

**Health Information Technology Policy Committee**  
**Final**  
**Summary of the August 1, 2012, Meeting**

**KEY TOPICS**

**1. Call to Order**

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 39<sup>th</sup> 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 HITPC Chair Paul Tang.

**2. Review of the Agenda**

Tang reviewed the day's agenda and then received approval for the minutes of last month's HITPC meeting.

**Action Item #1:** Minutes from the July 10, 2012, meeting were approved by consensus.

**3. Remarks**

ONC Deputy National Coordinator for Programs and Policy Judy Murphy enumerated several milestones relating to health IT. As of June, over \$6 billion has been paid out in the Medicare and Medicaid incentive payments, with about 50% of hospitals and about 20% of eligible professionals achieving incentive payments. She also noted that the American Olympic athletes, along with their trainers and physicians, were tracking their health using electronic health records (EHRs).

Certification is moving from the temporary program to the permanent one. Five permanent certification bodies and the five permanent test labs were announced a few weeks ago for the certification program. Also, September will mark the one-year anniversary of the consumer e-Health Pledge program. This will be celebrated as part of National Health IT week on Monday, September 10<sup>th</sup> at the Department of Health and Human Services (HHS).

A Government Accounting Office (GAO) report was released last week and indicated that Regional Extension Centers (RECs) are working with over 40% of U.S. primary care providers. The report stated that those working with a REC are 2.3 times more likely to achieve meaningful use than are those working on their own. ONC is proud of this finding—the RECs were stood up with the specific purpose of helping those who need assistance with selecting, implementing, and adopting EHRs.

Murphy also announced that ONC is migrating away from the site [healthit.hhs.gov](http://healthit.hhs.gov) to [healthit.gov](http://healthit.gov). For a time, users will be redirected to the new site, but eventually everyone should update their bookmarks.

#### **4. Meaningful Use Workgroup: Preliminary Draft Recommendations for Meaningful Use Stage 3**

Tang, speaking as Chair of the Meaningful Use Workgroup, presented results of the group's deliberations on Meaningful Use Stage 3 along with Workgroup Co-Chair George Hripesak. He noted that this is the first of four presentations to the full HITPC. This is very preliminary, and they are looking for the Committee's feedback. The workgroup will incorporate Committee input and revisit the recommendations at the Committee's October meeting prior to the Request for Comments (RFC).

In the slide presentation, Tang reviewed the group's guiding principles (i.e., supports a new model of care, addresses national health priorities, has broad applicability, promotes advancement, is achievable), and then reviewed the findings of the Meaningful Use Workgroup's Subgroups 1 and 2, indicating that Hripesak would cover Subgroups 3 and 4.

The Meaningful Use Workgroup's Subgroups covered the following areas:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health.

Tang and Hripesak proceeded through the workgroup's worksheet category by category for each subgroup and asked for feedback.

##### ***Discussion – Subgroup 1 (Improve Quality, Safety, Efficiency, and Reduce Health Disparities)***

Paul Eggerman asked which of the items on the list addresses reduction of health disparities. Tang pointed to the additional demographic information, like sexual orientation, gender identity, disability status and occupation. This gives more information about an individual. Another area is the addition of more items to the patient list and dashboard function, which result in more and better reporting tools.

Christine Bechtel said that in Stage 2, there was discussion about having the generation of lists of patients be organized not just by specific conditions, but also by demographic variables. She does not see that reflected here and suggested adding it. Also, Bechtel noted that Item 15, the patient dashboard, does not have a measure associated with it. She suggested a measure that would require users to report dashboard results longitudinally, and have providers pick one or two variables to use. Tang pointed to work that the Quality Measures Workgroup was doing around longitudinal reporting. Bechtel said she would like to see an approach like the one the Quality Measures Workgroup is working on as well as a measure around some sort of structural criterion. In that way, they know the functionality exists and that it is being used.

