HIT Policy Committee
DRAFT
Summary of the June 10, 2014 Virtual Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 60th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with an opportunity for public comment (limited to three minutes per person), and that a transcript will be posted on the ONC website. She instructed members to identify themselves for the transcript before speaking. She called the roll and introduced the three new members: Kim Schofield – consumer representative; Christoph U. Lehmann – vulnerable populations representative; and Neal Patterson – vendor representative.

Remarks

National Coordinator and HITPC Chairperson Karen DeSalvo announced a realignment of the ONC organizational table. A Statement of Organization, Functions, and Delegations of Authority; Office of the National Coordinator for Health Information Technology was released June 3, 2014. (https://www.federalregister.gov/articles/2014/06/03/2014-12981/statement-of-organization-functions-and-delegations-of-authority-office-of-the-national-coordinator) She indicated that an e-mail describing the new structure had been sent to the committee members. ONC is transitioning from grant making in the ARRA era to policy development and coordination with a focus on interoperability and an implementation road map. Therefore, several of the units have been retitled to be consistent with the new emphasis. She mentioned a few examples. There will be a greater emphasis on evaluation. Jodi Daniel will continue to have responsibility for the FACAs. Steve Posnack's role has been expanded, as has Judy Murphy's. An invitation to dialogue around interoperability has been released. Interoperability will be expanded beyond health care per se to other factors that influence health.

Review of Agenda

Vice Chairperson Paul Tang noted each of the items on the agenda, which was distributed by e-mail prior to the meeting. No additions to the agenda were requested. He asked for and received a motion to approve the summary of the May meeting. The motion made by Gayle Harrell and seconded by Christine Bechtel was approved unanimously by voice vote.

> **Action item #1: The summary of the May 2014 HITPC meeting was approved unanimously by voice vote.**

Data Review – ONC Update

Jennifer King reported on the status of EP participation over the three years of the meaningful use program in response to previous requests from committee members. Fifty-nine percent of EPs have

attested to Stage 1. She showed slides describing variation in attestation by age, specialty, and practice size. Participation in a REC and PCMH certification increased likelihood of attestation. EPs located in counties with higher proportions of the Hispanic, black or below-federal poverty level populations were somewhat less likely to have attested. Of those that attested in 2011, 74 percent continued to attest in 2012 and 2013. Another slide showed some variation among specialties in non-attesters in 2012 or 2013. In terms of achievement of core objective thresholds in their third year of attestation, EPs scored an average of 86 percent above the thresholds across all core objectives. Small differences were observed by practice characteristics. She said that next month she intends to report on Stage 2 attestation.

In response to a question about the operational definition of average performance above thresholds, she said that for each core objective for each reporting provider the percent above the threshold was used to compute a mean across objectives and providers. She supplied the calculation formula by e-mail. Analysts are working on an ACO/non-ACO comparison to be reported on at a later time.

Data Review – CMS Update

Elisabeth Myers showed slides and presented the standard monthly report. As of April, 316,303 Medicare EPs – 156,641 Medicaid eligible – and 4,727 EHs had registered. Three hundred eighty-three thousand (383,000) unique providers have been paid. Nearly 95 percent of EHs have registered and 91 percent have been paid. About 12 percent of EPs have not yet registered. By June 1, 2014, 1,497 EPs had attested for the 2014 reporting year. Two hundred thirty (230) of them are new participants, and 447 attested to Stage 2. Seventy-five EHs have attested for 2014; 21 are new participants, and eight attested to Stage 2. She went on to describe the CMS and ONC NPRM, published on May 20, proposing 2014 CEHRT flexibility and an extension of Stage 2. The NPRM proposes to allow providers to meet meaningful use with EHRs certified to the 2011 or the 2014 Edition criteria, or a combination of both Editions in 2014. It would require providers to report using the 2014 Edition CEHRT for the 2015 EHR reporting period and extends Stage 2 through 2016. She referred to her slides and explained the three proposed options for attesting to Stage 1 in 2014 and the three options for attesting to Stage 2 in 2014. Public comments will be accepted through July 21, 2014 at the following URL: http://www.regulations.gov/#!submitComment;D=CMS-2014-0064-0002.

