

American Health Information Community
Workgroup on Electronic Health Records
Summary of the Web Conference held Thursday, March 21, 2006
(3rd Web Conference of This Workgroup)

Charges for the Electronic Health Record (EHR) Workgroup

Broad Charge: Make recommendations to the American Health Information Community (the Community) on ways to achieve widespread adoption of certified EHRs, minimizing gaps in adoption among providers.

Specific Charge: Make recommendations to the Community so that within 1 year, standardized, widely available, and secure solutions for accessing current and historical laboratory results and interpretations are deployed for clinical care by authorized parties.

1. Call to Order and Introductory Remarks – Dr. Jonathan Perlin and Dr. David Brailer

Dr. Perlin called the meeting to order shortly after 1 p.m. and welcomed members of the AHIC EHR Workgroup to the meeting. He thanked Dr. Brailer for his exceptional leadership and asked him to make a few comments.

Dr. Brailer emphasized that the recommendations presented by the EHR Workgroup to the Community in May 2006 are going to be critical, as it will take time for the government to work through recommendations and – evaluate what policies could change or what other actions it could take. He urged them not to get bogged down in discussions of technology at this juncture, but to stay focused on the key leverage points, principles, and governing ideas about how to go forward. One of the very key issues, he said, is whether the EHR Workgroup recommends that the model for the exchange of lab data be person-centric, clinician-centric, or lab-centric. The answer to that question will set the tone for everything else that the EHR Workgroup does.

2. Review of Call-in Procedures and FACA Guidelines – Dr. Karen Bell, Office of the National Coordinator for Health Information Technology (ONC)

EHR Workgroup members were briefed on Web conference call-in procedures. Dr. Bell explained that many of the materials for the EHR Workgroup (except for those still in draft form) are available on the Web site http://www.hhs.gov/healthit/ahic/ehr_main.html.

Finally, noting that Workgroup members may be asked to speak in public settings, Dr. Bell provided the following guidance:

- First, all of the recommendations from the EHR Workgroup go the Community; Workgroups do not and cannot provide advice or recommendation to anyone, including the Secretary, the Department, or any Federal official outside of a meeting of the full Community.
- Second, when presenting in public forums, Workgroup members must acknowledge that any comments outside of the information that is currently publicly available cannot be attributed to the EHR Workgroup or to the work that has been done in the context of the EHR Workgroup.

3. Introduction of Participants

Meeting participants were introduced. (See the list of participants at end of this document.)

4. Review and Acceptance of Minutes from the February 22 Meeting of the EHR Workgroup – Dr. Perlin

Two corrections were made to the minutes of the February 22 meeting of the EHR Workgroup: regarding the correct spellings of the names of Connie Laubenthal and John Houston. Dr. Perlin indicated that he would allow an additional 24 hours for anyone with additional corrections to communicate them to either Dr. Bell or Alicia Bradford or other ONC staff members; then the minutes would be fully accepted.

5. Brief Summaries of Previous Workgroup and Community Meetings – Dr. Perlin

Dr. Perlin noted that at the March 7 Community meeting there had been broad discussion of and enthusiasm for advancing EHRs using the three models discussed at the EHR Workgroup's previous meeting: (a) a standardized peer-to-peer model, (b) a Web-based portal, and (c) a regional health information organization (RHIO) model.

Dr. Perlin also reported that U.S. Department of Health and Human Services (HHS) Secretary Mike Leavitt had given the EHR Workgroup an additional charge in the wake of Hurricane Katrina: *The EHR Workgroup should advance EHRs that are able to support first responders and populations in emergency situations.* Dr. Brailer explained that charge is an additional charge, not a substitute for the EHR Workgroup's specific and broad charges. He further clarified the AHIC discussion stating that electronic health records, as they come forward, should be able to support first responders in terms of having adequate information to be able to serve patients and, in fact, populations in emergency situations. He stated that he believes we best honor the Secretary's specific charge by moving forward on our broad and specific charge, which is the advancement of health records and the determining mechanisms to support and advance the three models.

