

# Health Information Technology Policy Committee

**DRAFT**

## Summary of the August 3, 2011, Meeting

### KEY TOPICS

#### 1. Call to Order

Judy Sparrow, Office of the National Coordinator (ONC), welcomed participants to the 26<sup>th</sup> 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 then turned the meeting over to HITPC Chair Paul Tang.

#### 2. Review of the Agenda

Tang reviewed the agenda, noting that a meaningful use update from ONC will become a regular agenda item at these Committee meetings. He noted that National Coordinator for Health Information Technology Farzad Mostashari would be calling in from Minnesota during the course of the meeting.

**Action Item #1:** Minutes from the July 6, 2011, HITPC meeting were approved by consensus.

#### 3. Privacy and Security Tiger Team Recommendations

Privacy and Security Tiger Team Chair Deven McGraw noted that this meeting's discussion would focus on view and download functionality. The Team has already sent a recommendation to the Centers for Medicare and Medicaid Services (CMS) indicating that in meaningful use Stage 2, both hospitals and eligible professionals must provide a view and download function for their patients.

She noted that the measure as presented in the slide deck was accurate; an error in the transmittal letter will be corrected to reflect the wording on the slide.

McGraw reminded the group that the Committee asked the Tiger Team to consider whether a privacy and security warning should be a part of standards and certification criteria. This would inform patients that by downloading their information, they are moving it into their own hands, which might involve some risk. The Team has been examining the transparency implications of providing patients with the capability to view and download.

McGraw said that they did not have to start from scratch in terms of policy recommendations. The Markle Foundation worked on this issue with the Veterans Administration (VA), Medicare, and others through their Connecting for Health collaborative effort. The Blue Button Initiative offers view and download functionality, and the Markle Foundation issued a policy brief about

this, addressing the transparency aspect. In the brief, the Foundation provided a clear, short explanation of the download function and its implications, and also provided links for people who want to get more information about risks, etc. My Health eVet has similar capabilities.

The Tiger Team recommends that certification criteria for electronic health records (EHRs) require a notice of this type. Their concern with sending this through a certification process is that it would result in over-specification and inflexibility as to what is in the notice. Providers should be able to tailor notices to their own patients. Instead of recommending a certification process, the Tiger Team instead recommends best practice guidance for meaningful users and for software developers who serve those providers.

Tiger Team Co-Chair Paul Egerman walked the Committee through the four recommendations dealing with best practices. McGraw explained that for many on the Team, there was a distinction between the risks of viewing and of downloading, which is why they were treated slightly differently in the recommendations. The recommendations were as follows:

- Providers participating in the meaningful use program should offer patients clear and simple guidance regarding use of the view and download functionality in Stage 2.
  - This should be offered at the time there is a desire to download and it should address the following three items: (1) remind patients that they will be in control of the copy of their medical information that they have downloaded and should take steps to protect this information in the same way that they protect other types of sensitive information; (2) include a link or links to resources with more information on such topics as the download process and how best to protect information; and (3) obtain independent confirmation that the patient wants to complete the download transaction or transactions.
- Providers should also consider whether to offer clear and simple guidance at the time of viewing a record.
  - Alerting patients to the potential risks of viewing sensitive information on a public computer, or on a screen visible to others, or failing to properly log out.
- Providers should also request vendors and software developers to configure the view and download functionality in a way that no cache copies are retained after the view session is terminated.
  - ONC should also provide such guidance to vendors and software developers, such as through entities conducting EHR certification.
- Providers can review the Markle Foundation policy brief, and the guidance provided to patients as part of the MyHealtheVet Blue Button and Medicare Blue Button, for examples of guidance provided to patients using view and download capabilities.

### ***Discussion***

- Paul Tang praised this as a balanced approach. If the Team overprescribes this, they could end up in a less helpful situation. Best practices are clear and useful.

