HIT Policy Committee
FINAL
Summary of the July 8, 2014 Meeting

ATTENDANCE (see below)

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 61st 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 two opportunities 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. Members introduced themselves.

Remarks

National Coordinator and HITPC Chairperson Karen DeSalvo yielded to Joy Pritts, ONC, whose resignation is effective July 10. Pritts thanked the members for the opportunity to work with them. She said that Katherine Marchesini will serve as acting Privacy and Security Officer. DeSalvo thanked Pritts for her important contributions. Vice Chairperson Paul Tang thanked her on behalf of himself and the committee.

Review of Agenda

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 June meeting, saying that he had submitted editorial comments to Consolazio. A motion was made and seconded to approve the summary report. The motion was approved unanimously by voice vote.

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

Data Review – CMS Update

Elisabeth Myers showed slides and, rather than presenting the standard monthly report, said that she wished to inform members about what her reports do and do not say. There were 2,823 EPs that attested for the 2014 reporting year. There are 443 new participants, and 972 attested to Stage 2. For the 2014 reporting year, there were 128 EHs to attest. Seventy are new participants, and 10 attested to Stage 2. Although in the period from June 1 through July the numbers nearly doubled, this increase is only a change in the total attestations. The 2,823 EPs that attested for the 2014 reporting year in the first quarter constitute about 1% of EPs, and the 128 EHs are about 3% of all EHs. Required to upgrade to the 2014 Edition CEHRT for the 2014 EHR reporting period are 375,000 providers, which makes it difficult to show the status of attestations. Because of the different definitions of reporting periods from

2011 to 2014, it is impossible to make valid comparisons of attestation rates. That the majority of new attestations occur in the fourth quarter is a clear trend.

Data Review – ONC Update

Jennifer King cautioned against drawing conclusions on early attestation data. Comparing Stage 2 attesters to those from Stage 1, urban and physician EPs are somewhat over-represented, with little difference in practice size. To date, many fewer vendors are represented among attesters. She also showed slides on objectives scores for EPs and EHs, as well as the vendor companies represented among Stage 2 attesters.

Q&A

Tang repeated the caution against drawing conclusions from small numbers. Each year of meaningful use has been different, making comparisons unreliable.

David Bates observed that Epic was absent from the listing of EH vendors. King referred to the small "n."

Chris Lehmann asked that "suburban" be added to the urban-rural comparison. King said that the classification is based on the county location being in an MSA.

Paul Egerman noticed that some slides showed eight EHs, while others showed 10. King informed him that the slides referred to different points in time. As of July 1, 2014, 10 EPs had attested for Stage 2. Egerman concluded that two EPs had attested during June 2014, a 25% increase from the previous month. The vast majority of EPs and EHs are still in Stage 1. Myers explained again that those yet to attest to Stage 2 are not necessarily off schedule. Reporting periods are static, and any conclusion about a 25% increase is not warranted.

Gayle Harrell asked how many providers should be advancing to Stage 2. Myers agreed to locate the number. King said that specialty data can be presented at a later time.

Meaningful Use Experience

Invitee Tom Johnson, DuBois Regional Medical Center, reported that his organization in rural Pennsylvania attempted all menu items. The organization was one of the first to attest to Stage 1, and meaningful use was integrated throughout. Preparations for Stage 2 were initiated in Stage 1. Cerner was invaluable. DuBois focused on the most difficult objectives—patient engagement and information exchange. A full time licensed practical nurse (LPN) was hired to work with patients. The community is relatively well connected, though it is located in a rural area, so that aspect of meaningful use did not add much value. Getting clear interpretations of the rule was very difficult, though Cerner was helpful. Continuous pressure on providers is necessary for compliance. There are many moving parts per reimbursement in the current environment. The key to success is to be small and flexible and to integrate meaningful use into everything.