6. Review and Discussion of Potential Workgroup Recommendations – Dr. Bell

Dr. Bell reviewed the timeline for the EHR Workgroup's work in the coming weeks, noting that ONC would be working closely with the Co-chairs and members of the Workgroup to accomplish several objectives:

- No later than April 14: Draft initial high-level recommendations from the EHR Workgroup. Also identify outstanding issues and plan for resolution.
- Week of April 17: Draft detailed recommendations from the EHR Workgroup in letter format.
- Week of April 24: Review and edit the detailed draft recommendations from the EHR Workgroup.
- No later than May 1: Make available final recommendations from the EHR Workgroup for distribution to the Community.

Dr. Bell suggested several topics for discussion by the EHR Workgroup on the basis of her notes from the EHR and other Workgroups, noting that the most important decision by the EHR Workgroup at this meeting was whether the flow of electronic laboratory information in EHRs recommended in the EHR Workgroup's specific charge should be patient-centric, lab-centric, or clinician-centric:

- **Patient-centric model.** Information or results from multiple labs are collected wherever a patient may be; current and historical results for the patient are made available electronically to any clinician authorized to have the patient's information.
- **Lab-centric model.** This model is fairly common at present. A single laboratory, generally as part of a large, integrated delivery system or a very large clinic, makes its lab results available online in a person-centric way to selected clinicians who access the information from a specific portal or an encrypted portal. For clinicians who do not belong to the integrated delivery system or do not have some sort of formal arrangement with that delivery system, results are transmitted by paper to whoever orders the lab tests using the standard approach (e.g., faxing).
- **Clinician--centric model.** A clinician with an EHR will develop an interface with multiple labs where patients can be sent (e.g., when the third-party payer allows reimbursement only if certain labs are accessed). The clinician controls the ordering and receives the lab results. Historic lab data are not available, and data are available electronically only from a lab with which the clinician has created a separate interface.

Key Questions and Comments

Dr. Blackford Middleton asked Dr. Bell to crosswalk the models she described with the options that had been considered on the last call. Dr. Bell explained that (a) the patient-centric model could be either a hospital-based model (if the hospital had access to lab results from multiple other labs) or a RHIO-based model; (b) the clinician-centric model is like the peer-to-peer model; and (c) the lab-centric model is essentially the existing hospital-based model, where most hospitals receive lab results only for what they have tested themselves, not results from what other labs have tested.

Dr. Brailer added that after the March 7 AHIC meeting presentation we received feedback that it would be clearer if both the potential technology deployments and conceptual way of organizing the information were not coupled at this time. Dr. Brailer stated that the first thing the EHR Workgroup needs to decide is, "What is the right conceptual form for organizing information?" Should lab information be organized in a patient-centric, clinician-centric, or lab-centric way? Once that decision is made, the Workgroup can address which deployment schemes and technologies to use.

7. Scheduled Presentations – Dr. Perlin

The four presentations introduced by Dr. Perlin were as follows:

- An overview of a core group of RHIOs that currently are exchanging lab data, by Dr. Scott Young, Agency for Healthcare Research and Quality's (AHRQ)
- Privacy/security issues related to the EHR Workgroup's charge, by EHR Workgroup members John Houston
- Policy issues related to the Health Insurance Portability and Accountability Act (HIPAA), by Susan McAndrew from the Office for Civil Rights of HHS
- A discussion of the Clinical Laboratory Improvement Amendments (CLIA) and regulations, by Judith Yost, Director of Laboratories, Centers for Medicare and Medicaid Services (CMS).