- Adam Clark asked what is to be downloaded, a PDF file, or data that can be used through free market enterprises, where patients can use the information in multiple ways? Paul Egerman said that the way he understands the Standards Committee's proposal is that the download would be some machine-readable file. Clark indicated that additional clarity on this topic would be helpful, particularly from the clinical trials perspective and the ability for patients to match themselves to new treatments and the like. McGraw confirmed that meaningful use recommendations and the Standards Committee have already taken that on.
- One Committee member asked whether, within the Health Insurance Portability and Accountability Act (HIPAA), liability for patient information can be shifted to users who are downloading it. Is the liability transferred only if the organization has used the right language? McGraw explained that the language has no bearing on who has the legal risk for the data. The fact is, if it is in the possession of the institution, then it is the institution's obligation to protect it. If the patient takes a copy, then the patient is responsible for it.
- Another participant noted that the Markle policy brief makes a point to distinguish between an individual versus a "bot," or some type of organized request. Given that a consumer might choose to access the information using some kind of third party tool or service, that issue might be relevant. Also, it might be worthwhile to think of best practices to minimize hacking by people pretending to be patients.
- Egerman explained that the way the recommendations are written, they would apply to a situation in which a patient was creating an arrangement whereby a patient health record (PHR) or something like it was automatically retrieving information from a provider's EHR system. Some sort of notification to the patient would be required before that series of transactions is initiated.
- Regarding the second recommendation, Christine Bechtel suggested that providers be asked to offer guidance about viewing their record, not just to "consider" offering such guidance. She sees a number of situations where this would be helpful, and suggested it could be harmful not to have it. Egerman said that there was not a consensus on the Tiger Team that this was important. Some echoed Bechtel's sentiment; others assumed users would already have this knowledge.
- Judy Murphy emphasized the need to carefully track the balance between being cautiously reasonable and overly prescriptive. Her thinking on the Tiger Team was that people get sensitive e-mail without a sign that says, "be careful about where to view this." The same applies to Web sites. She has a sense that in general, people know that if they are in a public place and they do not want people to possibly see this information, then they will not access the information at that time.
- Murphy also noted that paper records do not have this warning on them. In the future, this is going to be so commonplace that it will feel overly prescriptive to say, "don't read this stuff in public," because people will know better.

- McGraw noted that the transmittal letter reads: “Providers should consider whether their particular patient population would benefit from having clear guidance....” The Tiger Team was addressing the challenges of specific populations. Also, she pointed out that all of the other people looking at this focused on the download portion, and not the view function.
- Gayle Harrell argued on the side of caution, and said they should make sure they inform people. They should cover the eventuality in case people do not know about the risks of viewing their health information in an unsecure location. She especially emphasized the logout reminder, noting that everybody forgets to log out on occasion.
- Charles Kennedy noted that various new ways are evolving for patients to download their data. The result is an output that varies based on the type of deployment. Therefore, do they need to provide guidance to the population regarding the variability of completeness and accuracy of their record when it comes from a variety of sources? He referred to testimony from ePatient Dave as an example of this. Tang commented that he would raise this notion of public education about electronic health information with the ONC. Jodi Daniel indicated that the ONC is not specifically addressing this issue, although it does have a consumer education campaign. She encouraged the Committee to offer recommendations about areas where the ONC could provide specific guidance. Kennedy acknowledged that this pushes the bounds of what the group was asked to do, but there will be variability in the information out there on a source-by-source basis. Some policy thinking is needed around what the public does and does not get through such channels. Tang concurred, noting that in the ePatient Dave example, there were some wrong diagnoses in his health record. Some of those misdiagnoses could have prevented life-saving drugs from being administered.

The Committee agreed to the following amendments to the Privacy and Security Tiger Team’s recommendations:

- Include auto log-off as part of the third recommendation.
- Recommendation 1 will indicate that patients should be offered clear and simple guidance regarding the view and download functionality (removing the language about providers “considering” whether to offer such guidance), with links to more information for those people who want it. Then, with regard to download, the recommendation will continue as before.