Invitee Paul Merrywell, Mountain States Health Alliance, indicated that he agreed with Johnson. His organization is comprised of 14 hospitals across two states. Epic is the vendor, and its staff was in a time-crunch. EHs attested at various times. Vendors struggled with their command centers. The HITPC should take into account vendor and provider lack of readiness. Their attitude is that this is temporary. Some of the 90 clinics and 450 physicians in his organization were early adopters; some were resistant. The regulations did not allow sufficient time for implementation. Patient portals are not standardized. ONC's recent establishment of a division on interoperability is good because multiple government agencies are involved and often work at cross purposes. There is too much focus on EMR technology without consideration of downstream problems.

Q&A

Egerman referred to the full-time patient engagement staff person and asked whether patients use view/download/transmit (VDT). Thompson responded that his organization eventually realized that it was better to hire one person to perform patient training, rather than to rely on individual nurses. Only 7% of patients signed up for the portal, which was sufficient to meet requirements. They used the portal to view lab results. In small communities, transmit capability may have low demand. The staff person works with patients when they are hospitalized.

DeSalvo informed Merrywell that agency coordination and alignment is expected to be enhanced with the federal HIT strategic plan, in which 36 federal agencies are involved. The infrastructure must be more hospitable for different sources and levels of data.

Listening Session Update

In his role of Meaningful Use Workgroup Chairperson, Tang and Co-chair George Hripcsak presented slides prepared by staff to summarize main points of agreement among the invited panelists at the May 20 and 27 listening sessions. The panelists suggested ways to improve meaningful use. The government should focus on challenges only it can solve. For the interoperability infrastructure, the government should select standards, require exchange, and avoid penalizing early adopters, who depend on recipients being ready. Governance should be addressed. To ensure essential HIT functionality, it is necessary to certify to ensure that functionality is available and require implementation in support of care coordination. But the details should be flexible to accommodate diversity of specialties and locations. The focus of meaningful use should be on what, not how, such as functional certification and fixing Direct. The results of certification should be made transparent. The emphasis should be on clinical quality measures that measure outcomes that matter to patients and their alignment with payment reform programs to reduce duplication. A coordinated and aligned end-to-end certification process must be in place. The federal government should provide a national database of public health agencies ready to receive reports. Stakeholders want a public feedback mechanism with authoritative answers to frequently asked questions and rapid turnaround time. Providers want a way to learn from each other.

Discussion

Someone inquired about sequence being a problem. Tang said that he did not recall comments about sequence. Most of the complaints were about the short time provided for implementation.

Lehmann declared that pediatricians want to streamline state Medicaid requirements. The federal government should intervene.

Egerman announced that he had observed the recent listening sessions. Most people do not differentiate certification and meaningful use. He referred to a report from Certification and Adoption Workgroup Co-chairperson Larry Wolf, who said that certification should not be used for new concepts. Would it be better to select among existing standards? Tang replied that one must start somewhere, such as with the transfer of care document for which nothing was previously in place. The relevant timeline is new models of care, not necessarily meaningful use. Egerman said that he was questioning the national roll-out via Direct: Should there have been an intermediate step? Tang agreed that that concern was revealed in the listening sessions. Hripcsak pointed out that the previously relied-on bottom-up approach was taking too long. He recognized the importance of being flexible and learning from mistakes. Egerman observed that in order to learn from mistakes, they must first be acknowledged. Some people are reluctant to admit mistakes. Hripcsak said that Direct should have been more flexible. He acknowledged that the listening session panelists were not necessarily representative.

Harrell talked about Direct, having spent hundreds of millions on interoperability without an assessment of results. How effective is Direct? The HITPC should have this information in order to make recommendations. She applauded the listening sessions. Tang said that it takes time to measure and evaluate. And what should be the basis of comparison since the current paper-based approach is not effective?

Saying that he is on the front line, Troy Seagondollar wondered about Direct being under fire. It was a collaborative effort with broad involvement. So what in Direct that should be fixed? It appears that panelists talked about the need for a fix, but failed to describe the problems. He related his experience to a nurse who had printed a 160-page CCDA. There should be more testing prior to deployment. Tang said that more work needs to be done.