A. RHIO Demonstration Projects – Dr. Scott Young, AHRQ

Dr. Young gave a background on the AHRQ HIT portfolio. They are funding 122 projects in 41 States, covering around 40 million American lives. He gave an overview of three of AHRQ's State and regional

demonstrations (SRDs) of health information technology that are exchanging lab data. As background, he noted that SRDs are 5-year State-based contracts begun in fiscal year 2004 to help States secure statewide networks using health information technology to improve care. The initial five SRDs in Colorado, Indiana, Rhode Island, Tennessee, and Utah were awarded about \$1 million each. Grantees: Mark Frisse of Tennessee and Mark Overage of Indiana participated in the presentation and fielded questions from the workgroup.

Utah's SRD. Utah's Health Information Network operates as a trusted, neutral third party (like the post office) for electronic data exchange. It regards clinical and administrative data as essentially the same thing – personalized health information. The network has developed a tool that allows a person to pick up a standardized HL7 file or a PDF file and mail it from one entity to another, regardless of whether a particular entity has an electronic medical record. There is no search capability. The network is deeply involved in standards development, both nationally and at the local level.

Tennessee's SRD. Tennessee's SRD has taken the form of a hospital-based initiative designed to create a utility to inform physician practices to exchange hospital-based information with both hospitals and practices. This initiative is implemented county by county. It currently includes 12 hospitals, which are feeding data in three counties, which include 1 million people, 250,000 of whom are from adjacent States. The hospital-based initiative was chosen, because the Governor felt that with the hospitals as the driving force, it would inform rural practitioners more effectively.

In terms of hospital-based opportunities, Tennessee has found that hospital data feeds are fairly easy to develop. The hospitals include their own lab tests as well as lab tests from outside clinical labs. The aggregation of data comes at the receiving end through the record locator service/record access service aggregation function. The primary challenges have been around translating the data into appropriate standardized forms and formats. They have found that this is best accomplished if one does not expect the hospital to do the programming. Standardizing some core elements is essential for comparison and use. Standardizing all lab values initially may not be cost effective prior to demonstrating value. The problem is simplified, because the associations with patient identifiers are straightforward.

An early lesson learned with respect to the governance and financial models is that the return on investment should be considered not just in financial terms but also in non-fiscal terms, such as improved quality and efficiency. A paradox is that Tennessee's announcement of the county-by-county route actually accelerated some point-to-point initiatives.

Indiana's SRD. Indiana's SRD is the most mature SRD in terms of the exchange of lab data. It evolved from the Indiana Network for Patient Care, which was created by the Regenstrief Institute and has been operational for about 10 years. Out of a population base of 1.7 million and 150 HL7 message feeds, there have been almost a billion structured observations (e.g., lab results or vital signs). About 80 million results are added annually, and all data coded using [Logical Observation Identifiers Names and Codes \(LOINC®\)](#) for identifying laboratory observations. The Indiana project uses a federated data model (centrally managed); data are standardized as received, and there is deterministic patient matching.

Indiana has many complexities, including tremendous fragmentation of labs – hospital labs, regional labs, national labs, reference labs, public health labs, and labs in physician offices. No two labs use the same codes, and labs change codes frequently. A typical lab has 5,000 unique results. Labs often do not retain results online more than 60 days. The mapping of a single lab requires about 6 person months. Indiana has worked around these complexities using the following sequence of strategies: (a) accumulate a large sample of laboratory results, (b) build a database, (c) clean up those units, (d) evaluate lab terms (analyze name words), (e) use the Regenstrief LOINC® Mapping Assistant (RELMA) to generate a first

pass, and (f) do iterative edits and error checks. The lessons are to limit the efforts to one lab section at a time and to limit the focus expertise. Chemistry and hematology are easiest; microbiology and blood bank are most difficult.

The good news is that in Indiana's experience nearly every laboratory can be automated. Essentially, every laboratory system can generate an outbound HL7 message. LOINC® is fairly comprehensive. RELMA facilitates the mapping process, but Indiana's experience has been that centralized mapping works, and decentralized mapping does not work.