McGraw said she would rework the language and send the new version around to the Committee electronically.

With regard to the notion of third party involvement in these transactions, McGraw said that these recommendations do not transfer to third parties. The Team is staying within the purview of the ONC, and these things will become a part of meaningful use Stage 2. PHR vendors, for example, are not a part of the meaningful use program, and this group does not set policy for them.

**Action Item #2:** The Committee agreed by consensus to accept the recommendations of the Privacy and Security Tiger Team, with the following two amendments:

- Include auto log-off as part of the third recommendation.
- Recommendation 1 will indicate that patients should be offered clear and simple guidance regarding the view and download functionality (removing the language about providers “considering” whether to offer such guidance), with links to more information for those people who want it. Then, with regard to download, the recommendation will continue as before.

#### **4. Quality Measures Workgroup**

Tang reminded the group that in an earlier meeting, the Committee approved framework that the Quality Measures Workgroup has proposed. Now, the HITPC will be considering the Workgroup’s full letter for review and approval.

Quality Measures Workgroup Chair David Lansky said the Workgroup be looking at more granular recommendations for how the framework methodologies should be used. In his presentation, he showed a summary of the group’s recent activities, and reminded the Committee of the framework, which consists of six categories of menu items arrayed around a central core. Their recommendation is that the CMS ask each provider to choose from at least one menu category, depending on the availability of appropriate measures in each of the proposed categories. Hopefully, this framework will be durable over a number of years, with improvements as more measures become available.

He presented a timeline of the group’s activities, and a listing of future activities. He then reviewed some specific methodological issues that are a part of the transmittal letter, which was included in Committee members’ meeting materials.

#### ***Discussion***

- Paul Egerman commented on the concept of EHRs having capacity and scalability, and the suggestion that an intermediate organization could aggregate this data. He believes that they should continue to be focused solely on the EHR system. Health information organizations (HIOs) have multiple models, some with centralization of data but many without that capability. Additionally, this concept raises a whole series of issues, including those related to privacy. The guidance should be to stay focused on the EHR system, requiring it to produce whatever aggregated information is necessary. Tang concurred, saying that in his organization, they struggle with getting quality measures out of their system, doing an aggregation quarterly, but they would like to do it on a daily basis. Building that capability into the EHR system would serve that goal.
- David McCallie noted that their larger goals go beyond the EHR to meaningful use goals: care coordination and patient engagement. These are powerful domains that, by definition,

stress the capacity of the EHR. There is a need to discuss how to achieve care coordination and patient engagement within the limits of their scope and the existing environment.

- Egerman pointed out that as long as they are talking about quality measures as part of the Meaningful Use program, then they have to be done by the EHR system. However, if they want to look at other issues, they must remember that there are other public policy levers beyond meaningful use.
- Christine Bechtel agreed that their primary focus is the EHR. However, the Health Information Technology for Economic and Clinical Health (HITECH) Act is not about electrifying paper. Clinical quality improvement and care coordination are not limited simply to automating the current system. It becomes problematic if they are thinking only in terms of data collection functions, and not also considering care coordination and patient/family engagement. These should be a part of evaluating the meaningful use program.
- David Lansky suggested that there could be modularity in the approach that a provider or hospital takes in trying to achieve meaningful use. He heard a suggestion that perhaps modules exist outside the EHR that achieve some of the desired quality metrics. For example, it may be possible that, out of the desire to get the best in quality metrics, someone would hook up their EHR to another module.
- Marc Probst pointed out that they are asking for a submittal of a normalized set of data to some organization. Those are the quality measures, from systems that do not have normalized data, and that is the problem. Everyone has the data, and through mechanisms, they can normalize that data. The way the methodological issues are presented draws attention to the point that not all EHRs do it the same way. So, there is a need to move forward to where EHRs can get a set of normalized data and use it. If they get too expansive on those quality measures outside of what the EHR collects, it creates a challenge.
- Judy Murphy reminded the group that there are limited resources. By raising the level of government regulation, of the things that have to be done, they are limiting the market's capacity to address the needs of the clinicians who use the system, and the development of new innovations.
- In answer to a series of questions by Gayle Harrell, Lansky explained that the appendix of the transmittal is an inventory of measures that are either approved or about to be approved by the National Quality Forum (NQF) and other bodies. They are essentially saying to CMS, "here is a library of measures from which specific menus can be constructed for inclusion in the rules." They have not indicated a particular approach about how these menus would be set up, although they did examine some specific possibilities. This list consists of everything they are aware of that has made it through the endorsement process, plus measure concepts that are in development. There is a list of federally qualified contractors who are able to bid on a contract to respond to this list of measure concepts, and a publically listed procurement process. CMS and ONC will select a vendor, who will work with academic organizations and others to create measures for meaningful use Stage 3, and perhaps even some for Stage 2.

