Health Information Technology Policy Committee
Final
Summary of the June 8, 2011, Meeting

KEY TOPICS

1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 24th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC Web site. She asked the Committee members to introduce themselves, and turned the meeting over to HITPC Chair Paul Tang.

2. Opening Remarks and Review of the Agenda

Tang thanked the Committee for their participation and attendance at the meeting. He then reviewed the agenda. The group approved the minutes from last month's meeting by consensus.

> **Action Item #1:** Minutes from the May 11, 2011, HITPC meeting were approved by consensus.

3. Meaningful Use Workgroup: Recommendations on Meaningful Use Stage 2 and Timing

Tang, who is also Chair of the Meaningful Use Workgroup, explained that this presentation was a response to the feedback received from the Workgroup's deliberations and HITPC's discussion from last month. He commented that it was gratifying to hear the panelists at a hearing last month unanimously indicate that although it was challenging to meet the meaningful use Stage 1 objectives, they found that it helps them meet their core mission of improved care. The group was asked whether any of the criteria are such a burden that they not worth the value they got out of it, and they unanimously said "no, none of them." This was a selected group of early adopters, but it was useful to have that input.

Tang reminded the Committee of the Meaningful Use Workgroup's key principles for this project, including alignment with the National Quality Strategies and with the original Health Information Technology for Economic and Clinical Health (HITECH) statute and the Affordable Care Act. They must be synchronized with these to help move the country along on a roadmap towards having an HIT structure ready for health care reform. Also, the Workgroup must take counterbalancing measures in terms of making sure their proposals are feasible from technical and implementation standpoints. Finally, the Meaningful Use Workgroup wants to be sure not to penalize people for being early adopters. Workgroup members will discuss the timing issue around meaningful use Stage 1 that actually has penalized these early adopters in an attempt to identify a solution.

Tang then reviewed changes to the Workgroup's objectives that were made since last meeting. The Committee discussed each of these in turn after they were presented.

Improving Quality, Safety, Efficiency and Reducing Disparities

- In response to a question by Larry Wolf, Tang explained that the Workgroup is trying to make sure that objectives reach a threshold at which they are included in the organizations' values and workflow.

- Wolf suggested that there could be a timing check to make sure that the right dose of medications are being given at the right times. It was noted that this could be problematic with false positive test results, and the group needs to be mindful that they are setting the floor for requirements in this area.

- Gayle Harrell addressed advanced directives, noting that in hospitals, 50% may be appropriate. However, many specialists do not incorporate advanced directives into their normal workflow. Podiatrists and ophthalmologists, for example, do not generally ask about advanced directives. With regard to the specialist needing to have 25 unique patients with advanced directives in the system, she asked whether the specialist is obligated to have patients create one if they do not already have one. Many providers are questioning this requirement, especially if it is a core requirement. Tang clarified that specialists merely need to note the presence of an advanced directive in a patient's record, and not necessarily record the advanced directive in the system themselves. He suggested that most if not all specialists have at least 25 patients with an advanced directive on file. He further clarified that when a specialist asks, and the patient has one, they must obtain a copy of it in at least 25 cases.

- Judy Murphy suggested that the title of this section may be more appropriately termed "productivity" rather than "efficiency." She recounted a recent visit she had to her primary care physician (PCP), indicating that it was not a good experience. There were a number of things she wanted to discuss, and some documentation that she had for the PCP. She was told that the PCP did not have time to read the information that she provided. Practitioners need some time to have a holistic view of the patient. A large amount of information that is very usable can be collected, but if the doctor does not have time to actually see the patient because of this data collection, it is a problem.

- Murphy also addressed the issue of connectivity, saying that 2 years ago there were areas of the country that did not have good connectivity, and many people did not use the Internet. If a practitioner provides connectivity to 50% of patients, but the patients do not actually receive it, is that acceptable? She suggested that the target should be 50% of those with connectivity, or 50% of those who want to participate.

- In response to a question from Gayle Harrell, Christine Bechtel noted that the intent was not to get granular about the format of information that is provided to patients. They would like it to be human readable and also potentially machine readable, or as structured as possible so that other applications could accept it. The HIT Standards Committee (HITSC) could be

asked to comment on standards and structure for this. Harrell emphasized that there should be a specification that this should be formatted in such a way that it can be integrated into a personal health record (PHR).

