

# Health Information Technology Policy Committee

**DRAFT**

## Summary of the May 2, 2012, Meeting

### KEY TOPICS

#### 1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 36th Health Information Technology Policy Committee (HITPC) meeting. 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 conducted roll call, and then turned the meeting over to National Coordinator Health Information Technology Farzad Mostashari.

#### 2. Remarks

Mostashari announced that ONC was issuing a Request for Information (RFI) on conditions for exchange. This is integrally related to the major push in Meaningful Use Stage 2. Standards and requirements for EHRs are a critical building block for interoperability, but they are not sufficient to address conditions of privacy protection, technical interoperability conditions, and some of the services that will be needed for exchange to take off.

The ONC has heard a lot in the Meaningful Use proposal around exchange requirements that one may use with a certified health record to meet this requirement, or the NHIN or an organization that has been validated to be a part of NHIN. The question arises, what might be criteria for service providers, data intermediaries, and a wide range of organizations that might want to be thus designated as validated for NHIN, as a condition for trusted exchange? Such a set of criteria would reduce the cost of information exchange and increase its value. Information will start to flow and trust will increase. In order to move beyond “first-name basis” information exchange, they need rules of the road that will enable that trust to emerge. Mostashari also noted the high cost of legal advice necessary to negotiate all those point-to-point agreements as to how the data will be held and treated. The ONC is coming out with a Request for Information prior to the Notice of Proposed Rulemaking (NPRM) because they want to obtain the broadest possible feedback prior to rulemaking.

Broadly speaking, the RFI proposes a voluntary program in which groups that wish to become a nationally validated entity might participate in order to receive a voluntary designation. Regional, state, local, specialty-based, or even state and federal agencies might choose to become designated. This would work similarly to an Energy Star label. The question to be addressed is, what are the conditions and how would one get that Energy Star label?

The ONC also recognizes that in the absence of a national program, states and other private sector consortia are already beginning to develop unique and potentially conflicting programs. This is resulting in duplication, different “rules of the road,” and creating huge burdens. They have heard from states that they would welcome federal guidelines.

Mostashari also believes this could enable a competitive market for electronic health exchange to emerge, while protecting the patient’s information. This foundation is necessary for future

meaningful use. It creates a mechanism to update and keep interoperability certification evergreen and to create another mechanism, other than biannual certification criteria, for electronic health records (EHRs) to recognize and develop interoperability standards. In addition to standards, the RFI addresses the Nationwide Health Information Network (NwHIN) serving as a source of policy as well as standards.

In order for information exchange to take off on a scalable level, there is a need for directories, and the mechanism for creating them. Rather than a single national phone book, Mostashari was referring to an interoperable approach. The policies, services, standards, and business practices will form the basis of governance of NwHIN, and will enable the same kind of dramatic increase that they have seen around adoption to take place around exchange and interoperability. This is tightly linked to what is happening with meaningful use and certification.

### **3. Review of the Agenda**

HITPC Chair Paul Tang thanked the Committee for its extremely dedicated work. Today, the group will be putting together the official Committee response for the ONC and Center for Medicare and Medicaid Services (CMS) as to the NPRMs that have been released. They will use the same method that the Standards Committee used, going through the NPRM line by line. This does not prevent any one person or organization from sending a separate response. Here, Committee consensus is needed in order to be helpful to the ONC. He noted that they are not here to rehash discussions and decisions that have already taken place, but to summarize what has been agreed upon.

Gayle Harrell and Deven McGraw noted that a tremendous amount of wordsmithing has already gone into the Workgroup responses to parts of the NPRM, and they expressed concern with incorporating all of the comments into the grid-style document. Mary Jo Deering noted that a formal letter would introduce the grid. Tang said that the deliberations of this Committee and its Workgroup are all publicly available, so the nuances of their discussions would not be lost.

Tang asked for approval of last month's meeting minutes. Judy Faulkner offered an amendment.