She offered to answer questions not related to interpretation of the NPRM. Paul Egerman asked to what extent are the EPs who made it to Stage 2 associated with successful EHs. Myers responded that a description of successful Stage 2 attesters was underway. Preliminary data suggest that they are mostly individual providers not necessarily associated with hospitals. They are using cloud-based software to a greater extent than non-attesters. The greatest impediment to attestation appears to be the functionality of CHERT. She informed Egerman that it is too early to determine the success with Stage 2. DeSalvo suggested that presentations from successful attesters on their challenges and solutions be invited.

Report on Certification Hearing

Tang used slides prepared by staff to report on the hearing held in May. After describing the structure of the hearing, he summarized the comments from the invited panelists. According to the invited providers, EHR products may meet certification criteria, but the way the functions are implemented may disrupt workflow. Some functions fulfill the letter of the criteria, but not the intent (e.g., clinical summaries, patient education). Some functions are implemented as check-the-box, which may be easy for a vendor, but creates burdens for the provider. Providers feel constrained to use products as

certified, with inefficient work flow. Certification does not adequately cover interoperability. More flexibility and time for implementation is needed. An ideal certification program would provide product comparisons in terms of functionality. According to the select vendors, the certification criteria for the meaningful use objectives, reports that measure the objectives, and the clinical quality measures are not aligned with each other and are not necessarily aligned with clinical practice. The testing tools and associated data are not properly tested before they are rolled out for use by vendors, and they change over time. They recommended that the complexity of the program be reduced and that a Kaizen process be used to support an effective review of the certification program. Certification should focus on a few functions, such as interoperability and CQMs. Invited representatives of certification and accreditation bodies said that new procedures and test tools should be tested prior to publication. Consistency across testing labs must be improved. Pilot tests should be a venue for all ATLs and ACBs to observe testing to understand the expected results, learn how the test tools operate, and then provide feedback to ONC. Testing tools need to be more automated to efficiently handle more test cases, reuse test data sets, and employ more robust types of testing methodologies, including testing the security of products. The private sector panelists said that additional up-front testing and quality assurance is needed. Mid-cycle revisions are disruptive to the overall program. Subject matter experts in program development are needed. Tang went on to say that there was no disagreement about the intent of meaningful use. But the process does not give sufficient time for product development and testing. He presented two recommendations: Use a Kaizen covering the end-to-end certification process from translation of objectives to certification criteria to development of testing scripts to development (and quality control and assurance) of testing tools to conduct of test to auditing; and limit the scope of certification to interoperability, privacy and security, and CQM.

Discussion

Saying that he participated in the hearing, Egerman questioned the consensus reported by Tang. He declared that Tang had not mentioned that one vendor on the vendor panel felt ~~one of the most frequent comments~~ that the cost of certification had been grossly miscalculated and was off by multiples. ONC staff dramatically underestimated the cost. He observed that ~~T~~the summary did not capture ~~ang had failed to capture in his summary~~ the intense unhappiness of some of the panelists. He went on to question the time period recommended for the application of the recommendations. Tang responded that the recommendations to ONC apply primarily to Stage 3. However, the Kaizen could apply to any stage.

Bechtel asked about the timeline for the recommendations, wondering how long a Kaizen would take to complete. Would the current processes and recommendations remain in place until Kaizen was completed? Tang replied that the process could be implemented fairly quickly. Some changes can be made sooner than others. DeSalvo declared that ONC wants to take every opportunity to improve the certification process. Saying that she was unsure how long such a process might take, she assured the committee that she wants to establish a culture of improvement. Bechtel wanted to add to the recommendation that current policies remain in place until any new process is underway. Egerman insisted that the process is broken. He preferred that everything be stopped and corrected. Bechtel pointed out that no one had considered the implications of pausing for redesign. That too would affect providers and vendors. Tang said that ONC officials have expressed willingness to improve the components of the process. The Kaizen is a new recommendation because it is a look at the entire process. Jacob Reider, ONC, reported on current efforts to improve efficiency. Staff is looking at the testing procedures and the causes of unnecessary pain. They are mapping out a life cycle. A Kaizen would be good but staff can do some work in advance with the test procedures, which are said to be

more prescriptive than needed. But the more prescriptive they are, the easier it is for the test labs. A happy medium is the goal. Shorter and cleaner test procedures and scripts, along with more scenario based testing will help.