- One Committee member commented that the Department of Veterans Affairs (VA) Blue Button is beneficial because it is getting used. However, this system assumes that reader tools are able to read text files; whereas the reader tool that most people have is a browser. The VA minimized the opportunity to do something more useful because it is all text. The Committee member made a strong plea that the good job VA has done in getting traction be acknowledged, but that it be understood it was not as technologically advanced as it could have been.

- Another Committee member noted the movement in many areas from menu flexibility to a more or less "all-or-nothing" scenario. George Hripcsak pointed out that Centers for Medicare and Medicaid Services (CMS) guidance has indicated that the menu set should become all-or-nothing. However, he said that it appears the CMS has flexibility to decide to use a menu system in the future.

- Christine Bechtel reminded the Committee that it agreed at its last meeting that because an extra year of time is being gained, it is important to create some advancements in criteria. She suggested that largely, this has not been done with new requirements, and so the advancement is in the move from menu to core for many of the items. Meaningful use will fall behind other initiatives if they continue with the menu approach.

- Neil Calman described a recent contest in which third-party applications were developed over a period of a few weeks. Contestants used the VA download button data and wrote widely varying applications for it. He suggested that this type of activity will occur in this area as well, because different groups of people will want to do different things with this information. He suggested avoiding being too prescriptive so that creativity is not discouraged. The goal is to start a process, but not define its endpoint.

Improved Care Coordination

- Neil Calman commented that it is a move backward to set the bar at just 10% for a summary of care with transition. George Hripcsak explained that this is a side effect of combining the care plan and the summary of care. The summary of care record is easy, but the care plan is more difficult, which resulted in the mark of 10%. By combining these, the Workgroup opted for the lower percentage. Calman explained that it is not difficult to add the care plan into the summary of care record—it is a small addition to the document that people are already being asked to put together.

- Tang commented that this area represents an important transition from just having the information recorded and delivered on paper, to being sent electronically. Hripcsak noted that the Workgroup was also considering specialists, so all physicians have some kind of plan for their patients; this creates a change in workflow for how it is recorded. Calman countered

that the "P" in a SOAP note is the plan. It is part of a well-written progress note, and he does not view this as being a significant addition.

- Christine Bechtel explained that the context in which the Workgroup combined the summary of care record and the care plan, it was thought that the care plan was going to be more robust when in actuality, only a free text field for goals was added. Given that, she commented that it probably makes sense to have two separate objectives: one for recording and one for transmission. If this is the case, there is a need to specify that a copy goes to the patient, because it now has a plan element, even if it is just goals and instructions. In this way, there could be a record goal of 50% and a transmit goal of 30%.

- David Bates spoke in favor of splitting the summary and care plan. He believes the care plan is going to evolve, and will be substantially more robust than it is today. Paul Tang reminded the group that this was a menu item in stage 1.

- Another Committee member suggested that the care team is much bigger than the Workgroup has been considering. Setting a low threshold at this point might be valuable.

- Bechtel explained that the Workgroup discussed using a health information exchange (HIE) system or Direct as being acceptable for sending a list of providers. This needs to be refined in the transmittal letter.

- Wolf pointed out that the Workgroup wants the summary to be a part of the community health record, recognizing that those repositories raise many privacy questions. Also, he noted that there seems to be a growing use of telehealth as a way to have values (e.g., blood pressure) checked at home and transmitted to the care team. He cautioned against building in a structure that dictates that the only way to provide care is through a live visit.

- Tang emphasized that area requires a decision at the Committee level because the Workgroup could not reach agreement. The elements to be considered were:
    1. Maintain the objective that 50% of patients have a summary of care record recorded in the EHR.
    2. To this the Workgroup is adding the care plan. The elements have been identified, and the list of them will be submitted to the HITSC for review and consideration. The two new items are goals and patient instructions. The HITSC can determine whether there is any way to improve these in standards form, or whether they need to remain in text format.
    3. There is a notion of team members, also loosely structured, but the floor is a listing of the PCP if there is one for that patient.

- Bechtel suggested that item 1 should read "provide" rather than "record." The referring entity "provides" a summary of care; it is a transmission, not just a recording.

- One Committee member suggested that to be valuable, a care plan should be more complex than this. The Committee member indicated that it may be more appropriate to include complex requirements for the plan and a lower threshold.

- Deven McGraw suggested that the Workgroup's recommendations reflect the fact that some of the Workgroup members disagree about the threshold. It is hoped that the environment will be radically different in a few years, and it may be appropriate to indicate in the recommendations that there is a difference of opinion.

- Judy Murphy asked if this would lead to duplicative work for the physician, given the way that SOAP notes are clustered at present. Will the plan part of the note be identified and pushed through, or will the physician have to enter it again?