- With regard to the inclusion of specialty practitioners, Lansky said that a letter is being sent to the CMS asking it to carry out more technical work in answering that question. He does not know if they will choose to display measures by their specialty or not, and part of that will be driven by the availability of measures.
- Patrick Connelly asked whether the core menu is for primary care providers, and if so, whether large numbers of people will be excluded. He also noted that some of the categories could be considered “disingenuous.” He cited patient and family engagement measures as an example. This discussion is all about process measures, and the same is true for efficiency and care coordination measures. The industry is done with measuring process measures. This group must set a reasonable, achievable base, and recognize that if they want to move outcomes and values, it will be due to industry delivering innovative solutions.
- Larry Wolf cautioned against including things in meaningful use Stage 2 because they are definable, rather than because they are actually useful.
- Lansky commented on the importance of sending a directional signal that will guide the work of the ONC partner agencies over the coming years, so that at least in stage 3 they will have begun to populate this framework. If that process is not started now, then the opportunity will probably be missed entirely. The contents of the transmittal letter’s appendix are not a proposal for what should be in the rules, but rather it is a library from which the CMS should choose for Stage 2.
- Wolf discussed the sending side of this process. As the HITPC, should the group be acknowledging the recipient side? There is the issue of CMS’ ability to receive this information. CMS is saying that Stage 1 is not sufficient for actually receiving measures, plus they do not have the technical capability to receive them. What is the appropriate timeline for the CMS to be able to receive this information?

The Committee approved the letter by consensus with a stipulation that quality measures must be developed in such a way that EHRs can produce them, and with a clarification on the intention of the transmittal letter’s appendix.

**Action Item #3:** The Committee approved the Quality Measures Workgroup’s letter with the above modifications with a stipulation that quality measures must be developed in such a way that EHRs can produce them, and with a clarification on the intention of the transmittal letter’s appendix.

## 5. Remarks From the National Coordinator for Health Information Technology

National Coordinator for HIT Farzad Mostashari addressed the Committee via teleconference. Based on what he is hearing in the field, there is an incredible amount of movement taking place. The guidelines and policies that this Committee works on are finding purchase in the real world. The changes are difficult to see from day to day, but in looking at where they were just a few years ago, transformation is real and it is happening.

The Secretary of Health and Human Services visited Joplin, MO, and spoke about how EHRs improved the ability to respond to the disaster that occurred there. With Hurricane Katrina, only the Veterans Administration was able to retrieve med records. In Joplin, the situation was much different. Some paper-based practices had to close their offices and give up practice. But many more had just converted to EHRs and were able to continue.

While they must be clear about scope when discussing meaningful use and HIT incentives, the mission for the HITPC and ONC extends beyond the incentive program. It is to provide health information collection, transformation, standardization, and the flow of that information. All of the activities they are engaged in address this, from meaningful use to the trust framework to S&I Framework. The HITPC is not the transformation, but they enable it to happen and they should not stand in its way.

Quality measures and care transitions are two areas of focus in the broader picture of reform. The HITPC and ONC need to deliver on the promise of better measures to reflect outcomes and values, yet there is no time. Mostashari emphasized the need to balance this urgency with what is actually needed.