One product that has come out of Indiana is the DOCS4DOCS clinical messaging system. This is an inexpensive bridge to the electronic medical record that delivers clinical results, including lab results, to clinicians in real time (minutes). There are three delivery options: (a) a secure inbox with just an Internet connection, personal computer, and browser in the physician's office (90 percent of physicians have an Internet connection); (b) delivery to an electronic medical record; or (c) facsimile (fax) delivery for physicians without an Internet connection.

Trends and Recommendations for the EHR Workgroup. According to Dr. Young, RHIOs are a viable strategy option to promote the electronic exchange of lab results and data. The team that helped put his presentation together offered the following comments on trends and recommendations to the EHR Workgroup:

- Paper-based offices are going to continue to constitute a significant portion of the health care landscape. For that reason, the EHR Workgroup should (a) adopt policy levers to promote electronic exchange of lab orders and results; (b) formally adopt a standardized image format; and (c) promote the creation/adoption of standardized, inexpensive (less than \$100) tools for physicians to securely send and receive standardized labs electronically (not fax or e-mail). The achievement of this exchange results in offices reorganizing workflows around electronic data interchange instead of phone, fax, e-mail, etc.
- There is a lack of standards for formatted messages. For that reason, the EHR Workgroup should (a) consider adopting the EHR-Lab Interoperability and Connectivity Standards (ELINCS) as the standard, (b) promote assistance for creating crosswalks between the plethora of proprietary lab codes and the appropriate LOINC® codes, and (c) assist LOINC® with developing appropriate codes and with developing workshops to help the health care community learn how to use these codes correctly and uniformly.
- There is a lack of health information exchange standards. For that reason, the EHR Workgroup should (a) convene and/or recognize core group of RHIOs to discuss and adopt a suite of RHIO-standardized messages, (b) recognize that lab exchange is not exclusively clinical (may encompass public health or administrative information), and (c) recognize the need to exchange labs using identical formats and codes regardless of how the destination is going to use them.
- Enabling factors include the following: (a) provision by lab system vendors of standardized HL7 outbound interfaces (b) drive adoption of LOINC®, and (c) adoption of a federated authentication model for providers (e.g., Connecting for Health).

Key Questions and Comments

Dr. Middleton asked what percentages of Utah's files are in PDF format compared to those using HL7. Dr. Young said he would get back to the group on the specific number.

Jason DuBois asked, “What is the agreed-upon way to send and receive laboratory results information in Utah?”. Dr. Young said he would get additional information about the standards Utah uses. He added that Utah uses a “bottoms-up” approach to drive a consensus among all the State’s diverse stakeholders to drive value.

Action Item: Dr. Young/AHRQ will find out what percentage of files in Utah’s system are in PDF format compared to those using HL7, and he also will find out what standards are used in Utah.

Update: pending

Chantal Worzala said she found Dr. Young’s point that centralized mapping works and decentralized mapping does not work troubling. Dr. Overhage said a group of people with specialized knowledge of the standardized coding systems and labs is needed; when mapping is decentralized, the wrong codes are often used.

Howard Eisenstein asked to what extent there had been incentives put into place for physicians to adopt. Dr. Young and Dr. Overhage replied that there are numerous non-financial incentives for physicians – e.g., a substantial saving in staff time require to organize and process lab results. Mr. DuBois asked about the possibility of providing positive incentives to labs to transmit results electronically. Dr. Overhage noted that Indiana’s DOCS4DOCS clinical messages enables hospital labs to stop printing, faxing, or providing a portal to the physicians to deliver their results, and the cost is lower than the labs might otherwise pay.

B. Privacy and Security Issues Related to the EHR Workgroup’s Charge – Mr. Houston and Mr. Kahn

Mr. Eisenstein noted that Mr. Houston had submitted a memo to the EHR Workgroup some time ago that wrestled with the issue of privacy in terms of the HIPAA privacy rule versus other regulations. The HIPAA privacy rule permits protected health information to be shared for treatment purposes without a patient’s authorization. However, individual State privacy laws prevent uniform sharing of personal health information on an interstate basis.