- Gayle Harrell suggested that the Committee give tentative approval of the concepts with a range of percentages, and re-examine the transmittal letter before it is submitted.

- Marc Probst expressed concern that although this process may create value in Stage 3, it will cause confusion for Stage 2.

- Deven McGraw commented that Committee members appear to agree with the elements. However, she indicated that she could not endorse the elements plus the proposed percentages. She asked that this discussion, and the Workgroup's transmission letter, reflect agreement on the elements and disagreement on the thresholds.

Tang called to a vote this portion of the Meaningful Use Workgroup recommendations, with the following threshold numbers: 50/10/25/10.

Committee members in favor: 9
Committee members opposed: 4

He noted that the Committee can indicate that the majority of members were in agreement with the numbers for recording of the care plan, while noting the desire on the part of some members to move to a higher threshold.

Action Item #2: Committee members voted 9 to 4 in supporting the Meaningful Use Workgroup proposed thresholds of 50/10/25/10 for the recording of the care plan.

Improving Population and Public Health

There was no Committee discussion on the items in this section.

Privacy and Security

- Christine Bechtel indicated that the Workgroup's intention in this area was that the technology itself have the capability of delivering the privacy notice. She asked if the Privacy and Security Tiger Team might want to review this and separately recommend the

contents of the notice. The meaningful use recommendation should drive the electronic capability.

- Neil Calman further explained that the intent is to have people attest that they have a policy addressing the encryption of data at rest.

Priorities for the HIT Standards Committee

- Regarding the privacy and security item stating that Stage 3 certification criteria should include compliance with Nationwide Health Information Network (NWHIN) governance policies, Deven McGraw noted that here, the Workgroup is signaling the intent to look for certification criteria and to consider whether it should be tied to meaningful use. George Hripcsak added that the Workgroup is indicating that people must perform or update a security risk assessment and address the encryption of data at rest. The recommendations are also specifying that NWHIN conditions of participation (COP) may be a required part of meaningful use Stage 3. This is consistent with the notion that the Workgroup does not yet know what the NWHIN recommendations are going to look like.

- Christine Bechtel suggested that the Workgroup try to ascertain whether standards for family history are available, and if they are, include them for Stage 2.

- With regard to Committee acceptance of the entire set of Workgroup recommendations, Tang summarized that they include the delay for one subset of early adopters, as well as a reference to the group's disagreement on thresholds and the question about standards that exist versus those that still need to be developed, and specifically about where LOINC stands.

- Charles Kennedy commented that he understands the reasoning for opting for a delay but expressed some concern about the trajectory of this path given that there are a number of groups who are not participating. He supports delaying as a tactic while emphasizing the need to take a fundamental look at meaningful use and consider additional or alternative paths.

- Paul Egerman expressed concern about the delay and how that will impact Stage 3. He suggested that more consideration needs to be given to the impact of delaying based on the timeline for Stage 3. He asked for additional information on the downstream implications of delaying Stage 2.

- Tang explained that there is no current schedule from CMS for Stage 3. He also pointed out that nothing prevents there being a stage 4. The penalty phase goes on in perpetuity. Also, this sits in a bigger context—it is not known how other initiatives are going to depend on meaningful use or its benefits.

- Gayle Harrell discussed issues related to moving many of the requirements to core. Many specialists are a key part of the care team, and this will exclude a large number of them. In order to have coordination of care, all the players must be at the table. Flexibility of menu

items is needed. She expressed hope that as CMS reviews these recommendations, they understand that by boosting thresholds and making them core, there will be significant fallout.

- Marc Probst voiced his concern that the delay is not long enough. He pointed out that under $200 million has been expended for the incentives. It is likely that some of the people collecting this incentive money have already had computerized physician order entry (CPOE) in place, and are only making minor changes.

- Larry Wolf emphasized the critical need to obtain better, richer feedback about what is actually happening in the field. Although valuable hearings have been held, it is early in the process and they speculating about what will happen in 2 or 3 years, which is an unknown. He suggested that ONC actively collect feedback and fund research as to best practices and variabilities. He proposed that a more exhaustive job be carried out to find successful groups and identify the reasons that others are lagging behind.

- With regard to examining alternate ways to achieve meaningful use, it was noted that the goal is to improve care. Once people have put in a basic infrastructure, do they really want to put other measures in place that become primary? One Committee member commented that there is an ever-lengthening list of details. He suggested engaging in some manner of planning exercise, with several groups working on the broad notion of a strategic plan.