Quality Measures Update

Quality Measures Workgroup Chairperson Helen Burstin and Co-chairperson Terry Cullen reported, noting that this was the final presentation of the workgroup. Referring to the 160-page CCDA, Cullen reported that users of the VA Blue Button frequently cancel downloads because of their length. She reviewed the workgroup's charge, which had expanded over time. She showed many slides, a number of which had been presented previously.

Burstin talked about recommendations in two tracks. She reviewed the rationale for recommendations, the domains, and recommendations previously approved by the HITPC. The following was recommended for Stage 3: There should be a subset of key measures (e.g., address priority health conditions). However, the workgroup recommended not designating these as core, as this term could confuse EPs and EHs on whether core measures are required or recommended. Given the types of measures that are developed or in development today, there are only a few measures that could be applicable to all providers. If there were a subset of required measures, there should be a small number applicable to all or most providers. Some members did not feel any measures should be required, only recommended. Specifically:

- Functional status assessment and patient goal-setting for patients with specific health conditions (e.g., congestive heart failure, chronic pain, rheumatoid arthritis, chronic obstructive pulmonary disease, asthma, total knee replacement);
- Improvement in symptoms among specific conditions (e.g., children with ADHD, rheumatoid arthritis);
- Condition-specific overall outcome measure (e.g., pediatric ADHD);
- Annual wellness assessment –assessment, management, and reduction of health risks (focused on specific domain (e.g., cancer) and/ or specific population group (e.g., based on age/gender/disease, etc.);
- Closing the referral loop – Critical information communicated with request for referral; integration of critical information in decision making process;
- Specific settings/conditions (e.g., rate of readmission to the ICU within 48 hours)

Burstin and Cullen went on to say that the workgroup also recommended development of functional status measures (delta over time for patient) to include: functional status assessment and patient goal-setting with the next step of individual goal achievement; measures that allow evaluation of delta over time for providers; and a focus on more generic functionality that can be applied to multiple conditions, as opposed to developing additional condition-specific measures. Regarding certification, the majority of members recommended that providers be able to report on as many measures as applicable, and therefore vendors should be required to certify the measures applicable to those providers. However,

members were concerned about the development costs and burden to EHR developers. Measure specifications and certification and development tools should assist EHR developers in creating high-quality e-measures efficiently to avoid rework.

The following recommendations on innovation pathways were presented:

- ONC and CMS should consider an optional innovation pathway whereby meaningful use participants would be able to waive one or more objectives by demonstrating that they are collecting data for innovative or locally-developed CQMs.
- Two possible approaches for implementing an innovation pathway are considered. One approach might allow Certified Development Organizations to develop, release and report proprietary CQMs for meaningful use. An alternate approach might open the process to any EP or EH but constrain allowable eCQMs expressed in national data, expression, and e-processing standards.
- Health care organizations and providers would be required to provide evidence that the measure can help to improve care in their organization.

Discussion

Bates asked who should support development. What about conformance testing by vendors? Burstin acknowledged that most of the measures are currently supported by CMS. There is opportunity for innovation. The workgroup recommended attributes of measures, but not the disease state. Cullen said that conformance testing is critical but burdensome. VA officials have considered establishment of a work bench using anonymous data sets. Operationalization is a burden that the workgroup did not discuss.

Devin Mann asked about quality reporting and measurement of efficiency. What are the practical measures of efficiency of documentation? Burstin acknowledged that the workgroup did not deal with documentation. There is a need to measure and consider the burden of documentation. Cullen talked about efficiency and care planning.

Harrell inquired about the development of specialist-specific measures in the future. Who will be in charge and make decisions about measures? Burstin talked about reporting to registries. Although interoperability between registries and EHRs is challenging, some specialty societies are moving in that direction and beginning to specify data elements. Harrell said that the HITPC should make recommendations on their coordination. Cullen talked about the need for alignment.