The default policy is that HIPAA should be the standard. However, given the time constraints on the EHR Workgroup and the Community in general, it does not seem feasible that Congress will amend HIPAA to preempt more stringent State law in the near future; nor is it practical to expect the adoption of a uniform State privacy law. Mr. Houston suggested that the solution to this problem would be the development of a patient authorization scheme that would enable patients to preauthorize the release of personal health information. Such a scheme would not have to be legislated. He believes this is the only thing that seems viable, given the aggressive timeline for the EHR Workgroup.

Key Questions and Comments

Alan Mertz said that in some States (Hawaii, Kentucky, Maryland), test results may not be reported to anyone other than the person requesting the test even with the patient’s consent.

C. Policy Issues Related to HIPAA Privacy Rules – Ms. McAndrew, Office for Civil Rights, HHS

Ms. McAndrew ran through the basic “who,” “what,” and “how” of HIPAA privacy rules and then provided some context in terms of questions about how HIPAA may interact with the EHR Workgroup’s

initiatives. She noted that HIPAA privacy and security requirements apply to health care providers (e.g., physicians, hospitals, clinics) that transmit information electronically, to individual and group health plans, and to health care clearinghouses. But there are many people with health information whom HIPAA does not cover, including employers, insurers who are not dealing with health insurance, entities such as banks and credit companies with medical information, and government entities such as public health and State plan and provider oversight entities.

Ms. McAndrew also explained the concept of a “business associate” of a HIPAA-covered entity. A business associate is a third party hired by a HIPAA-covered entity to perform a business function on its behalf. That third party may need protected health information to carry out the business function, and there must be a business associate agreement between the covered entity and the third party to ensure that the business associate that obtains the information provides adequate assurances that the information will be protected and adequately safeguarded. A business associate’s receipt of protected health information and assurance pursuant to its business associate contract do not make the business associate a HIPAA-covered entity.

To the extent that a RHIO is engaged in any kind of data aggregation or is the gateway for a disclosure activity by the HIPAA-covered entity, one might conceive of the RHIO as carrying out that disclosure function on behalf of all the membership in that RHIO – and thus being a business associate of all its members (the hub, in a hub and spoke arrangement). In other scenarios, where the intermediary may be more like an automatic switch, it would be more questionable. Whether the entity actually needs to have personal health information to perform that function may come into question.

In response to a comment about the requirements of HIPAA, State privacy laws, and CLIA, Ms. McAndrew noted that HIPAA does not mandate disclosures; it just limits them. Thus, if a State law imposes more stringent limitations than HIPAA in terms of what it does not allow to be disclosed or limits to whom that disclosure can be made, that more stringent law continues in force and effect under HIPAA. Under HIPAA, a physician can disclose personal health information to the patient, to other doctors involved in the treatment of that patient, and to public health authorities.

Noting that it is clear that there are a number of complementary, and potentially competing, legal and regulatory processes, co-chair Dr. Perlin left the meeting.. Dr. Robert Kolodner and Linda Fischetti continued as his designees for the U.S. Department of Veterans Affairs. Co-chair Lilee Gelinias, joined the meeting at this time.

D. CLIA and Regulations – Judith Yost, CMS

Judith Yost explained that CLIA’s intent is to ensure accurate, reliable, and timely test results, and the regulations are written broadly, allowing for any kind of information gathering and results transmission. CLIA does not specify that the information has to be on paper or that it has to be electronic. It can be in whatever format the laboratory needs to use in order to get the information to the provider in a timely fashion.

Ms. Yost summarized the CLIA regulations that apply to the processes that the EHR Workgroup had been discussing. She noted that the regulations are written in a way that follows the process of the testing specimen through the laboratory. Thus, the analytic section of the regulations includes all the requirements that apply to the phase where the specimen is, where test is ordered, and where the specimen is collected and processed. The analytic section requires, for example, that a laboratory must have a written or an electronic request for patient testing from an authorized person, and it defines the authorized person as the individual who is authorized under the State law to order tests or to receive results or both.