**Action Item #1:** Amended minutes from the April 4, 2012, HITPC meeting were approved by consensus.

### **4. CMS Update on EHR Incentives Programs**

CMS' Rob Anthony joined the group via telephone to offer a brief update on the current state of the CMS incentive program for EHRs. He promised a deeper analysis for presentation at the Committee's June's meeting, during which they may discuss what they have learned and barriers they have identified.

He presented final numbers for March, which were posted last week to the CMS Web site, and offered a snapshot of statistics showing where they are 1 year into the incentive program.

#### ***Discussion***

Mostashari commented that the progress is remarkable for a nation as large and complex as ours. It is hard to look at these statistics and not feel encouraged by the combination of policies, programs, and efforts at the state level by hospitals, providers, and eligible professionals. These numbers translate into a tremendous effort and execution on the part of our country. It is

beneficial to be able to see the information updated monthly, and encouraging that these statistics are openly available and used.

Mostashari recognized the efforts that they are making with the extension centers to make sure these benefits are accruing as widely as possible. The concern is always around disparities, and making sure that smaller practices and hospitals can move forward with adoption. They are making good progress, and more work needs to be done to make sure they continue to focus on the whole range of professionals and hospitals.

Judy Faulkner asked for a denominator column in future CMS updates.

Gayle Harrell asked for a breakdown of specialties, and looks forward to more time on this topic next month to delve into numbers, especially for rural and inner city areas. Tang affirmed that this would be a major item for the June meeting's agenda.

Neil Calman asked that data be published that highlights the people who have successfully attested, and identifies the systems they are using. He acknowledged that they cannot rate them, but he said people should know, by specialty, which systems have been the most successful. This would help vendors, and the public has a right to know which systems have been most successful at getting people to meaningful use.

Rob Tagalicod explained that information is publically available on healthdata.gov that provides a de-identified cross-index of those that have attested and the systems they have used. It is limited to successful attestation. They are also putting out a public use file on some of that attestation information, and they are hoping to post that sometime this week. This will give some of the data through at least the end of 2011, with details about ranges within individual objectives and performance for particular meaningful use objectives.

Calman asked whether this would be in a format that the average physician could use. Mostashari said that the approach the ONC has taken is, rather than trying to create formats and information presented in a particular way, to just put the data out there. They have had more than 1,000 downloads, and now that data is being used by industry and others to create useful guidance.

## **5. Discussion of Workgroups Draft Comments on Meaningful Use Notice of Proposed Rulemaking (MU NPRM)**

Tang introduced Michelle Nelson, who has been keeping up with the Workgroups in terms of comments. She will take note of comments in this meeting, and will incorporate them into the grid by close of business today. The grid was presented onscreen, showing each section of the NPRM and any Workgroup comments. Tang led the discussion through each section, and also presented the Meaningful Use Workgroup's findings. Information Exchange Workgroup Chair Micky Tripathi led the group through that group's issues. In many cases, the Committee had no further comments on particular sections. In other cases, there was considerable discussion, which is summarized in the following paragraphs.

### ***Computerized Physician Order Entry (CPOE) and Scribes***

Gayle Harrell said that last month, there was discussion about how CPOE ought to be directed to wherever the liability falls, and it is going to be difficult to determine who the "typist" is. The professional who is responsible for what is happening is who is liable. Tang noted that there are

two different issues here: the accountability for the order as an official licensed activity, and the decision support in the EHR.

Neil Calman said that the decision support should appear when the order is authorized, not necessarily when it is typed. The countersigner of the order is the person who needs the decision support—that's when it is important. David Bates strongly disagreed with this sentiment. Decision support is delivered as the order is being written; if providers are to respond to it, they have to see it when it is going in. Scribes are fine for other things, but not for this, he said. Also, Bates has never seen decision support happen on the other end, as Calman describes it. Calman said that the system he uses works the way he described.