- David Lansky suggested that ONC create a test bed with a virtual Stage 3 environment that follows Stage 2 and whatever is currently known about Stage 3. He also called for a tighter reanalysis of accountable care organizations, medical homes and the like, to address what they have heard from the field.

- Judy Murphy cautioned that they cannot be over-confident in the value of signals. The signals of Stage 1 caused thousands of hours of re-work. Care must be taken in considering and defining these signals. Furthermore, it is possible to finalize things incrementally, so that vendors can know how they will have to work.

- Bechtel voiced concern about the delay, explaining that patients do not want to wait for these capabilities any more. That said, she acknowledged the need to give meaningful use the best chance at succeeding—some providers have indicated that they will not be attesting because they do not think they can succeed. Regarding the specialist issue, she noted that there was a hearing on this topic recently, and more work is needed in this area. Rather than a core/menu approach, she suggested the Committee approve today's recommendations, but bring back some thinking about how to handle particular kinds of specialties in a way that is more workable for most specialties, recognizing that there is no option that will be workable for all specialties.

- Neil Calman agreed that a delay is inevitable and noted the need for a preamble to the transmission letter. Whatever is submitted will generate enormous pushback. He commented that this is about rewarding progress; it is not a subsidy program. Regardless of what this Workgroup recommends or how this Committee acts, in 10 years one will not be

able to go to the doctor and not get electronic care. The field is moving extremely fast, and the Workgroup and Committee share a public responsibility to make sure that the dollars they are spending are incentive dollars. These funds accelerate a process that would otherwise take place anyway.

> **Action Item #3:** The Committee voted 12 to 5 to send the Meaningful Use Workgroup's Stage 2 recommendations to CMS, with the transmittal letter noting the delay for one subset of early adopters, as well as a reference to the group's disagreement on thresholds and the question about standards that exist versus those that still need to be developed, and specifically about where LOINC stands.

4. Privacy and Security Tiger Team Recommendations

Privacy and Security Tiger Team Chair Deven McGraw opened the presentation of the Tiger Team's recommendations for certificate authority and provider entity authentication. Co-Chair Paul Egerman explained that a digital certificate is a concept that serves two purposes: (1) it provides information about the entity, and (2) it is involved in the encryption process. A certificate authority is an organization that issues digital certificates.

The group made recommendations last year that applied to provider organizations, but NWHIN will also include places that are not for treatment: labs, imaging centers, payers, claims clearing houses, state health agencies, CMS, the Centers for Disease Control and Prevention (CDC), and others. This is a vehicle for all of these organizations to communicate. The purpose is to provide a level of trust, an environment where a provider, for example, sends information to a hospital, with confidence that the receiver was actually the intended hospital. The Tiger Team recommended a high level of certainty that the organization is who they said they are. In the original recommendations, they said that identity had to be validated before a certificate was issued.

Egerman presented the group's previous recommendations related to certificate authority on provider authentication recommendations. Three alternatives for certificate authorities were considered. The team looked at exchange functionality considerations, security considerations, and implementation considerations.

Egerman presented the Team's current recommendations, then discussed Direct project stakeholder concerns. There were concerns that the Tiger Team recommendations may adversely affect deployment of the Direct project. In parallel, the S&I Framework is also looking at these issues, so the Tiger Team altered the recommendations as follows:

> "The HIT Policy Committee will revisit (or ask the HIT Standards Committee to revisit) this recommendation if the S&I Framework process to further investigate the costs and implementation burdens of requiring cross-certification to the Federal Bridge reveals new facts that call into question the conclusion that it is financially and operationally feasible for small or less resourced provider entities to obtain certificates pursuant to this recommendation."

With this addition, the Direct Project team is firmly in support of the Tiger Team's recommendations.

Discussion

- Joy Pritz explained that the Direct project is a pilot project to test standards for secure transmission. Directed exchange is anticipated to be part of NWHIN. NWHIN itself is moving towards encompassing all methods of exchange. Direct would be subsumed by NWHIN at a later point in time.

- In response to a comment by Larry Wolf, Egerman noted that this is only one component of authentication. This work is about the patient and providing a high enough bar so that patients and clinicians are comfortable exchanging information.

- In response to a question by Gayle Harrell, Egerman explained that the Tiger Team thinks this is better security than the method Direct employs, because the validation process has to occur before the certificate is issued.

- Pritz said that Direct project participants have certificates from commercial entities. McGraw said that commercial issuers do not use as robust a process as the Tiger Team would want.