The HITPC must recognize that there are different goals for different groups, so its work must reflect a broad set of priorities. This includes requirements for accountability that payers need. Information must be reliable, and not just for transparency purposes but for billions of dollars. There must be a high level of certitude regarding the validity of those measures. They must also be usable for quality improvement purposes on a daily basis, to reflect back in real time. All of this must balance with population health management across practices.

The kinds of discussions that this group is having, and the guidance they have been offering has been essential. Mostashari thanked Committee members for their work and dedication, noting that nowhere else is this level of discourse happening around how health information can serve the American people.

## **6. Review Results of First Meaningful Use Attestations**

Robert Tagalicod from the CMS offered a heartening, but very preliminary analysis of early meaningful use attestation data. It is too early to draw programmatic conclusions, but the CMS will be working closely with the ONC and this Committee to understand what these data say and how to interpret them and then translate them into something programmatic. Tagalicod is working with CMS' Elizabeth Holland to understand this data as well. They offered a series of statistics regarding who is participating and a series of highlights, including most popular and least popular menu objectives, noting that on average all thresholds were greatly exceeded.

Holland said that they have not drilled down yet to look at unsuccessful providers. She walked the group through statistics in the areas of quality, safety, efficiencies, reduction of health disparities, engagement of patients and families, care coordination, population and public health.

## *Discussion*

- Neil Calman said that once the capability of doing something exists in the system, people tend to do it more than the threshold that has been described. Once someone has the ability to do it, they are going to do it. He would not be surprised if these high levels are maintained as more people qualify.
- Calman also asked if they are looking at who the providers are in relation to geography. It was noted that this issue is not yet being examined.

## **7. Planning for Stage 3 Meaningful Use**

Speaking as Meaningful Use Workgroup Chair, Paul Tang led a discussion about Stage 3 planning. He said the group will be forming a new tiger team to discuss the issues of clinical summaries, and summaries of care, to cover transitions from one provider to another. The initial thought was to turn these issues over to the HIT Standards Committee (HITSC), but the HITSC has indicated that these are policy issues. That is a fair assessment, Tang acknowledged, given that there are not industry standards in these areas at present.

Christine Bechtel commented that 95 percent of this work has already been done by the Meaningful Use Workgroup. She and others have been working to pull the information together. She suggested that all of the group's existing work on the subject be given to ONC before a decision is made about whether a tiger team is needed.

Tang noted that this may be a good time to reassess the overall strategy for developing Stage 3. Everyone agrees that there was an extremely short timeline associated with Stage 1. The good news is, the framework that was set up was much appreciated, and the ONC is hearing in the field that it actually improves care. Stage 2 also has a tight schedule, and they must act without the benefit of field experience from Stage 1.

For Stage 3, they want to take advantage of the time between now and 2015 to look at the field and to consider larger strategies. Stage 3 is not the end, Tang reminded the group—although it is the end of the incentive, the statute permits the Secretary to have further stages that are increasingly stringent. The Secretary may or may not choose to use meaningful use as a way to put the infrastructure into place.

A public hearing has been tentatively scheduled for October 5-6 to examine progress, assess the needs in terms of health reform and CMS programs, and identify what future levers there may be to drive progress. They want to consider from an experience point of view whether things are playing out according to plan. Is the framework for meaningful use going well? Did they get the objectives correct? What about timing, and will it meet the needs of health reform? Are there unintended consequences? What are vendor challenges? Some providers have alerted them to vendors who promised things but did not deliver. This issue must be addressed.

Also, they must consider what infrastructure they can expect for 2015. For this, they must hear about what is going on in field from the regional extension centers (RECs) and state programs. With respect to the Accountable Care Act, they must consider different ways that delivery

systems can be structured, and different ways to pay them. These issues must be fleshed out so that they flow out of EHRs rather than being extracted retroactively.