If a State law does not address who may order tests or receive results, then anyone may order those tests or receive those results. Still, the laboratory must follow the requirements of the Social Security Act if it wishes to be reimbursed under Medicare for test ordering, and this may involve some sort of security levels. CLIA regulations also specify a number of other requirements. A laboratory must ensure that the test requisitions solicit certain information. If the lab transcribes the test requisition or authorization information into a record system, the lab must ensure that the information is entered accurately. Test report information must include specified types of information, including normal ranges.

A separate section of the CLIA regulations deal with the post-analytic phase that begins when the lab results are reported to an authorized person. Test results must be released only to the authorized person. The laboratory must immediately alert the individual responsible for using the test results when any test results indicate an imminently life-threatening condition or alert value. When test result errors are detected, a corrected report must be issued promptly to the authorized person, and the reports must indicate that they are corrected reports.

Ms. Yost added that her office is excited about what the EHR Workgroup is doing and will try very hard to provide flexibility where it can within the scope of the regulations to facilitate its efforts, or if need be, even to make regulatory changes. She apologized for not having any slides for her presentation but referred EHR Workgroup members to the CLIA Web site (www.cms.hhs.gov/clia) for additional information.

Key Questions & Comments

Ms. Gelinas noted that part of the EHR Workgroup's charge is to identify policies, laws, and regulations that may present obstacles to the adoption of EHRs. She noted that under HIPAA and CLIA, State laws are a barrier in some States.

Dr. Bell suggested having an offline discussion of the CLIA regulations and about how the EHR Workgroup might be able to craft some recommendations for either CLIA guidance or even long-term changes to CLIA, or perhaps even recommendations to the National Governors Association or someone else about the State laws. Ms. Yost said she would be willing to participate. Ms. Gelinas and several other EHR Workgroup members supported this recommendation.

Mr. Mertz said that there is a need for some strong Federal language to preempt State law. Mr. Kahn agreed but said that EHR Workgroup members should not assume Congress would do anything as rapidly as we would need. On the other hand, changing regulations might be possible if the HHS general counsel indicated the law allowed the regulatory changes. Dr. Bell said that although she agreed that the EHR Workgroup should not assume that Federal law could be changed, it could point out where Federal law limits the ability for electronic health information to be used to its fullest potential.

Ms. Gelinas quoted Mr. Houston in saying that the EHR Workgroup members should not shoot for pie in the sky but rather should do what is feasible. Mr. DuBois said Secretary Leavitt suggested keeping a realistic vision regarding what the EHR Workgroup does in its specific charge, while also working to achieve a pure vision (e.g. reaching out to the National Governors Association to discuss State privacy laws).

Ms. Gelinas, noting that the time was short and that there were other agenda items to consider, asked EHR Workgroup members to come to conclusions around this part of the agenda. Dr. Bell said it appeared that the EHR Workgroup could benefit from further consultations with its HIPAA and CLIA experts before drafting its recommendations that will go to the HHS Secretary by May 1st.

ACTION ITEM: ONC will schedule an offline discussion with EHR Workgroup members and experts on CLIA, HIPAA, and State laws for the purpose of considering issues (e.g., the sharing of historical lab data) that are relevant to the EHR Workgroup’s recommendations. Then in the coming weeks, ONC will circulate some recommendations to EHR Workgroup members for comment.

8. Review of Several Possible EHR Workgroup Concepts—Dr. Bell

Dr. Bell presented several concepts for EHR Workgroup members’ discussion and asked them to indicate whether or not they agreed with the concepts. She said the idea would be to craft the concepts approved by the Workgroup in a logical way, so that a very clear entity is responsible for taking a very clear action and that action occurs with some very strong rationale. People were asked to “opt-out” of the concepts if they disagreed with them.