Neil Patterson, Cerner, a vendor representative, wanted to make a "counter-comment" to a previous statement that everyone is "extremely unhappy." He said that his company is not~~said that his constituents are~~ "extremely ~~not~~ distressed" with the current process. He was in favor of the recommendations by the task force. Although end-to-end design would be a good approach, along with continuous quality improvement, immediate change is not necessary.

Bechtel referred to the proposed limited scope of certification: What would not get certified as a result? Tang indicated that would have to be worked out later. If may be possible to use functionalities to deliver better outcomes rather than to certify to each objective. Vendors would respond to their customers. Bechtel asked how vendors would be expected to respond to a new objective. Tang said that it would have to be worked out later. Reider wondered whether Tang was recommending that ONC focus exclusively on certification for meaningful use. Tang said that he did not think so. Bechtel repeated her concern that the full ramifications of the recommendations were not understood. Tang indicated willingness to modify the recommendation to limit the scope of certification, possibly (but not exclusively) to the three functions of interoperability, privacy and security, and CQMs.

Egerman gave examples of being less prescriptive with demographic data elements. He repeated that panelists agreed that the current system is broken.

Chris Lehmann said that as a representative of vulnerable populations, some of which may need special functions, he had reservations about any changes that would undermine certification. He requested that his concern be reflected in the record.

David Lansky said that the broader role of the private sector in government programs should be discussed. Tang ruled to take up the two recommendations separately. It was moved and seconded to recommend a Kaizen to cover certification end-to-end. The motion carried unanimously by voice vote.

> **Action item #2: A motion to recommend that ONC convene a Kaizen to cover certification end-to-end carried unanimously.**

Next, Tang asked for action on the draft recommendation to limit the focus of certification. Egerman moved to limit certification specifically to interoperability, privacy and security, and CQMs. Harrell seconded the motion. Tang then said that members could vote for one (or neither) of two options, the second option being to limit certification but without limiting it exclusively to interoperability, privacy and security, and CQMs. Egerman called a point of order, reminding Tang that a motion was on the floor. Tang asked Consolazio to take a roll call vote on Egerman's motion. The following voted yes: Egerman and Harrell. The following voted no: Bechtel, Lehmann, Kotz, Lansky, Bates, McGraw, Schofield, and Patterson. Probst voted for number 1. Gottlieb's response was not heard by writer.

> **Action item #3: A motion to recommend that certification be limited to interoperability, privacy and security, and CQMs was defeated.**

Next, McGraw moved to accept the second option—to recommend limiting certification but without limiting it exclusively to interoperability, privacy and security, and CQMs. Lansky seconded the motion. Tang told Consolazio to take a roll call vote. She called the roll with the following results: The following members voted yes: Kotz, Lansky, McGraw, Harrell, Schofield, Probst, and Patterson. Tang asked that his yes vote be counted. The following voted no: Bechtel, Lehmann, Bates, and Egerman. DeSalvo

abstained. Gottlieb's response was not heard by writer, and the totals are different from what was announced during meeting. Consolazio announced that the motion carried by a vote of 9 to 4. She changed it to 9 to 6, and then back to 9 in favor and 4 opposed.

> **Action item #4: A motion to recommend to ONC that the focus of certification be limited was approved by a vote of 9 to 4.**

Tang wondered about consideration of a counter proposal that would result in greater support. Bechtel suggested that the limitations of certification be incorporated into the Kaizen with consideration of the impact. Someone agreed. Tang said that its inclusion would be distracting to the Kaizen process. A better option would be to assign the topic to a workgroup. Harrell said that the Kaizen should not override the FACA process. Tang ruled that the recommendation would go forward with majority approval and acknowledgement of the minority opinions.

