind of SOAP Web services stacks; the eHealth Exchange uses SAML in the way Blue Button+ uses OpenID. OAuth2 and OpenID layer nicely with one another. This is an emerging standard in

limited (but growing) use for passing user authentication assertions. RHEx uses this analysis for the single sign-on capability. hData, a predecessor to FHIR, is also used by RHEx. It allows for the exposure of health care resources through a RESTful exchange, but will likely be superseded by FHIR, a new HL7 standard that is still in development. FHIR has very strong support from HL7 leadership across the board and rapidly emerging industry interest. It focuses on the resources used for exchange, including: defined, simple, structured data; extensions; and narrative. FHIR emphasizes simplicity, implementability, and human readability. It uses a single syntax for all resources and no licensing is required for using FHIR. The base specification for FHIR is complete and stable and is targeting about 150 resource definitions, after which point it will shift to profiles. It is currently used by Blue Button+ and the CommonWell Consortium. It may also be used in Web-centric social media applications.

Baker moved on to cover some of the higher-level protocols used by Blue Button+ Pull and RHEx. Blue Button+ was designed specifically for structured and secure transmission of health information on behalf of an individual consumer. It is comprised of two pieces: Blue Button Push and Blue Button Pull. Blue Button Pull is an API that enables an application to pull EHR data on behalf of a consumer. There are two kinds of registration defined in Blue Button+ Pull: open registration and trusted registration. Open registration is just that – open. Trusted registration requires the use of the Blue Button+ registry and those applications are vetted. The draft specification for Blue Button+ Pull is online. EHR vendors are currently underrepresented in the development of Blue Button+, and few have committed to implementing it. RHEx is an initiative jointly sponsored by the Federal Health Architecture and ONC. It applies open-source Web technologies to demonstrate the uses of RESTful, secure, standard-based approaches to health care exchanges. This initiative is a direct response to the Committee's 2011 recommendation regarding the need for a third (and secure) transport system. RHEx has completed two pilots, with several more planned.

Baker presented a slide depicting an evaluation system for determining readiness to become a national standard. According to the work completed by the Team, it seems that the HTTPS or secured RESTful transport is mature, adoptable, and ready to become a national standard. OAuth2 is broad, and sits on the border between the pilot stage and becoming a national standard. FHIR, RHEx, and OpenID Connect are still in the pilot stages. Blue Button+ Push is quite mature, but Blue Button+ Pull is still in its infancy.

The Team believes that secured RESTful transport, OpenID Connect, OAuth2, and FHIR can be used together to create a safe and appropriate set of standards for more complicated health care applications. Power Team Co-Chair David McCallie added that there are equivalent layers and power to previous standards, but that the new standards have Internet-friendly approaches.

Baker reviewed the preliminary recommendations from the Team. They recommended that ONC support and encourage the development and piloting of Blue Button+, FHIR, and RHEx. Blue Button+ Pull focuses on a specific, identified need to enable a consumer to access their own health information or to authorize a third-party application to do so. This is an emerging standard and its development should be supported. Early pilots and EHR vendor participation should be encouraged, because there are no known alternatives that address this need. FHIR is highly likely to become a key next-generation content standard for health care, and would be appropriate as a content standard for both Blue Button+ and RHEx. RHEx is a useful demonstration of how HTTPS, OpenID Connect, OAuth2, and FHIR can be used together to support robust, but simple health care exchange. It is responsive to an industry need for a simple means of transmitting large health care data objects (e.g., images) that cannot be accommodated by Direct. The team encourages the replacement of hData with FHIR. Finally, given the flexibility of the RHEx architecture and the optionality available from OAuth2, profiles based on the RHEx initiative may be more appropriate candidates as national standards than the full body of work.

The Team's next steps include presenting these preliminary recommendations to the Privacy and Security Workgroup and the Consumer Workgroup, asking them to consider questions including, but not limited to:

- Blue Button+ Pull considers "open registration" (i.e., non-vetted) appropriate only for new and experimental applications, and suggests displaying a warning with these applications. For a

higher level of assurance, applications can undergo a "trusted registration." What level of assurance is reasonable and appropriate for Blue Button+ Pull applications?

- How might OAuth2 apps be authenticated? Is TLS server authentication sufficient? Are there any other security concerns around the use of OAuth2 for enabling consumers to "pull" their data from certified EHRs?