### *Discussion*

- In response to a comment by Paul Eggerman, Tang explained that they propose to develop a set of goals for Stage 3 that may or may not look like an increment for Stage 2, and a roadmap for getting there. He questioned whether a Notice of Proposed Rulemaking process could happen sooner, instead of having it take place right before 2015. Robert Tagalicod noted that ONC is looking into this and is considering what other activities are ongoing or in development. He suggested that the Stage 3 planning work be moved into a much more project management-oriented discipline.
- Gayle Harrell agreed on the importance of getting Stage 3 recommendations out as early as possible. However, she cautioned that they must learn from the field experience that is happening now and get feedback to inform the process.
- Judy Murphy questioned whether the quality outcomes are feasible for vendors. She is getting feedback from vendors about the volume of measures and timelines, and suggested that the Committee and ONC proactively do more checking in the field.
- Neil Calman commented that the field is moving very quickly, so much so that if they publish anything in 2013, then by 2015, they run the risk of offering a set of criteria that will have been surpassed by the providers. He asked, who would have predicted 2 years ago that 90 percent of New York providers would have electronic health care records?
- Calman explained that the HITPC and ONC must use their clout to determine where the gaps are and where things will not move naturally. They have some ability to move things where there may not be enough natural movement. For this reason, perhaps patient engagement and other similar types of goals should be their focus.
- Calman also suggested that there be increased focus on improving efficiency and reducing cost. They should think about ways that EHRs could focus on these as important outcomes, and about integrating payer information into EHRs and identifying where those synergies exist.
- Tang suggested the possibility of establishing a lever for quality measure and data element infrastructure common to all EHR vendors. The Committee could review these types of issues at the infrastructure level, rather than picking individual measures. He commented that those are the kinds of things to be thinking about for Stage 3, rather than process or individual functions.

## 8. Update From ONC: Beacon Program

ONC's Jodi Daniel introduced this discussion, reporting that ONC is currently in the process of holding regional meetings across the country. Regarding the Strategic Plan, Daniel said that the Office is in the process of incorporating the comments it has received, and hopefully the final version will be released within the next month.

She has also heard questions from the Certification Adoption Workgroup on the subject of usability. The ONC is working with the National Institute of Standards and Technology (NIST) on a draft of an EHR usability protocol, addressing science and human factors of usability. A Wiki is in development that will make the work available for public input and discussion. There may still be an opportunity for input from this Committee. ONC's goals related to usability are to increase transparency and also increase usability without impeding innovation.

The ONC is coordinating several events in September to address consumer e-health. During the discussions about the Strategic Plan, consumer e-health is a topic that comes up over and over again and it is something this Committee stresses. Daniel said she appreciates that feedback. A new consumer-facing Web site will be launched in September to increase awareness about how consumers can use health IT to partner more effectively with providers.

Craig Brammer, representing ONC and the Beacon Program, discussed the program's aims. He explained that part of HITECH calls for the use of early innovators as learning laboratories. To that end, 17 providers have become Beacon Communities. They are working in the following areas: transitions of care, care management, computerized clinical decision support, physician data reporting and performance feedback, public health registry-based management, and others.

Brammer walked the group through a series of slides showing several examples of goals, timelines, and innovations that are coming out of the different communities. He noted that the ONC at first did not fully appreciate the functions that these Beacons are serving. What the ONC has come to appreciate more fully is the tremendous luxury of having a close relationship with these people. He encouraged the HITPC to consider how it might use these relationships as well.

In the fall, the ONC will be hosting a meeting about quality measurement and calling together people who are experts at figuring out these measurements in theory, and those who are expert at figuring them out in practice. The two groups are often not working in the same room; this will be an opportunity to work through this intersection in a deliberate way.

Vendor interface work has been a challenge in trying to investigate how to consistently aggregate or receive data. Most are using established health information exchanges (HIEs). They have worked with the vendor community about agreeing on common testing strategies. Vendors are helping the ONC to appreciate early adopter work with the S&I Framework, which is on a different timeline.