Judy Faulkner said that real-time dashboards would require significant processing power, but near real-time would probably be good enough. Tang concurred, and said the point was not to have a retrospective report that is generated in the IT department.

Gayle Harrell asked how they would determine the appropriateness of lab or radiology orders, and who would make that determination. For instance, what are the consequences if a second MRI is requested? Tang explained that with this radiology example, the American College of Radiologists has extensive guidelines in terms of what are the appropriate indications for ordering various tests. Vendors could program some of those guidelines into the clinical decision support in high-cost areas where there is overuse or, conversely, when there is underuse of a particular test. All these things are guidance only and it would be up to the organization to decide how to apply it. In areas where the literature already indicates that there is overuse or underuse of something, then they should try to make that correction.

Judy Murphy emphasized the idea that in some cases there are mature standards that will be worked right into the certification criteria and implementation guidance, while in other cases standards are not so mature. She encouraged using this process to drive those issues. In some cases they will follow where the industry is already, but in others they do need to drive the industry.

Terry Cullen pointed to the need for an internal dialogue with the federal partners on ways in which they can accelerate some of this work to share with industry in an open source fashion. Asking all the vendors to replicate a lot of this work will place an onerous fiscal burden on the industry as well on the provider. There may be segments that could be pulled out and provided. HHS has historically done this, and it may be a way to mitigate some of the concern that this acceleration may cause. From the federal perspective, Cullen said that they should look inside and see for what they can assume responsibility to help the agenda.

In an “editorial remark,” Tang commented that in the earlier stages for quality measures they did “retooling,” and they found that it does not work. It is not possible to retool the paper mentality, to update the way they thought about chart review in the past, to an electronic version of that chart review. Instead, they are thinking about completely different kinds of quality measurement. Similarly, with clinical decision support (CDS), they are headed in a direction where every vendor and provider does not have to reinvent their own CDS rules. Drug-drug interaction is another example of that: Instead of everybody fighting that battle, there is one group spending their whole research time on it. They are trying to project that this is where they are heading, and they hope both the research community and industry look at those signals and try to meet them, because there is now 3.5 years ahead of lead time.

Marc Probst referred to a Senate meeting yesterday during which a survey was discussed in which physicians indicated the things they want in terms of transitions of care. It struck him that this group does not have that data, and they do not have a lot of data for Meaningful Use Stage 1 that should have driven Stage 2 and clearly should be driving Stage 3. They are not being a learning health care system because they have not had the time or the data to do it. These measures are all well-considered functions and aspects of the systems that this group could be working on, but are they absolutely the best thing for the country? Probst said if they really nailed it down, there are four or five things that they could get in place that would dramatically improve security and privacy, and dramatically improve interoperability between systems. Simply laying on new functions isn’t answering that question.

Specifically, Probst said that problem lists can get so cluttered that they become useless. Functionality needs to play into how problems feed into diagnoses, which feed into orders and care programs. It would be helpful if this objective was more clear; he asked for more explicit wording for items 13 and 15.

***Discussion – Subgroup 2 (Engage Patients and Families)***

Bechtel noted that the last item presented, alerts for drug recalls, is listed as a placeholder for Stage 4. She clarified that it was not meant as a placeholder for Stage 4; it was a placeholder in the current construct. If Stage 2 maintains the ability to generate a patient list and the collection of communication preferences, than drug recall alerts would be doable immediately. In fact, she does not believe it would even need to be a requirement, because there is enough of a market impetus that people want to be able to communicate drug recalls and alerts. As long as those two things are in Stage 2, this can be removed entirely. Tang agreed.

Egerman agreed with the notion of having some things that are certification only.

Faulkner questioned the use of the term “blue button,” and whether they mean something exactly like the Blue Button, or just the general concept. She also expressed concern at the wording of the ability to designate where the documents are sent to “specific” care team members. Bechtel said that they were thinking of a care team more as a consumer would see it, as a group of practitioners that, collectively, takes care of a person. This is distinct from a team of five obstetricians working together in a practice and sharing records.