Baker then turned the discussion over to McCallie. He encouraged the Committee to think about OAuth2, OpenID Connect, and FHIR as new generation building blocks; the ease with which they can be manipulated and combined will raise interesting questions about how profiles are developed. Blue Button+ Pull is a good example of where building blocks have been appropriately profiled, constrained, and aligned for a specific use case. RHEx presents a portfolio of use cases that demonstrate the power of the building blocks but in and of themselves probably were not sufficiently profiled to become independent stand-alone standards at that higher-level. McCallie indicated that the challenge going forward will be how to create and manage the higher-level aggregations of lower-level protocols that improves interoperability. Future discussions may focus on the potential need for new models.

Discussion

Arien Malec noted that the HITSC has been asked to evaluate whether it is possible to further modularize EHRs and create an API layer around EHRs. He believes the stack Baker discussed lends itself to a good range of use cases for modularizing and composing portions of an EHR. The HITSC may want to evaluate the standards stack for purposes beyond that for which the NwHIN Power Team was requested.

Wes Rishel noted that the HITSC appears to be on the verge of recommending an emerging standard for meaningful use Stage 3. He suggested that the level of effort that goes into supporting various FHIR applications be accompanied by projects that demonstrate cross-vendor interoperability as soon as possible. Rishel also commented on the dynamic/trusted registration protocols for Blue Button+, expressing hope that the committee will look at all sides of the issue. How can there be a balance between the patient's rights to get their data and the physician's rights to not be compromised in releasing the data?

Leslie Kelly Hall wondered if asking the Privacy and Security Workgroup about levels of assurance with regard to consumers would be useful.

Eric Rose struggled to understand whether or not there are gaps that these new standards would fill, or whether they are expanding the use cases. Is there a risk of getting too far ahead of what can reasonably be implemented? Baker responded, indicating that there were no gaps, because the two requirements that came in HITECH were the capability for a provider to be able to download an EHR to a consumer and to provide a consumer's EHR data to a third party. In terms of workflow, the proposed standards would simplify the effort required and simplify the workflow for both the doctor and the consumer. Rose then asked if there was a mandate from the Health IT Policy Committee (HITPC) to pursue these kinds of use cases. Baker indicated that there was not. McCallie added that there was an ONC mandate to investigate Blue Button+ Push and Pull.

Keith Figlioli asked about next steps. Perlin indicated that at this time, there is a need for conceptual agreement on these topics. He also pushed for support of the recommendation that the ONC support and encourage development and piloting of Blue Button+, FHIR, and RHEx. Figlioli noted that there are broader ramifications of this discussion that must be recognized. Perlin articulated an action item for the NwHIN Power Team Co-Chairs, indicated that they must come back and describe some of the broader ramifications and potential use cases. McCallie solicited offline comments and suggestions from Committee members.

> **Action item #2:** The NwHIN Power Team was asked to review the broader ramifications and potential use cases associated with developing and piloting Blue Button+, FHIR, and RHEx.

Halamka noted that Blue Button has worked at Beth Israel Deaconess Hospital from both a patient and provider perspective. He believes that liquidity of data with low-barrier entry will be welcome in the industry.

Consumer Technology Workgroup Update

Consumer Technology Workgroup Chair Leslie Kelly Hall reviewed the workgroup's charge: to provide recommendations on standards, interoperability issues, and opportunities to strengthen the ability for consumers, patients, and lay caregivers to manage health and health care for themselves or others. The Workgroup will work focus on issues including the portability of patient data, patient access to and generation of their health data, and incorporating patient preferences for a variety of issues, such as care plans. The Workgroup will collaborate with the NwHIN Power Team, HITPC's Consumer Empowerment Workgroup, and HITSC's Meaningful Use Workgroup. It is likely that there will also be some involvement with the Implementation Workgroup.

The Consumer Technology Workgroup has only had three meetings to this point, but it has issued a Request for Comment on consumer strategies through ONC's planning room technology. They have also had a technical briefing on Blue Button and Blue Button+, and will seek a technical briefing from the NwHIN Power Team. The workgroup has begun an inventory of the standards that can support consumer and patient engagement. The workplan for the workgroup includes developing a thorough understanding of the proposed meaningful use objectives, examining current needs, and ensuring that existing standards are being repurposed where possible. The workgroup will begin with the content standards to support patient-generated health data (PGHD). One proposed objective deals with providing patients the capability to electronically submit PGHD. The workgroup will also attempt to find existing standards and ensure they are examined from a patient perspective. In addition, the workgroup is considering the patient's ability to request or amend their record online. Can the HIPAA policy framework be applied to PGHD? The use of secure electronic messaging is another element that the workgroup will consider.