Christine Bechtel announced her approval of the functionality focus. She reminded everyone that the concept of an innovation pathway was discussed in 2012. It would have to be easy. A missing piece is patient experience feedback and surveys. Portals can have survey capacity in Stage 3. Regarding the recommendation on certification, what about a plug-and-play approach for vendors to update their systems? Cullen said that the vast majority of measures are hard-coded with proprietary logic. Multiple data sources should be accommodated. Plug-and-play is a goal.

Troy Seagondollar said that clinicians do not like to enter data. Much of CQM is check-the-box, and accuracy is an issue. Documentation is different from actual quality care. Someone needs to educate quality assurance staff and researchers on expert systems to extract data. CQMs should be periodically considered for retirement.

David Lansky talked about where to go next. Two of the six domains are not carried over to the measures. The link between infrastructure and measures must be considered. Check-the-box may be acceptable for process measures. But quality measures require the infrastructure to connect data

longitudinally. Cullen indicated that infrastructure had not really been discussed. Now interoperability only gives us process measures. The next step should be interoperability to support outcomes measures longitudinally.

Egerman talked about data entry and documentation. Quality measures should be based upon existing data. Many quality reports are generated but are mostly not used. CMS should determine which measures to retire. Burstin reported that a CMS group is working on alignment, with private insurance representatives participating. E-measure feasibility assessments should be required. National Quality Forum is working on a related project. Egerman said that standardization of data is important, but quality measurement should not be burdensome.

Tom Greig noted that vendors use different methods for quality measurement. What about standardization of methodologies? According to Cullen, the workgroup did not deliberate on that issue. Bates reported that in the United Kingdom, 170 standard measures are used, which reduces the burden on the individual clinician.

Tang asked for a motion to approve the workgroup's recommendations. It was moved, seconded, and approved unanimously by voice vote to accept the recommendations of the Quality Measures Workgroup.

> **Action item #2: The recommendations of the Quality Measures Workgroup were approved unanimously by voice vote.**

Accountable Care Update

Accountable Care Workgroup Chairperson Charles Kennedy and Co-chairperson Grace Terrell reviewed the charge to the workgroup and the processes by which the members made recommendations in four general areas. In addition to writing (and submitting) strategy statements, the group presented what it referred to as the following actionable recommendations in four areas.

Exchanging information:

- CMS should leverage innovative service delivery models to encourage hospitals and other institutions to make admission, discharge, and transfer (ADT) feeds available to any appropriate receiving entity across their community.
- ONC should work with CMS to update hospital survey and certification standards to require institutions to make electronic discharge summaries available to external providers in a timely manner.
- Increase public transparency around hospital and health system performance on measures related to health information exchange through public reporting Web sites.
- Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible for EHR incentives.
- Issue additional guidance around sharing of information protected under 42 CFR Part 2 across participants in an accountable care organization.

Data portability for accountable care:

- Require certified products to either publish APIs or utilize a common API to allow increased access to data residing in EHRs by other types of HIT systems to support population health management, operations, financial management, and other functions.
- Pursue greater specificity in federal interoperability standards around transactional data.

- Strengthen data portability elements in certification criteria to ensure systems have demonstrated that they can receive and process data, not only send data.

Clinician use of data and information to improve care:

- Establish pilots to understand how clinicians can use electronic shared care planning tools to deliver effective team-based care across settings.
- Convene a group to accelerate clinical consensus around standards-based electronic shared care planning across the continuum of care and develop strategies to promote wider adoption of these tools.
- Pursue research with federal partners such as AHRQ around the effectiveness of clinical decision support to improve the impact of these tools.
- Increase the sensitivity and specificity of CDS algorithm tools by implementing standards that will support the incorporation of external data from multiple sources.

Leveraging existing sources of information to support a data infrastructure for value-based programs

- CMS, ONC and other HHS partners should work together to articulate a future strategy around how the government can advance a federated, scalable data infrastructure model to meet the data and reporting needs of providers in accountable care arrangements.
- ONC should coordinate across HHS to expand support for the development of state-level all-payer claims databases (APCDs) to support accountable care arrangements (inclusive of Medicare and Medicaid).
- Drive progress on standardization and capture of social determinants of health data elements that are most critical to accountable care delivery models.