## ***Discussion***

- Paul Tang asked whether there is a channel for this Committee ask questions to the Beacon Community. Their input would be helpful with some of these policy issues. Another Committee member said that because these people are out there working, they are going to know things that this group does not even know to ask about. It was suggested that the Beacon Communities be asked to provide feedback to the Committee.
- Art Davidson noted that the Committee has discussed how quality measures should be built into the EHR. Brammer gave some examples of Beacon Communities that have found a different way to solve these quality metrics. There are places where there could be aggregation of data to improve care for patients and providers, and an opportunity for benchmarking that might not be possible if all the analytics were built right into the EHR.
- Brammer commented that everyone is wrestling with the question of where the locus of aggregation, attribution, and analytics lies. There are communities working on that at a higher level than EHRs. Many would agree that this should not excuse the EHRs from using that analysis.

## **9. Public Comment**

Lori Bowman of Hospira discussed the the importance of clinical surveillance for health care-associated infections (HAIs) and antimicrobial resistance. This is closely aligned with two Stage 3 meaningful use objectives: to include a public health button for eligible hospitals and providers, and to include patient-generated data submitted to public health agencies. She provided full written testimony describing the scope of the problem, which causes or contributes to nearly 100,000 deaths annually. Real-time electronic surveillance improves the timeliness of identifying affected patients and also reduces time spent on surveillance. Diagnosing and treating HAIs earlier would result in \$800 million per year in savings to the United States. Hospira urges the Committee to add the use of electronic clinical surveillance systems in meaningful use Stage 3.

Dr. Cheryl Whitacre, CMO of Emerge Healthcare and Chair of the Illinois Health Exchange Authority, explained that as they attempt to stand up their HIO in Illinois, several EMR vendors are charging large sums for the interface from EMRs to HIEs. This is an important part of the sustainability equation. These costs are so high that they can actually absorb all of the incentive money. EMR vendors have concerns about constructing point-to-point interfaces because the standards are so loose, resulting in the high costs. One set of interfaces would allow costs to be decreased. She encourages an annual process in which standards are added according to a public schedule, and that EMRs are recertified according to these schedules.

Julie Canter-Weinberg from the College of American Pathologists commended the Committee for getting the report from the CMS on the experience thus far of meaningful use adoption. The highest uptake was among family and internal medicine physicians. In June, the Meaningful Use Workgroup pledged to return to the topic of how meaningful use would map to specialists. This

pattern of uptake highlights the importance of that work. Specialists are urgently hoping for this information.

Tom Leary from the Healthcare Information and Management Systems Society (HIMSS) was very encouraged by today's discussion and the announcement of the October 5-6 public hearing. He encouraged the Committee to invite the seven organizations that submitted observations in a letter and presentation to the Secretary (Association of Medical Directors of Information Systems, American Medical Association, American Hospital Association, Electronic Health Record Association, College of Healthcare Information Management Executives, Federation of American Hospitals, and HIMSS). He also noted that September 12-16 is National Health IT Week. Eighty-four organizations have signed up to support the week's activities, including participants from the academic, for-profit, and nonprofit communities.

## **SUMMARY OF ACTION ITEMS:**

**Action Item #1:** Minutes from the July 6, 2011, HITPC meeting were approved by consensus.

**Action Item #2:** The Committee agreed by consensus to accept the recommendations of the Privacy and Security Tiger Team, with the following two amendments:

- Include auto log-off as part of the third recommendation.
- Recommendation 1 will indicate that patients should be offered clear and simple guidance regarding the view and download functionality (removing the language about providers "considering" whether to offer such guidance), with links to more information for those people who want it. Then, with regard to download, the recommendation will continue as before.

**Action Item #3:** The Committee approved the Quality Measures Workgroup's letter with the above modifications with a stipulation that quality measures must be developed in such a way that EHRs can produce them, and with a clarification on the intention of the transmittal letter's appendix.