George Hripcsak suggested that it should be left as “Licensed professional receives the decision support.” Calman concurred, saying they should not be overly prescriptive. They also want to encourage people to work at the top of their license; currently a nurse can enter orders, and it is not until the doctor countersigns that the CPOE would come into play. That is how it works in his organization. If they put this back in the hands of physicians so that somebody can see a decision support message, then they will be loading physicians with work that they otherwise have absolutely no requirement to do. He believes this is the kind of thing that affects the rate at which people are likely to adopt. Tang said that if they opted for Calman's proposal, they would need to modify system auditability to indicate that a system is set with the functional capability to produce decision support for everybody who comes in contact with that order. Harrell pointed out that the licensed entity is the one responsible and needs to see the decision support. Not everybody needs to see it; the one who is responsible needs to see it.

The committee took a vote. Three people voted for the measure as written. Five people voted for a revised version that includes the EHR having the capability to show an authorizing provider the decision support. Four abstained. Tang acknowledged that this was clearly a split vote; the pros and cons of this discussion will be recorded for CMS and ONC review.

### ***Drug Formulary Checks***

One Committee member asked if this will require a private doctor to have access to all formularies. Another member answered that the EHR would be required to be certified for automated formulary checking, and physicians will only be responsible for whatever is made available through the EHR. That will encourage more formularies to become available through electronic channels.

Paul Egerman indicated that he believes this to be incredibly important from a patient point of view. But his concern is what it will cost for small providers to get formularies, or figure out how to load and update them, from insurance companies who might not provide formularies through a single source. They should be concerned if this is indicating that a provider must have every formulary that is technically available; that is asking for more technological know-how than many providers have. Micky Tripathi said the intent was not to make this more complicated. They may be able to work on the language so that it is clear that this should be about what is available to them through their EHR. The formulary should be appropriate to the medication, the patient, and the insurer.

Paul Tang pointed out that even knowing the patient's health plan represents a large amount of information that is not always kept up to date.

The Committee accepted the language with some modifications for clarification.

### ***Advanced Directives***

Christine Bechtel said their original recommendation was also around providing some instruction on how to access an advanced directive if it does exist. They backed off of trying to store and retrieve it. She said she hates to lose the notion of giving direction on how to access it, and suggested adding a comment that CMS and ONC should lay the groundwork now for adding directions for how to access the advanced directive in Stage 3.

Tang said they have been asked to have a hearing on this topic, to address the state and other issues surrounding it.

### ***Clinical Decision Support***

Tang said that there is a health information exchange (HIE) requirement about hospital labs sending structured results, and they are not discussing that in this forum.

### ***Generating Patient Lists***

Christine Bechtel suggested they strengthen the language to indicate that the Committee strongly recommends this.

### ***Imaging***

Neil Calman asked whether there are transmission issues with regard to transmitting images that go beyond what some people might have capability for. Will this cause a technical slow-down of the system? Also, what about storage requirement for these images? Are they calling something out that will require additional storage to be available on the systems? Tang said the NPRM allows linkage to images, not just local storage. Bandwidth could be an impediment. Tang noted that this is of high value to many specialists, and there is no use requirement.

Judy Faulkner reported that the way this is being done is going under a significant amount of change at present. They must be careful how they write this, as the process may not actually be incorporating the image.

### ***Family History***

Bechtel said that because this is a menu measure, she is less worried about specialists and others to which it may not apply. She asked whether they had received Standards Committee input as to available standards for family history. Mary Jo Deering said that the HITSC is not recommending a standard in Stage 2. They discussed the HL7 pedigree standard, but made no recommendation.

Egerman pointed out that this topic is important. As they use decision support to call out screening methods, much of this is being connected to family history and other ways of assessing risk. For example, the literature indicates that there should be very different bases for screening mammography based on family history. If there is a way of capturing this information in a standard way, they should begin the process. If not, they need to make sure that experts are working through this between now and Stage 3.

David Bates said there are several different standards that can be used for decision support. The wording in the NPRM is sufficiently flexible.