Discussion

Bates said that research on better care coordination tools is needed. His study on the use of IT for care plans found very little use.

Lansky commented that the recommendations could be stronger on outcome measures. Rather than measure the process of coordination, the outcomes for the patient should be measured. Although he agreed on the need for research, it is too early for federal consensus work. Regarding opportunities to leverage claims data, what about having cost information available at the point of care? Terrell responded that although it was not discussed, many providers say that there is already too much information interjected at the point of care. They want the right information. Prescription price information is already there.

Bechtel reported that her employer contacted many organizations about care plans, hoping to identify a standard template. Instead, staff found that many organizations were trying to identify what patients want in terms of care planning. A set of principles was generated. There is opportunity to work from both the consumer and clinical angles. She asked that consumers be added to the recommendation. Terrell opined that is was a great idea to add patients.

Lehmann reported that CMS had awarded an $18 million grant to Vanderbilt University for a related project.

Someone observed that much depends on available standards and wondered how all of these recommendations can be accomplished.

Neal Patterson pointed out that the care plan should be consumable by various EHRs, but payers are not willing to share claims data. Interoperability has been an issue in every presentation. The lack of a unique identifier prohibits interoperability. Kennedy said that some plans are sharing data, but certainly not all. Although the workgroup members recognized that the lack of an identifier is a major issue, they chose not to ponder it. Terrell talked about her employer obtaining claims data from several provider organizations via a Medicaid claims share project. Having such information is very helpful.

Kim Schofield mentioned the importance of capturing data on social determinants.

Egerman declared that transparency of data storage is important. Referring to slide 13 on APIs and access to data, he suggested a change to real-time data access. He wondered why it is needed for population health reports. Kennedy explained that there is a great time lag between seeing a patient and receipt of a report on gaps of care. The clinician wants the information immediately in order to intervene with the patient.

Troy Seagondollar spoke about the need for standard vocabulary on care plans. Regarding Bechtel's report on care plans, he reminded everyone that the nursing field has used care plans and tools for years. Once again he urged the committee to sponsor a listening session or presentation on the state of the art of care planning in nursing. He wondered about the recommendation on petitioning professions. Terrell responded that the recommendation had been added after Seagondollar's suggestion at the previous meeting. The intent is to know more about the status of care planning across professions. Bechtel interjected that her employer had found many care plan examples but no agreement on elements across organizations. Disability-related organizations had the best examples. Seagondollar asked that she send him more information and offered to assist her.

Cullen listed concerns that she had prior to voting on the recommendations—sharing savings, issuing additional guidance, strengthening data portability needing more definition, increasing sensitivity of standards, knowing about any previous recommendation around CFR 42, increasing sensitivity, and applying more broadly to models beyond ACOs. Wordsmithing efforts ensued.

Tang said that the recommendations could be expanded to cover her concerns; for example, the VA could be listed among the federal partners and expanding beyond ACOs added. A member asked to vote on the recommendations as presented.

Harrell said that value of care should be emphasized over cost. There should be more emphasis on portability and interoperability and their influence on outcomes. Terrell reminded her that earlier on the quality aspect was assigned to another workgroup.

Tang observed that there were no serious disagreements and suggested the committee vote on the spirit of the recommendations to be followed by edits approved by email. Lansky asked that members submit comments and changes for the redistribution of a red-lined version for a final vote. Someone so moved, and another member seconded the motion. The motion was approved unanimously by voice vote. Suggested edits should be sent to Consolazio.

Action item #3: The recommendations presented by the Accountable Care Workgroup were approved in spirit with editing to follow and a final approval to be obtained by e-mail vote.