A. Central focus: Patient-, lab-, or clinician-centric model for electronic exchange of lab test results

Dr. Bell suggested that Dr. Young’s RHIO presentation had given the EHR Workgroup an understanding that there are patient-centric approaches that are being developed and are in use right now that could be explored in greater detail. The RHIO-based, patient-centric approach is alive and well, especially in Indiana.

Dr. Worzala countered with the observation the Utah’s model described by Dr. Young is basically making electronic the point-to-point reporting, which is more like a peer-to-peer model. In Tennessee, no data are actually being moved, although the State is using a hub and spoke RHIO approach. In Indiana, it appears that the place where they have made a good business case is the DOCS4DOCS portion, which is again a point-to-point model. Although everyone wants to get to the point where the data follow the patient, she said, she thought that the discussion at the previous meeting was favoring a staged approach.

Dr. Frisse agreed with Dr. Worzala’s comments about Tennessee’s model—that data are being moved but not used, but added that in the current regulatory environment, he sees physicians both as a necessary safeguard and a bottleneck in the long-term delivery of health care information. Although a physician-centric model is always appropriate, it should not be an exclusive model, he said. Dr. Overhage emphasized that Indiana’s DOCS4DOCS is not point-to-point delivery but delivery from the source to the health information exchange, which then delivers it to all designated recipients. He added that he did not think it would work to deliver information to physicians and then to expect physicians to send the information somewhere else.

Ms. Laubenthal suggested that if a peer-to-peer model were recommended to the Community, physicians would control lab results, and if a physician then feeds the results either to a RHIO with the patient’s permission or feeds it to another physician, the CLIA and State regulatory issues would not pose a barrier.

Dr. Kolodner said his perception was that the EHR Workgroup’s presentation to the Community and the HHS Secretary on March 7 was confusing, because it included no clear statement about which direction the Workgroup plans to go.

Mr. DuBois cited the EHR Workgroup’s specific charge, focusing on the phrase “widely available.” He noted that although there are RHIOs in some parts of the country, RHIOs are not widely available. He suggested that the initial widely available solution would be to drive peer-to-peer relationships, with the pure vision being a more patient-centric approach, whether in the form of an RX hub or a RHIO

relationship. Dr. Kolodner emphasized that the HHS Secretary wanted the EHR Workgroup to move to an end goal, not just to make something widely available that was taking everyone in a direction in which we do not want the country to go. Ms. Gelinis agreed.

To resolve the issue, a *roll call was taken* of EHR Workgroup members, and each was asked to indicate his or her preference for a patient-, lab-, or provider-centric model for electronic exchange of lab test results.

- Ms. Laubenthal favored the patient-centric model, with the understanding that a RHIO is not the only model that would support that. She added that it is very important to get physicians to adopt health information technology products. She and Dr. Sorace emphasized the importance of a single electronic standard for transmitting results.
- Mr. DuBois said that although he did not oppose the patient-centric model, he believed that to get something widely available and accomplished in the next 12 months, he thought it would be best to begin with peer-to-peer information exchange first.
- Dr. Bell said that even if the EHR Workgroup adopted a patient-centric approach, it could still support peer-to-peer initiatives as long as the recommendations were consistent with the patient-centric approach. She also said she thought it might be easier for physicians without an electronic medical record to go to a RHIO than to five different labs.
- Col. Harmon said that the Department of Defense had found that different models serve different purposes. He noted that it was hard to argue that the patient-centric model is not the best model, but other models could be perfectly valid and useful steps toward that end-state vision.
- Dr. Middleton strongly favored a patient-centric approach and thought it maximized the value proposition for clinical decision support and quality management, but said he thought that Col. Harmon's comments were insightful.
- Mr. Isenstein favored the patient-centric approach to maximize the value proposition to consumers and physicians.
- Mr. Houston said he tended to favor the patient-centric model as the end goal, but we talked about further discussion of CLIA about how to provide access to this information. He felt that that discussion needed to take place before the Workgroup could come to a final conclusion.
- Dr. Worzala favored the notion of an evolutionary model with the goal of reaching a patient-centric approach. She also supported focusing on standards and thinking about incentives to get people to standardize. She noted it was important not to lose sight of making short-term progress.
- Dr. Clancy recommended that the EHR Workgroup recognize the need for an evolutionary path and make recommendations to the Community that are staged but aim toward a patient-centric model at the end of the diffusion curve.