George Hripsak asked if it would make sense to have a quality measure. Family history is very broad. Should they identify what kinds of risks will be asked about? Do they want a quality measure that would use family history as part of the measurement, in order to steer it a little more specifically?

The Committee accepted the NPRM language as written.

### ***Hospital Labs***

One Committee member asked whether a discussion took place about whether this is within the scope of meaningful use within hospitals. This is not the use of the lab data for their own purposes, but for others. Micky Tripathi said the feeling was that this was within the scope. Egerman commented that this is like asking a hospital to be a responsible player, that is why it fits into the meaningful use category for hospitals.

### ***Provide Timely Access (Under the View, Download, Transmit Function)***

Gayle Harrell noted scenarios in which providers are required to be responsible for patients' behavior, especially in areas with a digital divide, always concern her. Are they going to kick somebody out of meaningful use qualification because they had 9% and not 10%, because none of their patients have a computer? There are some areas where this could be the case.

Judy Faulkner thought it was interesting that even organizations that have very large patient populations and a very high percentage of patients online still worried about others who were not in that situation. The issue of a digital divide came up, with areas that have poor Internet access, or Amish communities. Also, she asked about proxy access.

Deven McGraw said various consumer organizations have also had extensive conversations about this and they feel somewhat beleaguered. They fully understand the concerns about making providers responsible for behaviors of patients. On the other hand, they have heard much anecdotal evidence and testimony that, absent the work by providers to actively encourage the use of these tools, the usage numbers do not occur. She recommends that the Committee signal that they know this is going to take some effort, and they are keeping the threshold low in acknowledgement of that fact.

Neil Calman said that the excuse that providers cannot take responsibility for something the patients can do is ridiculous. Providers have the responsibility for their ability to convince patients to follow their recommendations. He said that this recommendation, which is critically important, is to have people take responsibility for their own health care. Providers need to show patients that getting involved in monitoring lab results and communicating with providers leads to better outcomes. This is a critical part of what real meaningful use is.

Calman also pointed out that passwords expire if an account is not used for some set period of time. They cannot give people credit for signing a patient up a year ago: people who no longer use the system and/or may no longer even have access. He suggested that they should not count the time when a user sets up a password, but when they actually use the system. That will make providers create real functionality for people and make systems useful.

Bechtel pointed out that the Policy Committee has recommended this before, and they should not go backwards. They should ask CMS for an exclusion based on broadband access, as Harrell suggested. They should also allow for proxy access. David Lansky spoke in support of Calman

and Bechtel's views, and suggested that the Committee pressure CMS and ONC to put in place more robust measures for whether patients are using this meaningfully.

David Bates explained that it is important to set a realistic, low threshold. Many people do not need to see the doctor once per year. Perhaps they could do a better job of defining the denominator. Many patients value online access, but they do not see their provider very often and that should be acceptable.

Faulkner said her experience is that 25% would be very high. When they look at those who do a lot of advertising and a lot of one-on-one discussions about this with patients, use is typically still below 50%. Tang reported that his organization has been doing this for 12 years, and 75% of their patients are online. It's a "try it, you'll like it" type of function. They do have to get people started, but it is easy to get them to like it.

Harrell said that 25% is overwhelming and there will be significant pushback. She also pointed out that small specialists and those who deal with one-time incidents might have no reason to follow up. For primary care physicians, it becomes much easier.

Tripathi said that there are clinicians from both ends of the spectrum (large and small organizations) on the Information Exchange Workgroup, and their sense was that if this was restricted to a one-time registration that it would be a challenge, but achievable because it is something that is relatively in their control. Neil Calman suggested that they do not need to call out a number for 4 years from now. They should call out what they are suggesting now, and recommend that the number increase over time.