Faulkner also questioned requiring practitioners to do some things that would be quite expensive for them. She commented that it is one thing to put the technology in place, but another for them to require every physician to use the capability 10% of the time. Tang pointed to the word “provide,” which is used here in the same way that they used it to say “provide for clinical summaries.” The capability is there, but the intent is not to force people to use it or pay for it.

Faulkner pointed to item 6 and expressed concern that screens and headings can be translated, but if a doctor enters medical information in English, she is concerned about that translation. Tang said this was intended only to refer to educational materials.

Faulkner also asked about item 9, which is the capability to query research enrollment systems. It says “explore.” Tang said they are trying to figure out how they can cue this up for people interested in participating in clinical trials, and how to make them aware of the relevant ones. Bechtel said the subgroup’s original formulation of this was to allow consumers to set their preferences for clinical trials and understand the inclusions and exclusions. However, they realized that there are no technical standards for this, and it gets complicated pretty quickly. So they offered this simple alternative, which works in much in the same way that the EHR uses the HL7 Info Button standard to identify relevant patient-specific education materials. In the same way, they could build this into the certification rule, but not necessarily require its use by the provider.

***Discussion – Subgroup 3 (Improve Care Coordination)***

Cullen said that she would like to see acceleration in the marketplace around the ability to exchange information.

Referring to item 3, which requires that 30% of summary of care records be sent electronically, Bechtel said that over the trajectory of meaningful use they have struggled to determine how to drive exchange and how to support the maintenance of that exchange. Therefore, she thought the workgroup would have a broader discussion of encouraging this. She emphasized focusing on identifying where the market is now, where it is going, and where it likely will be in two years—and whether this is the right construct.

Hripcsak explained that there are the functional requirements of what they want to happen clinically: In other words, you want this clinician to be connected to that clinician for this patient. They are not saying that this would be implemented via Direct, because that is one directory between the two. HIE, however, should support that function as it unfolds. Bechtel said she does not think they should be prescriptive, but questioned the 30% threshold as being too low. Hripcsak predicted they would get comments from the public during the comment period that would lead them to shift the number up or down. He does not think the percentage will change the market.

Judy Murphy referred to her earlier comments about where to let the market lead and where to push things, and she characterized this as an area where they need to push. Everybody has identified the importance of having the information ubiquitously available in all venues of care, but it is still lip service. Everyone is not there ready to do the work, ready to say they are willing to pay for this. When they think about the sustainability of the exchanges that exist today, it is still tenuous. It is important to get more information about the process.

Gayle Harrell said they are at a critical timeframe right now. She encouraged the Meaningful Use Workgroup, or perhaps the HITPC as a whole, to hold a public hearing and bring together the people who are out there struggling, to hear from them directly about what their problems are. In Florida and all over the Southeast, Harrell hears exactly what is going on, and if all those people were brought into the same room, it would be a revelation to this Committee. This group would be shocked at the difficulties out there and how far away they are from exchange.

Steve Posnak wonders if at this juncture they should de-emphasize the discussion of percentages, because it can be somewhat distracting and takes away from the discussion about policy. The public comment will give them a better sense of where the percentages should be. Framing the objective for what they want the policy to accomplish might yield a better response.

Cullen pointed to the need for a sharp prod to drive exchange, and whatever they have done up until now has not been successful in this regard.

***Discussion – Subgroup 4 (Improve Population and Public Health)***

Jon White said that the Agency for Healthcare Research and Quality (AHRQ) would like them to consider sending adverse event reports to them. Faulkner brought up the fact that different states handle immunization data differently.