Public Comment

Koryn Rubin, AMA, read a statement of her organization's concern with the lack of transparency of CMS and ONC's work prior to the establishment of new clinical quality measures. New measures must be tested in a variety of settings. AMA conducted a pilot project to identify issues in care coordination,

finding that vendor systems do not currently have the necessary capacity to support care coordination. As a result, providers are incurring great costs to customize their systems.

Tang asked if the agenda had allowed sufficient time for discussion. Members made no complaints.

FDASIA Report Review

Safety Task Force Chairperson David Bates showed slides to explain the charge to the task force and the rationale for the recommendations. He presented the following draft recommendations for the HIT safety center:

Governance:

- The governance structure of the HIT Safety Center should be a public-private partnership outside of government but resourced at least in part by ONC, though private funding is also desirable;
- HIT Safety Center needs a clearly defined mission, with related priorities;
- Avoid duplication of existing activities/complement safety activities in public /private sectors
- Look to other industries for examples of success and their governance models;
- ASIAS and NTSB programs are examples of current aviation safety programs and investigative systems;
- Starting with a small group of vendors and providers and building is attractive approach;
- The board could be a large board which is very inclusive, and then executive board with 10-12 members which would do decision-making. The membership should include both institutional, individual members;
- Need patient representation—likely from a consumer organization;
- Representation from key leaders who are dealing with this regularly—e.g. CIOs/CMIOs/CNIOs;
- Should be driven by front-line provider concerns which are the burning platform (multidisciplinary);
- Goal would be to grow organization and then redesign governance structure 18-24 months in—could thus start with just 10-12 member board above;
- Need to have incentives for reporting events; and need to be able to identify HIT related events

Focus:

- Should address all types of HIT, not just EHRs;
- Learning, not enforcement;
- Must consider sociotechnical issues as well as just technical;
- Incorporate a variety of data streams, not simply adverse event reports;
- Should include near-misses, hazard reports;
- Should rely on evidence when possible;
- Will need to include multiple disciplines;
- Should cover both broad trends and (less often) serious individual events

Bates continued with recommendations on functions.

Key Functions:

- Engagement of key stakeholders;
- Analysis of aggregate data streams of multiple types, including but not limited to data from PSOs;
- Convening for identification of best practices;
- Education and dissemination

Potential Functions:

- Usability role if any would need to be defined—could become part of certification (user-centered design already part);
- Should be two-way learning between safety center and certification program;
- Role in post-implementation testing if any would need to be defined;
- One potential function could be as clearinghouse for safety-related rules;
- Should promote guidelines and best practices (e.g. SAFER)

Data Sources:

Must be inclusive and in addition to PSOs include vendors, different types of providers, and patients.

Dissemination:

- Should include regular reporting to involved stakeholders;
- Main area of focus would be broad trends and not individual events;
- Key target groups would vary based on the specific issue involved;
- Full transparency

Other Issues:

- Might be better for safety center not to perform independent investigations of specific events itself, even though will be outside ONC;
- Safety centers in other industries do many investigations;
- But HIT Safety Center could partner with others (e.g. PSOs) that do investigations;
- Safety center should not be regulatory, make policy, develop standards itself;
- Safety center might not have legal protection of PSOs; yet would need to maintain transparency

Things to Avoid:

- Interrupting relationship between clients and vendors in which safety information is coming in;
- Duplication with existing efforts;
- Assuming that reporters can necessarily define whether an incident is HIT-related or not

He concluded that a safety center has potential to deliver substantial value. It will need adequate resources, and it will have to engage the key stakeholders effectively. The key functions are: engagement, analysis, convening, and education and dissemination.

Discussion

Grieg reported that the U.S. Army runs something similar to the safety center concept. It is preferable to take a non-punitive approach.

In response to questions about funding and liability, Bates said that federal funding would be required. Industry funding could be sought. The center would deal with broad issues using information from different places and organizations, such as PSOs, vendors, and providers. The center should synthesize extant data. Recommendations would be made to users, vendors, patients, or providers.

Bechtel asked for examples of going beyond EHRs, and Bates mentioned mobile apps and HIE data. Bechtel declared that her organization knows the best practices for consumer engagement in governance. There should be more than one consumer representative; they should be involved from the beginning, and both individuals and organizational representatives should serve on the governance board.