> **Action Item #4:** The Committee approved the recommendations of the Privacy and Security Tiger Team by consensus.

5. Quality Measures Workgroup: Discussion of Core Menu Framework

Quality Measures Workgroup Chair David Lansky noted that some of this work is being done jointly with the HITSC. In trying to harmonize requirements, they would like the methodology to be consistent with Department of Health and Human Services (HHS) as well as private and public sector strategies. Insurance exchanges will also have a quality reporting mechanism, so they want to have all these things working together.

In a call for public comment, more than 100 organizations responded with over 500 measures to populate this framework. The Quality Measures Workgroup also recently held a hearing on meaningful use Stage 1 quality measurement reporting. An overall theme that the Workgroup has been hearing is that more measures are not needed—better measures are needed.

Specialists have not felt well represented in this model to date. Alignment of measures is not working out yet, and it has been noted that there may be a need to report measures for a physician quality reporting system (PQRS) and for meaningful use, and those specifications are slightly different. It is not clear how many providers will be able to satisfy core measures in Stage 1. If it turns out that a large proportion of meaningful users cannot even meet a very small core, then whether the model is working needs to be questioned.

The Quality Measures Workgroup has heard that attention must be given to care coordination, patient safety, and efficiency. The group also heard from vendors about the difficulty of coding for new measures. They must be thoughtful about giving significant advance notice and/or being flexible in their strategies.

Lansky said they want those people affected by the measures—those reporting—to feel like they can see themselves in the measurement set. It should feel like this is not an externally set of goals imposed upon them, but rather it should reflect their own practice goals. He has heard from CMS that the specialty reporting menu structure will come back once it is determined how best to populate it.

Within that context, Lansky went through the specifics of the measures framework and then reviewed methodology challenges and areas needing HITSC input, as well as other additional work.

He said that today, the Workgroup is looking for Committee input regarding the proposed framework of core plus a menu of six domain areas, and some guidance on how to set requirements for reporting against those.

Discussion

- Gayle Harrell noted that specialists need to be given an opportunity to be a part of this endeavor, and applauded the Workgroup for moving in this direction.

- With regard to timing for meaningful use Stage 2 or 3, Lansky said that there are newer measures that would help populate these menus that may not be ready in time for Stage 2. It is likely that there will be some lower hanging fruit. Patients' experience might be one such area. On the other hand, items such as delta measures for blood sugar control may not be ready.

- Josh Seidman said that part of the goal is to identify methodological issues that impact potential functionality. Patient reported data is one example that obviously has implications for developers, providers, etc. So for things that are potentially on the table for Stage 2, there is a need to have ONC and CMS consider standards, criteria, and meaningful use rules. The goal is to get measure definitions into the notice of proposed rulemaking (NPRM), as in Stage 1, with actual electronic specifications by the final rule.

- Judy Murphy noted that Electronic Health Record Association members have indicated that if there are a large number of measures, it would take their members approximately 18 months to test and validate them. This should be considered in the timeline.

- Christine Bechtel supports the categorized menu approach, and commented that the categories themselves are a nice match to the National Quality Strategy. She asked whether the Workgroup expects that the measures in the core would evolve at all. They all appear to be process measures, but will they become any more outcomes oriented in the future? Lansky noted that he was unsure, and explained that "core" is a concept with a relatively

short lifespan. With more specialization of competencies, it will be difficult to have a core that works for people across a broad range of settings.

- David Bates supports the overall Workgroup approach, but pushed back against the notion that more measures will not be needed, rather only better ones will be needed. He noted that a lot of measures will be needed to accurately reflect quality.

6. Certification/Adoption Workgroup: Analysis of Usability Hearing

Certification/Adoption Workgroup member Larry Wolf offered a summary of the recent Usability Hearing. He reminded Committee members of the International Organization for Standardization definition of "usability," which is the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use. He then discussed desired outcomes of improved usability (e.g., increased safety, lower cost, lower frustration) and the attributes of usability (e.g., appearance, accuracy, workflow, access to data).

Wolf then reviewed a list of key usability issues/concepts, including: (1) multiplicity of systems; (2) role of standards or guidelines; (3) patient-physician interaction; (4) cognitive load; (5) abilities and disabilities; (6) system configuration; and (7) impact of regulation on usability, and testing and measuring usability. Wolf closed the presentation by describing areas proposed for further study and action. These include successful adoption and patient safety related to EHR use, identification of key use cases, context for measuring usability, guidelines for providers, and effect of regulations.