Art Davidson said that they are supposedly driving the market to a common standard with HL7, and there are standards established from both Centers for Disease Control and Prevention (CDC) and American Immunization Registry Association. Many states have implemented these. The goal is by trying to get more places to start sending information that they can drive those state registries to a more standard implementation. Faulkner said this is analogous to the lab systems. Lab systems use HL7 too, but it still can take six months to write an interface to a lab system. She questioned whether they have the power to require each state to change it, or if states have the wherewithal to make all the changes, especially if there is not a U.S. standard.

Faulkner also brought up the issue of authentication and standardization and directories—there are a lot of the same problems as with HIEs. Some of the registries charge significant fees, and some of them do not allow senders to also send the data to anyone else. She wanted to make sure they do not require everyone to end up in situations where they are very limited with registries. Hripsak said they were specific about this in Stage 2.

Cullen believes that if they rely on proprietary registries, they are actually not helping the states or the populations improve population and public health. They may instead be contributing to a database that is used for multiple reasons. She worries that they are sidestepping the larger issue, which is the need for public health State Department IT capacity.

Hripsak acknowledged Cullen's point and explained that some specialists may not be doing immunizations, but they may be participating in a registry relevant to their subspecialty. In this way, specialists can be included in the measure, although they may not have gotten it perfect.

Gayle Harrell said that presumably this is state dependent. If a state cannot receive the information, then a practitioner cannot transmit it. However, the Committee needs to be mindful that they do not have the ability to dictate this; that is up to the states. They can make it a goal, but they cannot enforce it.

Davidson suggested that the goal is to drive states to a more common standard themselves. One of the ongoing activities in the public health reporting initiative and at ONC is trying to find a standard that will make it easier for many programs that are funded in very different streams to coalesce around the technology that they are trying to build.

Cullen said she thinks they would be remiss to not to at least try to embody the goal of getting public health and population health to where individual patient health is in terms of Health IT. While she agrees with Harrell that states are not all ready, she does not know what would make them get ready. Obviously, financial incentives would help. Harrell said states are struggling financially and without the wherewithal to do this; there are no dollars out there. It takes incentive dollars, and this is an incentive program. Yes, they have given states significant dollars for exchange. Perhaps some of those dollars could be redirected towards population health. Somehow, they must put the dollars in place to do it.

Tang wondered about using certification criteria only to drive getting the capabilities in place in the EHRs, acknowledging that it is far from this program's purview to either force the providers or force the State Departments to be able to do things when the resources are not there. This might be an instance where they can get the infrastructure ready, but they cannot pull the trigger.

Tang then invited Marc Probst to lead a discussion about the five most important things they could do for HIT. Probst said that meaningful use has laid a tremendous foundation for electronic medical record usage, and that success should not be glanced over. However, with the \$6 billion they have spent deploying systems, they are not seeing evidence that meaningful use objectives addressing national priorities have been accomplished. He named interoperability, in particular, as something they are still largely not seeing. He likened it to the Australian Railroad, which was built on different gauges all over the country. Complicated devices were constructed to move materials from one type of train to another, but the underlying problem of incompatible tracks was never addressed. It comes back to the timing issue, which is causing them to do things very quickly without addressing underlying concerns.

Probst said he thinks they have done a lot of good and he is proud to be part of this Committee. But are they going to leave the legacy that they want to leave? He strongly believes that they are not addressing firmly enough some of the standards. Why wouldn't there be a standard for how states receive immunizations, store immunizations, and use them so that they can actually help a patient that goes from state to state? Why wouldn't there be data standards so that they can move real clinical computable data between information systems, so that they can care for patients and share knowledge? Who is addressing that? Probst does not know of anyone in the government who is willing to take on this 10-or 15-year vision that would actually fix health care. He would like to see this Committee be part of taking that step forward, versus adding more requirements that are just building on the investment that people have made.

Probst believes that the people who have bought these information systems will expand upon them. There is an opportunity to lay down some firm tracks to get the country on a single gauge of railroad in health care technology standards that would foster innovation, dramatically lower costs and save lives. He is worried that they continue to lay more requirements out rather than solving the real problem. They have a unique opportunity to do that.