The workgroup will work with the HITPC and its Consumer Empowerment Workgroup to identify what needs exist regarding care planning. This may include patient directions, patient care preferences, and values. Hall's hope is that the workgroup can effectively support collaborative care plans going forward. The workgroup will examine existing standards for patients in the same way they assess standards for providers, employing a model that relies on maturity and adoptability criteria. This will be done through the lens of repurposing and reusing existing standards that have already met the maturity and adoption criteria or are being put forward as emerging standards. The work will be biased toward repurposing existing standards with patients and family in mind.

Discussion

Hall indicated that there is an opportunity to collaborate across specific areas with regard to privacy and security and consumer vocabulary. Halamka asked for an expanded cultural commentary on data provenance and individual willingness to consume that data. Hall noted that patient engagement has improved simply by the opportunity for patients to be the author of the same information that has been historically transcribed on their behalf. Andy Wiesenthal indicated that the trickiest area of PGHD is in diagnosis, when a patient and a provider are in dispute. Baker agreed that PGHD is going to be a hot topic, indicating that metadata tags may help with the issue of data provenance. Nancy Orvis suggested tracking, over the course of the next year, other groups that are helping consumers generate accurate, helpful data.

Mary Jo Deering noted that the ONC has asked for technical expert panel to be convened on the subject of best practices surrounding PGHD. There will be a presentation to HITPC's Consumer Empowerment Workgroup; it may be helpful for other workgroups to attend as well. She also noted that the new FDASIA Workgroup may be touching on some of these patient safety issues.

Rishel expressed his concern that mandatory requirements, when imposed too soon, may prevent the industry from having time to perceive the user's needs and respond. He believes that culture may be a

more important element than workflow in this space. His recommendation was to find use cases that examine this issue.

Clinical Operations Workgroup Update

John Klimek reminded the committee that the workgroup is primarily looking at the core measure used to generate and transmit permissible prescriptions electronically. He reviewed the flow of an e-prescription, which outlines the basic flow of information that represents the standard for data exchange. The Formulary and Benefits Standard Version 4.0 was recently approved by the National Council for Prescription Drug Programs (NCPDP), although Version 1.0 is still the version widely used by industry today. Version 3.0 has been recommended to the Centers for Medicare and Medicaid Services (CMS); Klimek predicts a switch from 1.0 to 3.0 in the next year. The formulary and benefit process should help patients understand if their medications are covered and how much they might cost.

Klimek reviewed the responsibilities of a sender:

- Maintaining updated formulary and benefits information;
- Publishing the information regularly to keep recipients up to date;
- Providing a means for linking a patient to a formulary, either through cross-reference lists or through an eligibility transaction.

He then discussed the responsibilities of an intermediary:

- Facilitating the distribution of formulary and benefits information between the formulary publishers and retrievers;
- Documenting and communicating the data load specifications, processing, and usage guidelines particular to their service;
- Validating transmitted files against the standard specification (optional).

Finally, he reviewed the responsibilities of a receiver or technology vendor:

- Accepting or retrieving the formulary information from the sender (directly or via an intermediary) and integrate it into their point-of-care application;
- Associating formulary and benefits information to the patient or group, as appropriate, using the cross-reference list or an eligibility transaction;
- Within the context of a prescribing system, present the formulary and benefits information to the physician during the prescribing process, enabling him/her to make the most appropriate drug choice for the patient.

Klimek then drew the committee's attention to potential industry issues, such as the large file sizes required to provide accurate formulary and benefits data. This concern could be minimized through the use of RxNorm. Another issue arises when information is sent in batch form, and not in real time; there is no standard around this. Group-level variations and coverage are not being represented, so the provider does not see an accurate representation of drug-specific benefits. There must be the assumption that a patient's current drug insurance plan is identified through a successful eligibility check. The differences in coverage among various employer-level groups within individual health plans are a major source of inaccuracy in the formulary and benefits data presented to clinicians. The use of symbols in formulary interpretation that do not reflect actual drug-specific benefits at the point of care creates inconsistencies and variations. Finally, there is an issue when there is an inability to detect differences in primary and secondary prescription benefit coverage.