Long-term post-acute care (LTPAC) and Behavior Health (BH) Update – Certification and Adoption Workgroup

Chairperson Larry Wolf used slides prepared by staff to summarize comments from a listening session on voluntary certification for LTPAC and BH EHRs held May 22 as well as blog comments (n=6). The workgroup will present its complete recommendations to the committee in July. Comments were organized into general ones and those on specific meaningful use objectives. The workgroup members used the comments to finalize their recommendations, which were listed on the slides and presented by Wolf. In addition to setting specific recommendations for LTPAC patient assessments, BH patient assessments, and tracking trends, the workgroup delineated considerations for certification criteria relevant to some LTPAC and BH providers. Regarding LTPAC patient assessments, the use of ONC-specified HIT standards for a subset of patient assessment data to enable their reuse for clinical and administrative purposes (e.g., exchange of the LTPAC Assessment Summary CDA document) was recommended. Other recommendations were harmonization of federal content and format for patient assessments with ONC-specified HIT standards (e.g. consistent standards on demographics) and making the CMS data element library publically available and link content to nationally accepted standards. For the BH setting, the workgroup recommended: identification of vocabulary standards and data definitions to support BH patient assessments, and analysis of available standards and clarification on which standards are applicable to BH patient assessments. If gaps exist, expand upon existing standards to develop relevant certification criteria for this purpose. Regarding tracking, ONC should track national trends in LTPAC and BH IT adoption. Such efforts should include tracking use by functionality and by certification criteria. ONC should utilize EHR adoption definitions for LTPAC and BH that are consistent with those used in ONC and CMS initiatives.

Discussion

Given the length and content of Wolf's presentation, Tang asked precisely what committee action was requested. Wolf referred to the recommendation:

> Regarding LTPAC patient assessments, the use of ONC-specified HIT standards for a subset of patient assessment data to enable their reuse for clinical and administrative purposes (e.g., exchange of the LTPAC Assessment Summary CDA document; harmonization of federal content and format for patient assessments with ONC-specified HIT standards (e.g. consistent standards on demographics); and making the CMS data element library publically available and link content to nationally accepted standards.

Egerman reported that some of the workgroup members had expressed concern about the utility of receiving a 37-page assessment and its relationship to the ToC. Wolf said that the recommendation was to streamline the process. Providers need information in addition to the ToC. They want assessments from prior facilities. More work is needed to obtain mature standards. He said that the recommendation pertained to the standardization of data elements. The recommendation actually pertains to pre-certification status. Egerman questioned Wolf's presentation as representing consensus of the workgroup and objected to the recommendations. Wolf responded that LTPAC assessments are being used and transmitted to CMS, but are not being transmitted to other providers. Tang asked Wolf what he wanted action on. Wolf requested acceptance of the draft recommendations on the interoperability of LTPAC assessment data and work on standards by CMS and ONC. The second recommendation was to work on standards for BH assessments to pass from setting to setting. The third recommendation pertained to tracking by ONC. It was moved and seconded to approve the three recommendations. Tang asked that the motion include the draft ToC and privacy and security recommendations previously presented by the Certification and Adoption Workgroup. No objections were heard. The motion was approved unanimously by voice vote.

> **Action item #5: The draft recommendations to ONC on LTPAC and BH assessments, tracking, and privacy and security for LTPAC and BH voluntary EHR certification were approved unanimously.**

LTPAC and BH Measures – Quality Measures Workgroup

Workgroup Co-chairperson Terry Cullen reminded the committee members that the Certification and Adoption Workgroup had requested that the Quality Measures Workgroup discuss clinical quality measures and provide recommendations on potential LTPAC and BH CQM opportunities for voluntary EHR certification. Draft recommendations were presented at the May 6 HITPC meeting. The Certification and Adoption Workgroup convened a listening session on May 22 and solicited public comments on voluntary certification, including on the Quality Measures Workgroup's draft recommendations. The response to the draft recommendations was mixed. Therefore, the Quality Measures Workgroup decided that the recommendations are not ready for action by the committee, but could serve as a foundation for more exploratory work, such as the standardization and harmonization recommended by Wolf. ONC is expected to continue discussions with federal agencies and stakeholders to determine the policy and standards readiness for voluntary certification for quality measures.