Tang spoke about the limitation of scope of this Committee, which was set up to advise on one scope of the legislation and does not deal with standards. He also expressed a personal belief that patients are better off in quality, in safety, and even their satisfaction because of the meaningful use system that has been put in place. He feels that the percentages of use that they have achieved are extraordinary in the first year of a multiyear program.

Judy Murphy suggested that the HITPC could consider making a policy statement to the effect that states should not be able to define their own standards and in fact there should be a national standard related to the way immunization data is stored and accessed. They could partner with CDC or make a recommendation to them. If the Committee feels they want to do this, Murphy, with Steve Posnak's nod of agreement, said she believes it is within their purview.

Harrell liked the idea of having a hearing to get state input on this issue, and the notion of a policy recommendation to the states.

Cullen said that she is sensing dilution and requirements creep. She indicated feeling as though she was in a software development venture and now she has 40 things more to do when she could barely do her assigned 20. She wonders if the focus on five most important steps for HIT has more to do with an indication that additional core capabilities are needed. They need an architecture that supports it not only within the EHR but within the country. She does not want to detract from all this work, because she thinks it is amazing and she can support all of it. The concern is, do they have enough time, money, willpower, and consensus to do all of this and not dilute that magic number of things that they must do in order to get where they need to go?

Faulkner discussed a study on a health system that had a large number of clinical decision support alerts. They found that when they reduced them dramatically—they cut roughly 90% of the alerts—compliance for the remaining ones was significantly higher. She noted that this finding carries with it two messages. One is about questioning how to get the clinical decision support done right. The second is the general notion that identifying a few things to concentrate on might result in the job getting done better.

Bechtel indicated that she understood that complex approaches will be needed to solve complex health care problems. There are major categories of issues that are tremendously important, and a long list of critical functionalities, which fall into two categories. First, there are a number of measures that support current processes that people will not get rid of, like smoking status and clinical decision support. Then, there are many of new things that are designed to support providers in delivering care in a different way, reflective of the new models of care that this Committee thinks are coming in the future. That was our number one criteria in doing this.

If there were only five critical steps for HIT to achieve their goals, Bechtel continued, they would know what they are by now. One of the tools they used effectively was to identify a number of things that could just go in the certification rule, so that it did not create additional burden for providers. But, if they really want to create parsimony, they should think about removing some of the standard of care pieces, those functionalities that they know people need, want, and are going to use anyway. They should not cut out patient-generated health data, care coordination, and information exchange. Patients are ready for people to do this in a very different way. She hears from many patients who are not actually getting care that is any different, because the EHR is not being used in a different way. Stage 3 would be an opportune time to think about driving truly different care delivery.

#### **5. Privacy & Security Tiger Team: Report on Hearing on the National Strategy for Trusted Identity in Cyberspace (NSTIC)**

Deven McGraw reviewed some previously issued recommendations relating to authentication, and compared their findings from a few years ago to the current state-of-the-art. She discussed the major findings that came out of their recent hearing (as presented in the slide deck) and presented the resulting Privacy & Security Tiger Team recommendations:

- The Tiger Team believes that ONC should move toward individual-user level credentials to meet NIST Level of Assurance (LOA) 3 for riskier exchange transactions, ideally by Meaningful Use Stage 3.
- As an interim step, the ONC could require baseline two-factor authentication (per NIST 800-63-1) with existing organization-driven identity proofing (LOA “2.5”)
  - Two-factor authentication provides additional assurance
  - Entities not yet required to implement more robust identity proofing per NIST 800-63-1.
- This should extend to all clinical users accessing/exchanging data in the riskier exchange transactions.
- ONC’s work to implement this recommendation should be informed by NSTIC and aim to establish trust within the health care system, taking into account provider workflow needs and the impact of approaches to trusted identity on health care on health care quality and safety.
  - For example, NSTIC also will focus on the capability to pass along key attributes that can be attached to identity. The capability to pass key attributes (e.g., valid professional license) may be critical to facilitating access to data.
- ONC should consult with NIST about future iterations of NIST 800-63-1 to identify any unique needs in the healthcare environment that must be specifically addressed.