Mark Probst said that the concept is excellent, but that this requires a lot of logistics to make it happen legally and with the right security. They must be sensitive to that. Probst also raised the issue of proxy access to records of patients who are adolescents. Deven McGraw said that all they are doing is allowing people to count access to a patient's record. They are allowing the institutions to do their own policymaking. This issue varies by state, but the NPRM measure is simply about the count.

Christine Bechtel said she does not want patients to have 17,000 portals all over the place. The Information Exchange Workgroup said that the numerator could count view, download, or transmit. They could allow, in lieu of log-on, for the provider to transmit the information to wherever the patient directs, or to their Direct e-mail or the like.

Mostashari said there are rare instances in which scenarios like practitioners in Amish communities can be addressed more broadly, as in hardship exclusions. It is an interesting, but not too fruitful, exercise to see how many practices have patient panels that are more than 90% Amish. One Committee member noted that the comments from Mostashari said Bechtel related to transmitting was very useful. A designated electronic home should be established as the place where multiple providers send their documents as a permissible option.

Larry Wolf suggested that a patient could ask a specialist to send a copy of their record to their primary care physician. That is different from what they are discussing, but it also represents what may be a common practice. A practitioner could get credit for meaningful use by providing information back to the primary doctor. That would create more mass around the primary doctor.

In summary, Tang said that in the denominator would be all active patients: that is, all patients seen in the last 2 years minus those in adolescent category (which is state-defined). The numerator is those records that have been accessed through a log-in at any point in time. Proxy access counts. The ratio would have to be 10% or greater. Carve-outs already exist for those missing broadband access, and also provisions for special hardship cases. This refers to some way that information is viewed, downloaded, or transmitted in a way that is accessible to the patient.

### ***Secure Online Messaging***

Harrell again emphasized digital divide issues.

### ***Care Coordination: HIE***

Bechtel said she understands the notion that they have a limited number of levers to use to push the meaningful use agenda, but they should not throw this one out, as care coordination is one of the biggest consumer concerns. Having a one-off option is not the best approach, but Stage 1 remains Stage 1 in perpetuity, and it has no requirements around care coordination.

Tripathi said that taking the leap to start imposing things on Stage 1 was too big a step up. The idea is that providers are going to have technology with the ability to do these kinds of transactions, assuming they upgrade to the Stage 2, 2014 upgrades. So, this is a shrinking cohort. They heard in the CMS presentation earlier that roughly 40% of Medicare-eligible providers have already registered for Stage 1 and that is just for the first year.

Tang brought the issue to a vote, with two options presented. Option 1 was to drop and not replace the measure; option 2 was to replace it with one successful transmission. Three Committee members voted to drop and not replace the measure; six voted to replace it with one successful transmission.

### ***Medication Reconciliation***

At the 65% level, the caveat that the Meaningful Use Workgroup offered was first to know that there is a transmission that requires a reconciliation. That is a new requirement for EPs. The definition of a transition is clear in the numerator. The Meaningful Use Workgroup recommends lowering the threshold to 50% to accommodate the fact that sometimes, transitions do not require medication reconciliations.

Tripathi said that the Information Exchange Workgroup had the general comment that overall greater definition should be given to exclusion criteria for specialists. Harrell reiterated the importance of the clarification for exclusions.

The Committee voted unanimously to recommend the 50% threshold suggested by the Meaningful Use Workgroup.

### ***Summary of Care Record***

Tripathi said that planned transitions of care are the issue here. If the intent is that when a provider sends a patient to another care setting, the responsibility is on them to make sure the information is being made available at the appropriate time. That will rule out the query-retrieve function that would allow the receiving care provider to receive the information. It is a timing question, where it seemed it was absolving the sending provider of responsibility for getting the information to the receiver. They did allow for cases where there are HIE-type activities that

allow subscription, where there are models with repository-type functions, or a peer-to-peer type scenario, in which providers can subscribe to information coming from the sender. But the query-type function would not count.