Discussion

None

Behavioral Health Data Segmentation - Privacy and Security Tiger Team

Tiger Team Chairperson Deven McGraw presented draft recommendations on certification to enable exchange of BH data as requested by the Certification and Adoption Workgroup. She reminded them that she had explained the foundation for the recommendations at the May meeting, that is, the CFR 42 Part 2 requirements. She described four levels for the recipients of Part 2 information. At level 0, Part 2-covered data are not provided electronically to general health care providers. The status quo is to share Part 2-covered data via paper or fax. With level 1, the recipient EHR can receive and automatically recognize documents from Part 2 providers, but the document is sequestered from other EHR data. A recipient provider using DS4P would have the capability to view the restricted CCDA (or data element), but the CCDA or data cannot be automatically parsed, consumed, or inter-digitated into the EHR. Document level tagging can help prevent re-disclosure. At level 2, the recipient EHR can parse and

extract data from structured documents from Part 2 providers for use in local CDS and quality reporting engines, but data elements must be tagged and/or restricted to help prevent re-disclosure to other legal entities through manual or automated reporting or interfaces. This would allow the data to be used locally for CDS but would not require complicated re-disclosure logic for the EHR vendor. (Processes around re-disclosure are not well-defined). At level 3, the recipient EHR can consume patient authorization for re-disclosure from a Part 2 provider and act on such authorizations at a data level. At a minimum, the recipient EHR would need to make the user aware of whether additional Part 2 consent is required before re-disclosing any particular data element to another legal entity, and allow recording of patient authorization for re-disclosure at the data level. Processes for re-disclosure are well-defined. McGraw went on. Ideally for Stage 3, technical capabilities should include level 1 send-and-receive functionality in a voluntary certification program for BH providers. BH EHRs must be able to control which recipients can be sent Part 2-covered electronic documents. Capabilities should include level 1 receiver functionality as voluntary certification criterion for CEHRT. Only recipient providers interested in being at level 1 would request the capability from vendors. Moving from sender status quo of 0 requires level 1 capabilities for the sender and at least level 1 capabilities for a recipient. Levels 2 and 3 are beyond Stage 3. Co-chairperson Micky Tripathi briefly spoke about the complexity of the issues involved in considering the technical capabilities to move from regulations and procedures enacted for a paper world to a digital system. The tigers used DS4P as a window, but the recommendations are not tied to DS4P.

McGraw continued with the draft recommendations. Additional pilots and guidance are needed to clarify recipient responses under several situations. Providers and patients should be educated with regard to the obligations that come with Part 2 data, especially around re-disclosure, which are not yet fully understood. SAMHSA should provide additional written guidance on how to operationalize statutory requirements in a digital environment, specifically on how recipients are expected to handle a restricted CCDA and clarify the circumstances under which this information can be subsequently sourced from the patient in an informed way. SAMHSA should gather user feedback to ensure that any new guidance does not impose workflow barriers that would substantially inhibit existing or future flow of Part 2 information. In addition, it was recommended that the HITSC consider two questions: Is DS4P or any other standard sufficiently mature and feasible for BH EHR voluntary certification, and if so, at what level of granularity? Is DS4P or any other standard mature and feasible enough for general EHR voluntary certification, and if so, at what level of granularity?