***Discussion***

Steve Posnak asked for more clarity in the language of the recommendations, particularly around the uses of level 2 and level 3 security. McGraw said there are multiple ways to get at this, and the “how” is a big question. She is not sure how much they should be dictating that, or how well the government would be served for them to dive down into more details, such as indicating which are the riskier exchange transactions.

Marc Probst asked if the group talked about the overhead of managing security at level 2 or level 3. McGraw said they did not get enough testimony on that, and she acknowledged that the recommendation focuses on workflow rather than resources. Joy Pritts said that one of the problems with getting a handle on the cost of this is that business models vary so dramatically in how people intend to provide security credentials.

Jon White suggested that the Policy Committee look at the case that drives this security. He referred to recent Drug Enforcement Agency (DEA) work on ePrescribing controlled substances, saying the point is to prevent diversion. They don’t care that people in pain get the medicine they need; the goal is to prevent diversion. What is the case that drives this Committee’s work?

Faulkner said that in her experience, the unauthorized breaches are people who are authorized to access the system but are accessing unauthorized records. She has never known of someone from the outside breaking into the system. She also added up all the seconds, minutes and hours that would be spent if they used the type of authentication requiring unique codes sent to cell phones. She recommended taking the time to study what the issue really is that they are trying to prevent, so that they can put effort where it is needed.

McGraw said they had figures on breaches nationwide, not just with health care data, and the number of breaches due to low-authentication thresholds was significantly high. They discussed the frequency of having to re-authenticate, and the misuse of authentication that happens when one provider uses another's authentication in the same care setting. Faulkner made the point that it is important to figure out what the nature of the breaches really is. How much borrowing is there, versus someone from the outside coming in? Then it can be more targeted to exactly those things that are going wrong the most.

Egerman said that he thinks the problem of sharing credentials is much more prevalent than the problem of inappropriate remote access. This may be where the focus should lie. Tang asked whether this presentation was directly mainly towards exchange or if it was intended to cover both. McGraw said they are trying to create trusted exchange among disparate providers. However, that trust will not exist if organizations do not trust each other to properly safeguard information within their own institutions.

Cullen asked whether the Tiger Team considered jumping up to level 4, given that there are so many unsecure networks in use. She brought up a statistic from a recent survey that found that 50% of all hospital local area networks (LANs) are not secure. McGraw said that they were thinking that level 3 was a baseline, a first step that people could certainly choose to exceed. She said they were advised by at least one other entity to go to level 4, especially considering that much of identity proofing is done in person in health care, which is an advantage this industry has in meeting one prong of level 4.

Cullen also pointed out that they need to be very clear that if organizations meet level 3 requirements, they still will not be satisfying DEA's level 4 requirement, which will be necessary for narcotic ePrescribing.

Tang recommended combining the first and third recommendations, and he asked whether these recommendations were standalone or if the Tiger Team was targeting these to be a part of Meaningful Use Stage 3 recommendations. McGraw said they were using Stage 3 as a benchmark for timing, but they were not necessarily suggesting these be meaningful use criterion. Today's recommendations are separate work that simply goes to ONC.

Tang then asked at what point they planned to define "riskier exchanges." McGraw said if in fact the Committee would like to hear more about these riskier transactions, the Tiger Team is on board, but they would like to know more about what some of those would be.