He then discussed how information gets from EHR vendors to physicians and the EHR system. There are two methods: (1) automatic push, in which formulary data information is automatically pushed into the provider's system in real time without any provider intervention, and (2) manual pull, in which the provider must take the initiative and manually download the updated data.

Some proposed short-term recommendations around these issues include:

- NCPDP Formulary and Benefit Standard Version v3.0 (current standard – batch files) should be supported in certified EHR technology for formulary and benefits transmission to EHRs;

- Formulary and benefits transmission with NCPDP 3.0 should be required to use RxNorm to facilitate accurate exchange of data and to reduce file size;
- Certified EHR technology should have functionality to match the patient not only to their medical benefits but also to their pharmacy benefits utilizing PCN/BIN/Issuer;
- Certified EHR technology should be required to support acceptance of automatic updates or push functionality to update formulary and benefits data at the provider level to minimize latency in information at the point of care;
- Having formulary and benefits data presented at the point of care should, at minimum, represent the patient's group pharmacy benefit.

In the long-term, Klimek recommends that certified EHRs should develop the functionality to run patient-level formulary checks against the patient's actual drug benefit for a specific drug and dose in a timely manner. This would require a new standard or transaction.

Discussion

Ferguson asked how this would align with the migration of Medicare Part D. Klimek responded that hopefully, Version 3.0 will be included in new Medicare requirements.

McCallie asked about the status of work on making prior authorization part of a formulary benefit model. Klimek noted that at the May workgroup meeting, the release of the updated version of the electronic prior authorization process was approved. There should soon be some major initiatives in industry moving toward that point. The hope is to have this process occur entirely at the physician level to cut out waste and redundancy.

Malec asked if Klimek's recommendation stipulates that RxNorm replace NDC or have it supported in addition to NDC. Klimek indicated that the standard allows for both. The benefit of RxNorm is in the smaller file size. Malec's concern lies in existence of the cost to do this kind of transition both on the payer or PBM side and on the EHR vendor side. Ferguson clarified that RxNorm would, in Klimek's recommendation, be required and NDC would be optional. Ferguson pointed out that it is not realistic to expect full adoption of formulary and benefits without the migration to RxNorm.

Malec asked if would be useful to look at the prevalence of provider practices that routinely collect Rx BIN and PCN numbers. It may be useful to look at the practice work flow and technology support for that change. Rose noted that typically, the eligibility transaction does not require that the EHR send any identifiers. Malec suggested that the question of pushed notifications of formulary information should be given to the Privacy and Security Workgroup.

Rishel discussed the difference between HIPAA and NCPDP regulations and standards surrounding prior authorization. He wondered if it will be necessary to revise industry expectations about how much the physician can know or rethink the standards in terms of mandatory services provided by PBMs that provide pre-adjudication online in support of this decision process in an EHR. McCallie added that it is absurd that patients and physicians cannot make a decision without knowing the cost of the decision at the point of care. Ferguson noted that in order to keep in sync with Part D, this will need to be a short-term recommendation. Ferguson requested that this topic be taken back to the Clinical Operations Workgroup and replaced on the agenda for the next HITSC meeting.

Ferguson discussed image sharing standards, noting that the Clinical Operations Workgroup began addressing this topic by reviewing use cases, candidate standards, and methods for image sharing; they are still in this stage. In the future, they will work to refine the use case scenarios at a more detailed level and make recommendations aligned with those scenarios. The initial use cases included provider to consumer image sharing, clinician-to-clinician image sharing, and care team/network/community images sharing. A potential additional use case may involve consumer-mediated provider to provider image sharing.

Halamka made a point about EKGs—they are not actually images, but the patient may perceive them as such.

McCallie asked about the Radiological Society of North America (RSNA) image sharing pilot. Ferguson indicated that this has been reviewed with the RSNA representatives at a high level, and will continue to be refined in the Workgroup. Halamka informed the Committee that the Workgroup is aware of the need to think through DICOM and non-DICOM alternatives in image sharing.

Hall noted that this Workgroup has an opportunity to resolve the problem of sustaining hyperlinks across asynchronous upgraded systems. Is this something that Workgroup could look at broadly, or specifically related to DICOM? Ferguson indicated that this would be considered with more than just DICOM. McCallie saw this as a good use case for OAuth2, highlighting not only issues with links that are sustainable, but also authorizations that are sustained as well.

Orvis noted that working with RSNA was a good move, because that organization has been made lead on terminology and vocabulary by the National Library of Medicine.