Discussion

- Paul Egerman noted that people who are doing a lot of different things are constantly being asked to enter more data; it is difficult to know what the user defines as usability.

- Neil Calman explained that one of the biggest factors they have seen in his practice is the extent to which computer reminders create a provider agenda, rather than the patient's agenda. The patient comes in with one set of concerns, and the practitioner asks questions that are different than the patient's agenda. To some extent, setting the expectations for the public has been ignored. There is a need to identify what ONC's and other's responsibilities are in terms of explaining the transition to the electronic arena to the public. There is also a need to teach providers how to work in this environment. Furthermore, there is a curriculum area that has not yet been addressed. The point is to not see these as impediments, but rather as the creation of a new area to work on so that patient experience is not negatively impacted.

- One speaker noted that that it is impressive how much the National Institute of Standards and Technology (NIST) is putting this forward as a process.

- Lansky pointed out that it often is assumed that the market will drive people towards greater usability products, although legacy investments may make this less true. What is the role of

this Committee within that market environment? In general, the Committee should shy away from dictating what is or is not good usability.

- David Bates echoed the sentiment that innovations in the marketplace should not be slowed. However, there is also a persistent undertone that not all systems, not all implementations, and not all providers are doing a good job. There is a lot of variability, and examples keep surfacing of issues that are "turn the system off" type issues. If a system cannot consistently convert from kilograms to pounds, then it cannot carry out dose calculations. It is better to have no computer than a system like that. Broad safety issues need to be addressed. When it is not clear what is on the screen, when fields run together, when text gets cut off, those types of problems need to be resolved. Bates explained that there needs to be a floor for safety issues. It does not take too many bad examples to lead people to a conclusion that EHRs aren't safe.

- Charles Kennedy noted that there are opportunities to leverage data, and the Workgroup may be missing some of those value propositions in the way it has looked at usability to date. Other processes may be eliminated, workflow can be shifted and changed, and perhaps the doctor's overall load could be reduced. Another Committee member noted that opportunities for data reuse are huge, and once those data are available, this will become more obvious.

- Paul Tang explained that one of the most time-consuming tasks is text entry, and ironically, the tools built to solve this problem actually decrease the value of notes, so this problem has been made worse, in a sense. If the field is moving towards a world in which outcomes are being delivered, it should be possible to push down the emphasis on data entry. In moving towards a non-transaction-based reimbursement system, can we move away from a documentation system?

- Larry Wolf indicated that the Workgroup is looking for guidance from the HITPC and from ONC. Without obtaining more information, the Workgroup is unable to offer anything stronger than what is in its letter to the ONC. If safety is an issue, perhaps the Workgroup can take a deeper look at safety and usability, and then build some usability testing around those findings, with a consensus on the approach.

- Judy Murphy agreed that more should be done in the areas of safety and meaningful use. Also, time must be built in for testing and experimentation.

- Tang noted that that the ONC has already commissioned a study on safety issues associated with EHRs. He said it would be helpful for the Workgroup to recommend an approach on usability and how it interacts with meaningful use. The group has laid out a number of issues and framed them. What kind of approach would the Workgroup recommend to the HITPC?

7. Public Comment

Carol Bickford from the American Nurses Association said that with regard to meaningful use objectives in relation to improved care coordination, the way the recommendation is framed

currently seems to imply that the care plan is the clinical summary, but these are not the same. It should be clearly identified in the document that this is a new requirement for inclusion.

Christian Warner from the Altarum Institute said that last year they convened a panel in collaboration with ARC. The overall findings were that, while the research recommended was complex, the policy recommendations were simple. First, they recommended certifying usability evaluations, starting with the documentation of practices and processes of evaluations that were being conducted in-house. Second, they recommended the development of a national usability lab to develop tools and processes to refine usability constructs around design and safety.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the May 11, 2011, HITPC meeting were approved by consensus.

Action Item #2: Committee members voted 9 to 4 in supporting the Meaningful Use Workgroup proposed thresholds of 50/10/25/10 for the recording of the care plan.

Action Item #3: The Committee voted 12 to 5 to send the Meaningful Use Workgroup's Stage 2 recommendations to CMS, with the transmittal letter noting the delay for one subset of early adopters, as well as a reference to the group's disagreement on thresholds and the question about standards that exist versus those that still need to be developed, and specifically about where LOINC stands.

Action Item #4: The Committee approved the recommendations of the Privacy and Security Tiger Team by consensus.