## **6. Update from the Office of the Privacy Officer**

ONC Chief Privacy Officer Joy Pritts offered an update on ONC's activities with regard to the Privacy and Security Rule. She updated the group on some projects that they have discussed before, and also gave some information about where privacy and security is, policy-wise, in the health sphere in general. She covered the following topics in her slide deck:

- State HIE Privacy and Security Program Information Notice. This Notice was issued in March 2012 and provides guidance on expectations for privacy and security frameworks based on fair information practices. It incorporates HITPC recommendations regarding informed choice to participate and strong provider authentication.
- ID proofing. Pritts discussed the National Strategy for Trusted Identities in Cyberspace (NSTIC) as well as Privacy and Security Tiger Team hearings (with a provider focus in July 2012 and a patient focus scheduled for later this year).
- Health Information Technology for Economic and Clinical Health (HITECH) modifications to the Health Insurance Portability and Accountability Act (HIPAA). The Final Rule was sent to the Office of Management and Budget (OMB) on March 24, 2012. Key provisions include finalizing the breach notification rule and extending use and disclosure provisions of the HIPA Privacy Rule and most requirements of the HIPAA Security Rule to business associates.
- The Affordable Care Act. The Final Rule appeared in the *Federal Register* in November of 2011. Highlights include: (1) ACOs may be business associates, (2) providers in ACO are eligible to receive Medicare claims data generated by other providers, (3) individuals may opt out of having certain identifiable information shared.
- OCPO research and internal initiatives. Pritts provided a brief overview of some of these initiatives, including data segmentation for the Privacy Initiative, the eConsent Trial Project, mobile device portfolio, and a consumer privacy and security perspectives survey.

### ***Discussion***

Deven McGraw expressed an interest in hearing the response from the grantees as to how they implemented the guidance on fair information practices and meaningful consent. Pritts said that the grantees are on a cycle as to when they must submit their plans, so ONC has no feedback yet. McGraw said this might be worth pursuing because it is interesting to see the policy choices that different entities are making even within that kind of broader framework. This is a good source of information about what is happening in the field.

Gayle Harrell asked if ONC would be convening a workshop on health information exchange. An update on what the grantees are doing might be an appropriate time to get some of that feedback and find out if that could all be timed together. As they start standing up exchanges that are going to link into state HIEs, they will want to make sure they have access and that they implement the same policies. She suggested that they might require all parties to have the same policy in place in order to link to the statewide and grantee funded exchange.

Terry Cullen said that last week there was a large OMB meeting about mobile devices to try to get some consistent guidance across the federal space for privacy and security. They are trying to figure out the privacy issues related to citizen users downloading their own data from a federal system onto their device. For example, a person downloads a radiological image and then their device gets stolen. Is the federal government then in trouble—who owns the information at that point? Pritts said that issue comes up repeatedly and it befuddles her. If they gave the patient the information on paper, there would be no question that the patient is responsible for it, and they have to maintain it and protect it. Cullen said this is a new space and no one knows whether there needs to be a regulation or guidelines around it. The Committee agreed to discuss this issue in depth at a later meeting.

## **7. Public Comment**

Larry Wolf of Kindred Healthcare suggested that the Committee should be looking broadly at policy measures, not just those tied to meaningful use regulations. The Committee also should look carefully at what really is the minimum necessary to enable the kinds of exchanges they want. He also said that if they start looking at architectural principles of the systems they are designing and a roadmap for getting to those principles, it might help to frame some of the discussion. It might get them to look beyond just what is achievable today and to consider what they would actually like to achieve and what they need to do to get there. Wolf said that the risks around data conversion are high and well documented, and the cost of existing systems needs to be considered. Moving off of one data set to another data standard is a key issue to work through.