ONC Updates

Doug Fridsma of ONC updated the Committee on some of the operating metrics of the Standards and Interoperability (S&I) Framework initiative. He reported that 28 months into the process, approximately there are 2,400 wiki registrants, roughly 700 of which are committed members. There are almost 550 committed organizations and nearly 1,600 working sessions. The face-to-face meetings run about 3.5 hours long, and on June 20, the group will be launching one of the first international standards and interoperability framework activities jointly between the United States and European Union (EU). This launch is intended to support the Memorandum of Understanding (MOU) between the United States and EU to establish an internationally recognized vocabulary, structure, and patient empowerment to create a larger marketplace for HIT and to empower citizens that move across borders to be able to access their information in standardized ways. Some processes and mechanisms have been put in place so that members of the EU can participate in constructing and editing, and working on the wiki.

Fridsma drew attention to some of the projects within the S&I Initiative portfolio. He noted that a new Presidential Innovation Fellow recently joined the ONC to work on some aspects of the Blue Button Program, and will attempt to add different kinds of use cases, different kinds of content specification, and different kinds of transport mechanisms that can be used to support consumer engagement and patient access. It was also noted that the Prescription Drug Monitoring Program has been revived.

Fridsma summarized the status of various S&I initiatives. Transitions of care, laboratory results interface, and data segmentation for privacy are initiatives in “maintenance mode.” The activities surrounding query health, community-led public health reporting, longitudinal coordination of care, laboratory orders interface, Health eDecisions, Blue Button, and structured data capture are still active. Fridsma indicated that the community has come together and started to explore options and alternatives around standards.

Halamka turned the meeting over to Seth Pazinski, who discussed policy and program updates from the ONC. Pazinski informed Committee members that in October, the HITSC will move to schedule of bimonthly in-person meetings. He provided updates on the Beacon Community activities, noting that the ONC held a “lessons learned” event on May 22, gathering members of the 17 different Beacon Communities. He reminded the Committee that the Beacon Community Program was focused on identifying ways to increase quality, efficiency, and sustainability of health care through HIT. The ONC has also released the first Beacon Nation Learning Guide, which focused on improving hospital transitions and chronic disease management using admission, discharge, and transfer-based alerts. There will be five other lessons learned documents published over the course of the next year.

Pazinski informed the Committee that the Health Information Exchange (HIE) Governance Forum, established by the ONC in conjunction with the National eHealth Collaborative, now has more than 30 organizations representing various HIE governance bodies. The Forum will be focused on the development of best practice information, looking first at privacy and security and meaningful choice. He also highlighted some contracts and reports coming out of ONC. Two were focused on unintended consequences of HIT and HIE. Other reports examined consumer eHealth and HIE that identified some of

the key categories to focus on with regards to potential unintended consequences. Another report offered advice to health information organizations (HIOs) and health information service providers (HISPs) related to the meaningful use Stage 2 transitions of care measure and some guidance to HIOs and HISPs on how to achieve that and support that. The last report was focused on understanding the impact of HIT in underserved communities and those with health disparities. These reports are available publicly online at www.healthit.gov. There is a page on www.healthit.gov dedicated to certification technical resources, offering a mixture of presentations, slide sets, as well as some additional documents as technical resources for certification.

The ONC recently awarded a contract that will support work on the patient-centered outcome research strategic opportunities. This contract will explore the standard policies and services that will be required to establish a core infrastructure. The Affordable Care Act made an estimated $200 million in funds available through FY 2019 for this work.

Dixie Baker informed the Committee of a public Privacy and Security Tiger Team hearing on non-targeted query scheduled for Monday, June 24. Robertson offered to provide more information to interested Committee members. Perlin informed members that, as a matter of convenience and economy, virtual meetings may become more standard for future HITSC meetings.

Public Comment

No public comments were given.

Adjourn

Perlin noted the discussions from this meeting were remarkable, and thanked the Committee members. Halamka noted that he was looking forward to “metered progress and continuous progress.” Robertson reminded Committee members that the next meeting will be an in-person meeting on July 17th at the DuPont Circle Hotel. Perlin thanked the Committee and ONC staff again, and adjourned the call.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the April 2013 HITSC meeting was approved as circulated.

Action item #2: The NwHIN Power Team was asked to review the broader ramifications and potential use cases associated with developing and piloting Blue Button+, FHIR, and RHEx.