George Hripcsak said that what they do with the denominator depends on the goal. One goal is care coordination. This is where they put the care team and the care plan. So if they take it out of the denominator, do they not need a care plan, because they can query? Tang said that somehow providers must document that a transition is about to happen—that is just a consequence of this measure. Everyone agrees that there are unintended consequences to requiring cross-EHR vendor transitions. Practitioners must follow the standards, but will not be penalized for transmitting to an organization that happens to use the same EHR. They must transmit across organizations.

Nine committee members voted to lower the percentage to 50%. Two opposed.

As to the denominator: in the NPRM it is all those who go through a transition as described. An alternative denominator is all those who go through a transition where there is not query access to the referring entity.

Neil Calman said that in New York City, there is query access from almost all of the voluntary hospitals for any discharge and any emergency room visit. Is every single one of those transitions going to be excluded? New York City practitioners also get notifications through their systems that there is new information on the system about a patient. Is this going to be excluded? Bechtel asked about counting these in the numerator. In the numerator, they do not care how practitioners go about transmitting. Mostashari added that this is his understanding of what the NPRM currently says, as long as it is certified EHR technology.

Tripathi said that allowing a query is functionally equivalent to providing access. Egerman commented that they do not want to be prescriptive about this. They are trying to get people to exchange information. In that case, they would want to say yes, it should count.

The next question in line, Tang said, is whether a minimum of 10% of the transmissions of the summary of care document should occur electronically. Bechtel said yes, and given the CMS data they received earlier, she thinks this is too low. Harrell disagreed, saying they do not know where those attesting providers are located. They do not know where there are holes, and where people not equipped to do this. She thinks 10% is adequate.

David Lansky said he would like to see a standard where meaningful user-to-meaningful user exchange is virtually always electronic, at 70-80%. It should not be hard to execute that.

The Committee voted to keep the wording as written.

### ***Registries***

Tang said he is hoping that a menu requirement, even if it is not widely subscribed to, would motivate those working in the standards, vendor, and EHR environments to move forward in this area.

Calman asked if it is plausible to think that a single standard could be developed for all registries. Or, would each one have a single set of standards? He said they need to think about what issues they need to push on that will not happen otherwise. If people are going to be using registries

more and more, then they are going to look to their EHRs to do that. Nobody is going to want to keep paying a clerk to extract this data; when the data is in the EHR, they will want to be able to get it out.

Mostashari said that there are particular groups of specialist providers who are reporting to their registries who perhaps should get some credit for meaningful use of their EHR. They may not interact with immunization registries, but they do use some registry and they ought to get credit for that. David Lansky noted that this dovetails with what the specialty societies want to be doing: taking a subset of what is in the registry with what is in the EHR. EHRs capable of populating the registries are a big win. Vendors have been asking for uniformity around value sets. To the extent that these registries will define value sets for these specialties, there is a synergy here about what constitutes what populates the EHR, so this is a stimulus for a lot of positive change.

The group supported the notion of discussing in the NPRM preamble specific, government-funded registries that already exist.

### ***Clinical Quality Measure Comments***

Quality Measures Workgroup Co-chair David Lansky distributed a supplementary handout, saying that the Workgroup asked that the Committee receive a copy of this and consider adding it to the recommendations. He said the quality measures section needs continual evolution, not just tweaking and adding bullet points. It is structurally not where it needs to be in terms of being functional. It is important for CMS and ONC to take firm steps and bolder action to get the quality measures approach right—he commented that the NPRM does not.

Lansky suggested that the Committee, CMS, and ONC should contemplate using the meaningful use program as a place to test measures that are close to being ready, rather than redeploying measures that are already well understood. They should also consider the page they just received on the Vendor Tiger Team as activity that they would ask CMS to undertake.

It was noted that the quality measure development process is stalemated, and they are not producing the standards that are needed.

Lansky said there are some things they could be doing to improve measurement capability in EHRs. For example, they could constrain value sets for 2 years. If they did that, vendors would feel that they could be more adaptive in producing query and analytic tools. If that makes sense to this group, they might recommend this to ONC and CMS to develop such a platform over the next year.