Discussion

Egerman said that at the May meeting he had expressed preference for a cascading process for informed consent related to the same episode. Regarding pilot testing and complexity of workflow, he asked how many patients were actually involved in the pilots. McGraw called on Joy Pritts, ONC, who indicated that she could not answer the question. There were six different pilots. The pilots focused on Part 2, an issue for all states. In one of the pilots, the BH provider was transitioning its entire census to another type of care. Egerman said that he did not agree with the HITSC ruling on the maturity of standards related to the issue. David Coates moved to accept the recommendations. The motion was seconded and it carried unanimously by a voice vote with Egerman abstaining.

> **Action item #6: The recommendations presented by the Privacy and Security Tiger Team on voluntary certification of BH patient data for privacy and security were approved by voice vote with Egerman's abstention.**

JASON Report

DeSalvo prefaced the presentation by saying that recommendations on the report will be important for ONC's work. P. Jonathan White, AHRQ, acknowledged that JASON primarily does work for the Department of Defense and the Department of Homeland Security. He showed slides and described major findings from the report commissioned by AHRQ and RWJ. The current lack of interoperability among data sources for EHRs is a major impediment to the unencumbered exchange of health information and the development of a robust health data infrastructure. Interoperability issues can be resolved only by establishing comprehensive, transparent, and overarching software architecture for health information. The twin goals of improved health care and lowered health care costs will be realized only if health-related data can be used for both clinical practice and biomedical research. That will require implementing technical solutions that both protect patient privacy and enable data integration across patients. He pointed out that for the purposes of the report, software architecture defines a set of interfaces and interactions among the major components of a software system that ensures specified functionality. JASON delineated the following principles:

- Recognize that the patient owns his or her data
- Be agnostic as to the type, scale, platform, and storage location of the data
- Use published APIs and open standards, interfaces and protocols
- Encrypt data at rest and in transit
- Separate key management from data management
- Include metadata, context, and provenance of the data
- Represent the data as atomic data with associated metadata
- Follow the robustness principle: "*Be liberal in what you accept, and conservative in what you send.*"
- Provide a migration path from legacy EHR systems.

A patient privacy bundle is a collection of fine-grained settings of default permission and inheritance settings for access privileges to electronic health data. Both atomic data and metadata must be associated with permissions. The patient controls access by electing a privacy bundle. A fine-grained permission system is flexible, and can accommodate many different types of security policies. The choice of a patient privacy bundle implies an assumption of different levels of risk by the patient in return for different benefits for themselves and society.

The report includes a number of recommendations, two of which White presented for discussion.

- Within 12 months, ONC should define overarching software architecture for the health data infrastructure.
- EHR vendors should be required to develop and publish APIs that support the architecture of the health data infrastructure.

He gave them three suggested topics for discussion: ONC should define an architecture this year; patient privacy and related risk management should be addressed by the use of patient privacy bundles; and the architecture should be supported by openly developed, published and tested APIs. The report was published in April. The recommendations are very ambitious and do not necessarily represent an understanding of current systems.

Q&A

Lansky reported having read the report three times. Consumer users were not included among the briefers and only a limited number of payers and purchasers participated. Public transparency and safety of the use of data should be among the use cases. The architecture seems to apply mostly to clinical care and does not consider longitudinal data and aggregation. Expansion to address other uses is needed. White suggested that patients' access to their information could be a way to achieve a longitudinal view. McGraw said that she intends to participate in the interoperability group that will discuss a response to the report. She reported that after reading it once, she concluded that it was like a PCAST part 2. Both reports say the entire approach must be shifted. The JASON report reflects a fundamental misunderstanding of the purpose of provider EHRs. A change to other uses would require radical adjustments. But if another approach could be an avenue to a longitudinal view, it could be worthwhile.

Consolazio announced that ONC staff is convening a HIT joint task force to respond to the JASON Report. Micky Tripathi and David McCallie were appointed co-chairs.

Tang wondered how much knowledge is required for an individual to make an informed choice about the use and release of her data and to what extent cost and feasibility, both globally and individually, were taken into account. White talked about individuals' choices about immunization and the effects on herd immunity. Individuals recognize that sharing their information has benefits beyond their own selves. Trusted organizations would play a role by making recommendations to individuals. He acknowledged that cost was not included in the charge for the report, which was restricted to technical concerns.