~~A member~~ Neal Patterson talked about his organization voluntarily submitting data on errors to FDA. More transparency in reporting errors in medical devices via current mechanisms is needed. The mechanism is already in place. Providers already use it for reporting on medical devices. Neal noted there is lot of sensitivity around the use of the term "medical device," and there was discussion as to why a new mechanism for reporting is needed when MedWatch currently exists.

Tang referred to an Institute of Medicine (IOM) safety committee that recommended transparency but with little result. Jodi Daniel reminded the members that ONC worked with FDA and FCA on recommendations for HIT safety. The center was recommended as a place to receive information and come up with recommendations. Not all providers work with PSOs. A member repeated that the HIT industry should report as with medical devices. Bates responded that the idea is to establish a center outside of FDA regulation. Daniel said that ONC has an MOU with FDA. Tang said that a non-enforcement organization will obtain better cooperation with reporting.

Harrell commented that if the center is publically funded, then someone must have oversight. Who will do that? Bates referred to other public-private functions. Daniel said that according to the draft report, ONC would have oversight.

Seagondollar asked about overlap with the Joint Commission. Bates said that the Joint Commission could be a source of data, but the safety center would have a much broader scope. The Joint Commission has a different purpose. It captures only a small proportion of adverse events. Daniel reported that ONC contracted with the Joint Commission to explore its capture of IT-related events among in-patients. Bates went on to say that the task force discussed placement in a private organization based on an award process.

Chris Lehmann suggested a focus on what makes patients vulnerable since what makes patients vulnerable in general likely makes them more vulnerable to IT errors. He also asked about analytics. Bates acknowledged the point about vulnerability. He related that the task force had not discussed the resources that such a center would require. He went on to say that the function of a center is not regulation so there would be no assurance that loops would be closed. The center would have to pass some issues on to another organization with regulatory authority. Cullen talked about the VA being involved in many efforts, none of which duplicate the proposed safety center. No organization is currently performing this function; it is a ripe area. Vendors do not allow sharing of this information. She wondered where biomedical devices would fall. Bates acknowledged that biomedical devices are a blurry area since they are often integrated with other technologies. In general, they fall within the purview of FDA.

Judy Murphy, ONC, asked whether the center would develop a classification scheme. Bates commented that the existing scheme needs improvement. Perhaps the center would have a role in development of a new scheme.

Tang called for a motion for approval of the Safety Task Force's recommendations. It was moved and seconded to accept the recommendations. The motion was unanimously approved by voice vote.

Action item #4: The motion to accept the recommendations of the Safety Task Force on an HIT safety center was unanimously approved by voice vote.

Workforce Update

Certification and Adoption Workgroup Chairperson Larry Wolf presented recommendations from the HIT Workforce Development Subgroup. First, he showed slides prepared by staff that listed recommendations approved by the HITPC May 2013. For each recommendation, a slide listed ONC's relevant actions or on-going efforts, if any. Regarding the recommendation that ONC host a SOC input process, he expanded in great detail on the work of the subgroup itself. The subgroup convened meetings to solicit input and feedback into a proposed comment for the SOC via a summary report to recommend a SOC for health informatics. The report is being finalized. Responses to the Federal Register notice are due July 21, 2014. He went on to present the new recommendations for HITPC action:

- The focus on health IT workforce is retained in the new HITPC workgroup structure as part of health IT implementation
- The ONC continues to connect with other federal agencies and key stakeholders to further the workforce needs required to establish and sustain an effective and efficient interoperable health IT ecosystem
- ONC continues and expands its work in these areas: a comprehensive health IT and informatics career framework; a centralized health IT workforce development resource to curate, update and amplify investments; maintain and update the competencies model; include new training models, such as apprenticeships and CMS innovation best practices; and support family caregivers as an extension of the workforce

Discussion

Tang asked for clarification as to what action was being requested. He reminded Wolf that there is no funding for ONC to act on the recommendations. According to Wolf, there may be funding from other departments. Wolf said that the subgroup wanted acceptance of its recommendation for ONC cooperation with the SOC request and the three recommendations listed above. DeSalvo interjected that there is opportunity for cooperation with other federal agencies. The private sector is also interested in workforce development. She suggested adding something about playing a coordinative role without funding.