### ***Privacy and Security with EHR Modules***

Privacy and Security Tiger Team Co-chair Deven McGraw walked the Committee through the team's findings.

Mostashari asked if the Team considered mobile and other means of accessing view/download/transmit information as counting towards the measure. McGraw said no, they were referring to basic security functions through the portal. At least single-factor security is needed, for example. The ONC said in the NPRM that those details are so ubiquitous that they do not need to be required; the Workgroup disagrees.

With respect to information reconciliation, Mostashari asked whether there should be a certification requirement about patient reconciliation as it relates to the step in the workflow before information is integrated in a patient match. The question was whether the health record might assist in reconciling by comparing diagnoses, medications, and the like. McGraw said that they pulled the NPRM text verbatim and sent questions to four of the entities that testified at their hearing. All four of them interpreted it to mean some kind of machine-matching function, or reconciling without the need for human intervention. Mostashari said it would be helpful if the comments included some feedback on the generic functionality of having identity reconciliation as a part of information reconciliation, however the tool does that. He referred to the notion of looking at the information they have on the patient and making a determination of whether this is the right person, before the data are merged.

Tiger Team Co-Chair Paul Egerman spoke on the issue of EHR modules. The Stage 1 NPRM preamble indicated the need to test each module for security, which created difficulties for vendors. They would have to redesign their systems just so they would pass certification, as opposed to improving security. In Stage 2, they no longer have to carry out security testing of EHR modules, but the system must meet all security and legal requirements. Security is not tested at each module. Some people are very concerned about reduction in terms of testing for security and a number of alternatives were suggested, but the Team came to no consensus about any of those alternatives. Egerman's comment was that this sometimes happens in the security world—sometimes they implement something that does not work right and they have to take a step back.

Egerman noted that module purchasers are generally more sophisticated consumers, and their own IT departments would test this out. Tang pointed out that the Health Insurance Portability and Accountability Act still covers all of this.

## **6. Discussion of Workgroup Comments on Standards and Certification NPRM**

Time was running short, and Certification and Adoption Workgroup Co-Chair Larry Wolf pointed out that 1 hour of discussion was initially planned for at this meeting. In light of a tightened timeframe, he pulled out a few items from the presentation for discussion. He said that aside from the privacy and security requirements, there could still be integration questions if modules are not tested together. He asked if there was value to voluntary integration testing, when a vendor has all the pieces to make up a base and then tests it as a base.

Regarding price transparency, Wolf said they felt pricing was a complicated area, and trying to put a single dollar amount was not going to communicate anything of any value. For an organization that could potentially spend more on implementation, workflow changes, etc., than on the software itself, that is almost worse than no pricing at all. Mostashari clarified that the certification part of this addresses provider concerns that they thought they bought a complete EHR, but in fact the vendor comes back to them and tells them that another \$10,000 add-on is necessary for a complete system.

The Committee agreed to complete this discussion via telephone on the day after this meeting.

## **7. Public Comment**

Kellan Baker from LGBT Research thanked the group for all their work. He spoke in support of the discussion around the question of including data on sexual orientation and gender identity.

There are many reasons for this, among them the fact that the lesbian/gay/bisexual/transgender (LGBT) population experiences many health disparities. He referenced the current activities of agencies including the Department of Health and Human Services to collect better data, starting with national surveys on the health of the LGBT population. They will be convening a workshop later in the year with the Institute of Medicine to determine the challenges and the best ways to support patients and providers in collecting this data. He spoke in support of the discussions that this Committee is having and emphasized that they recommend that CMS and ONC commit to collecting this data in Stage 3. In order to make sure the community will be well prepared, they recommend that these data be collected in Stage 3, and that Stage 2 include the policy language to do this.

### **SUMMARY OF ACTION ITEMS:**

**Action Item #1:** Amended minutes from the April 4, 2012, HITPC meeting were approved by consensus.