Egerman agree that the JASON report is equivalent to the PCAST report. He reminded the committee that he had chaired a group that evaluated the PCAST recommendations. His group's report was approved by the HITPC. He requested that members of the new joint task force carefully review that report on PCAST. ONC did implement some of the PCAST recommendations, according to Egerman. He noted that JASON refers to EHRs as legacies in a pejorative way. They are actually systems in operation. They work. White observed that JASON went one level deeper than PCAST did in 2010. Egerman said that the data models for research are very different than those required for clinical care.

Tang repeated that ONC is forming a joint task force, which will report in August. He said that McGraw has volunteered to serve. Other members can communicate their interest to ONC.

Public Comment

Shelly Shapiro, Pharmacy HIT Collaborative, referred to her previous testimony before the HITPC on certification for LTPAC and BH providers. She read a statement on the contributions pharmacists are making. Pharmacists have developed standards for structured documents and for the Part D take away document as well as EHR functional profiles to support messaging of pharmaceutical related information. She requested that the committee ask ONC to provide guidance for pharmacists to implement voluntary certification.

Koryn Rubin, AMA, read a statement on quality measurement reporting. The AMA has repeatedly requested that ONC and CMS provide more information on the development of CQMs. These requests have largely been ignored. Some Stage 3 measures have been posted for comment without a formal solicitation for comments. Many are new measures with unproven validity and are based on questionable scientific foundations. Numerators and denominators are inconsistent across related

measures. The proposed measures assume interoperability, which is not yet in effect. Measures should not be proposed in the absence of their scientific validity. Consolazio called the three-minute limit.

The next meeting is scheduled for July 8, 2014.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the May 2014 HITPC meeting was approved unanimously by voice vote.

Action item #2: A motion to recommend that ONC convene a Kaizen to cover certification end-to-end carried unanimously.

Action item #3: A motion to recommend that certification be limited to interoperability, privacy and security, and CQMs was defeated.

Action item #4: A motion to recommend to ONC that the focus of certification be limited was approved by a vote of 9 to 4.

Action item #5: The draft recommendations to ONC on LTPAC and BH assessments, tracking, and privacy and security for LTPAC and BH voluntary EHR certification were approved unanimously.

Action item #6: The recommendations presented by the Privacy and Security Tiger Team on voluntary certification of BH patient data for privacy and security were approved by voice vote with Egerman's abstention.

Meeting Materials

- Agenda
- Summary of May 2014 meeting
- Presentations and reports slides
- Average performance relative to core objective thresholds: calculation details

Meeting Attendance

Name	06/10/14	05/08/14	05/07/14	05/06/14	04/09/14	03/11/14	02/04/14	01/14/14
Alicia Staley				X	X			
Aury Nagy							X	X
Charles Kennedy				X	X		X	X
Chesley Richards				X				
Christine Bechtel	X			X	X	X	X	X
Christoph U. Lehmann	X			X				
David Kotz	X			X	X	X	X	X

David Lansky	X			X	X	X	X	X
David W Bates	X			X				
Deven McGraw	X			X	X	X		
Devin Mann				X		X	X	X
Gayle B. Harrell	X			X		X	X	
Joshua M. Sharfstein				X	X	X	X	X
Karen Desalvo	X			X	X	X	X	
Kim Schofield	X							
Madhulika Agarwal				X	X	X	X	X
Marc Probst	X		X	X	X	X	X	X
Neal Patterson	X							
Patrick Conway								
Paul Egerman	X	X	X	X	X	X	X	X
Paul Tang	X	X	X	X	X	X	X	X
Robert Tagalicod				X	X	X	X	X
Scott Gottlieb	X				X	X	X	
Thomas W. Greig	X			X	X			X
Troy Seagondollar				X	X	X	X	
Total Attendees	**15**	**2**	**3**	**20**	**17**	**18**	**19**	**16**