Someone suggested that other job titles be added. Wolf said that in doing the subgroup's work, the lack of data on workforce numbers was a major impediment. Without a specific classification, numbers cannot be generated.

Tang pointed out that the first recommendation pertains to internal procedures. The ONC Coordinator has indicated approval of the second recommendation; the real meat is the third recommendation. Tang wondered whether a formal transmission letter is needed. DeSalvo asked for a letter that ONC can send to DoL. Wolf agreed to furnish such a letter. A member moved to accept the recommendations with DeSalvo's addition. The motion was seconded and carried unanimously by voice vote.

Action item #5: The motion to accept the recommendations of the Workforce Development Subgroup was unanimously approved by voice vote.

Announcements

DeSalvo announced the new workgroup structure, which will consist of six workgroups:

- HIT Strategy and Innovation, David Lansky to chair
- Advanced Health Models and Meaningful Use, Tang to chair
- HIT Implementation and Safety, Bates to chair
- Interoperability and Information Exchange, Micky Tripathi to chair
- Privacy and Security, Deven McGraw to chair
- Consumer Perspective and Engagement, Christine Bechtel to chair

Phase-in has been initiated with the entire structure expected to be in operation October 2014. Member assignments will be announced at a later time. A joint meeting with the HITSC is being planned for October or November.

Public Comment

Gerald Roberts, a nurse who works for a policy research group and member of American Nurses Association, commented on issues that need attention. Interoperability is viewed too narrowly. From a public health perspective, the patient's point of view must be taken into account and what providers can do to act on information to benefit the patient. The person is the denominator. The well person, as well as the patient, are important. Regarding quality measures, developers should look at the workflow deltas.

SUMMARY OF ACTION ITEMS

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

Action item #2: The recommendations of the Quality Measures Workgroup were approved unanimously by voice vote.

Action item #3: The recommendations presented by the Accountable Care Workgroup were approved in spirit with editing to follow and a final approval to be obtained by e-mail vote.

Action item #4: The motion to accept the recommendations of the Safety Task Force on an HIT safety center was unanimously approved by voice vote.

Action item #5: The motion to accept the recommendations of the Workforce Development Subgroup was unanimously approved by voice vote.

Meeting Materials

- Agenda
- Summary of June 2014 meeting
- Presentations and reports slides

Meeting Attendance								
Name	**07/08/14**	**06/10/14**	**05/08/14**	**05/07/14**	**05/06/14**	**04/09/14**	**03/11/14**	**02/04/14**
Alicia Staley	**X**				**X**	**X**		
Aury Nagy								**X**
Charles Kennedy	**X**				**X**	**X**		**X**

Chesley Richards					X			
Christine Bechtel	X	X			X	X	X	X
Christopher U. Lehmann	X	X						
David Kotz		X			X	X	X	X
David Lansky	X	X			X	X	X	X
David W Bates	X	X			X			
Deven McGraw		X			X	X	X	
Devin Mann	X				X		X	X
Gayle B. Harrell	X	X			X		X	X
Joshua M. Sharfstein					X	X	X	X
Karen DeSalvo	X	X			X	X	X	X
Kim Schofield	X	X						
Madhulika Agarwal					X	X	X	X
Marc Probst	X	X		X	X	X	X	X
Neal Patterson	X	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
Scott	X	X				X	X	X

Gottlieb								
Thomas W. Greig	**X**	**X**			**X**	**X**		
Troy Seagondollar	**X**				**X**	**X**	**X**	**X**
Total Attendees	**17**	**15**	**2**	**3**	**19**	**17**	**18**	**19**