Darryl Roberts with the American Nurses Association spoke about authentication levels, saying that he understands the value of limiting records access only to those persons authorized to view them, but it does not seem that level of authentication (LOA) 3 actually does that, except by association. In many cases people have gained illegal access to records that they actually have access to, but they are using the information inappropriately, or accessing inappropriate information. LOA 3 does not limit that in any way; it only makes users think twice about it. Frankly, the news stories about providers accessing information they should not have access to would not have been prevented by LOA 3. These providers had ulterior motives, sometimes financial, that allowed them to overlook their fiduciary and professional responsibilities. He also pointed to an earlier comment by Judy Faulkner regarding the time it takes to re-authenticate using an iPhone or similar device. Each time a provider has to enter credentials to authenticate increases the likelihood that they are going to take time away from that patient, and it also causes a bit of aggravation. He did not hear any discussion today about biometrics. Roberts pointed out that his thumbprint is attached to him, and he cannot lend it to someone else. That would not prevent him from logging into his device and handing it to someone else, but through a higher level of association he thinks it would limit the likelihood that he would do so. He acknowledged the higher cost of such systems, but also pointed out the time lost with people having to re-authenticate and also with people losing their passwords and having them reset. Roberts noted that a considerable part of the help desk's workload is taken up with resetting people's passwords.

Julie Cantor-Weinberg with the College of American Pathologists said that with regard to Meaningful Use Stage 3, they have not discussed the pressure being put on laboratories, although they rely on laboratories for meeting many of these objectives. They also continue to have a concern that, while they are up to 20% adoption by eligible providers of Meaningful Use, the requirements really do not fit pathology at all. Pathologists practice in the laboratory information systems not in certified EHRs. Most of the objectives that had been promulgated in Stage 1 and 2 and that are being considered for Stage 3 do not fit within their scope of practice, and even when they do, they are written from the perspective of the provider placing an order rather than the radiologist or pathologist receiving the order. While they have five quality measures in the Physician Quality Reporting System (PQRS), none of those have been on the table thus far. She urged the Committee to review those measures. Although pathologists are not counted in CDC surveys and uptake rates of EHRs, they are considered eligible providers and thus eligible for incentives and penalties. She also asked that the Committee move slowly and cautiously on objectives that rely on laboratory data. They are part of many of the standards and interoperability (S&I) efforts, but there is a need to proceed with caution because the Laboratory Information System (LIS)-EHR interfaces are under strain, and if they do not assure that the data moving from the LIS to the EHR is correct and appears in the right format, it could cause many problems with patient safety and the like.

Tom Leary with Healthcare Information and Management Systems Society (HIMSS) said that they are interested in learning more about how organizations can get involved in the activity that was referenced on the OMB meeting on mobile devices. He also reminded the group that

National Health IT week is scheduled for September 10<sup>th</sup> through the 14<sup>th</sup>. They are hoping for over 200 organizations to serve as supporters and are anticipating a presidential proclamation and Senate and House proclamations, as well as some state-level proclamations.

Seth Foldy from the CDC referred to the discussion about how immunization information was handled and whether or not this was proving to be a great dysfunction in Meaningful Use Stage 1. He said that considerable work has been done with the lessons from the first year of Meaningful Use Stage 1. This work has been included in the Communities of Practice implementation group at ONC and CDC, with vendors, and at the Immunization Registry Association to find ways to tighten up the implementation. Lessons learned have been spread to other public health types of reporting, so that each of the implementation guides used in Stage 1 will soon come with conformance statements and other improvements to facilitate more uniform implementation between EHRs and the many public health agencies.

Foldy said he would in no way detract from the statements of concern about how much funding is available for public health implementation, because that is always an issue. However, it is important to know that the pressure of the meaningful use objectives is resulting in progressive change towards more standardization on the public health side, as well as among health care providers. He also concurs with those who are concerned about the adequacy of the structures for health information exchange. In many ways the public health reporting objectives are some of the most aggressive forms of health information exchange that are embodied in Meaningful Use Stage 1. Like other parts of the industry, public health continues to look for clarity and a vision about the role of HIE, the protocols, and HIE organizations moving into the future.

## **SUMMARY OF ACTION ITEMS:**

**Action Item #1:** Minutes from the July 10, 2012, meeting were approved by consensus.