Consensus: The EHR Workgroup recommends that the ultimate goal be a patient-centric model at the end of the diffusion curve, but recognizes the need for an evolutionary path toward that goal.

B. The Health Information Technology Standards Panel (HITSP) should make as one of its top priorities standards for vocabulary, transmission, and implementation of lab result data.

Dr. Bell explained that ONC has a contract with HITSP to develop standards and suggested that standards for lab result data should be a priority. Workgroup members agreed to this concept.

One Workgroup member noted that she would like to understand how the use cases apply to the EHR Workgroup's work in this area. Dr. Bell said there were plans to have the contractors that did the use cases talk to the EHR Workgroup, but that the contractors would not be able to do this by May 1st.

C. All labs will adopt HITSP standards. (modified)

One Workgroup member noted that it would be important to find out more about how lab reports are generated by different labs (physician labs, hospital labs, clinical labs, referral labs) and what it would take to adopt the standards. In response, Dr. Bell suggested modifying this concept to remove the word "all" and perhaps softening the tone by suggesting that labs will be given incentives to adopt HITSP standards.

D. Lab data provision through a central "hub" with data centered around individual patients. (deleted)

Workgroup members agreed this concept was at a lower level of detail than the others and should be dropped.

E. Identification of barriers to patient-centric exchange of historical data. (slightly modified)

Dr. Bell noted that three of the AHRQ contractors have identified a number of barriers to the exchange of historical data. Workgroup members agreed to this concept, but also to add the word "current and" before historical.

F. Necessary actions to enable appropriate exchange historical data. (slightly modified)

Workgroup members agreed to this concept, but also to add the word "current and" before historical.

G. Guidance or regulatory changes to CLIA and/or HIPAA that will facilitate clinician access to lab data. (might be modified)

Workgroup members did not object to this concept, noting that they already had agreed to discuss it in more detail. Dr. Kolodner suggested adding something about exploring the preemption of State statutes or patient opt-in.

H. Federally-owned and operated care delivery facilities and labs actions regarding policies, technologies, and HITSP standards for interoperability that will support use of patient-centric exchange of historical data.

Workgroup members did not object to this concept. Dr. Bell said as HITSP standards become available, DOD, VA, the Health Resources and Services Administration, the Indian Health Service, etc., would adopt the HITSP standards for interoperability. Workgroup members agreed to this concept. Col. Harmon said DOD and VA are already doing this. Dr. Bell said she would focus on the alignment part of this.

I. Federal procurement shall support use of HITSP standards for interoperability in patient-centric exchange of historical data.

Workgroup members did not object to this concept, but one Workgroup member emphasized that this concept should not be the backdoor way to insert "must adopt."

J. HITSP standards a condition of reimbursement in the future. (reword)

Mr. Houston said he thought this concept was too draconian. Dr. Worzala suggested coming up with a few options for rewording this based on existing practices and prior experiences.

K. Other Concepts?

Jason Dubois proposed guidance or regulatory changes to HIPAA or State privacy laws.

9. Timeline Discussion

The next topic Ms. Gelinis raised was the timeline. Activities for March were the following:

- (a) Present detailed recommendations to the March 7th Community meeting (those recommendations were discussed at the present meeting)
- (b) Identify policy and privacy issues (begun).

EHR Workgroup members and staff had nearly completed most of their January to March 2006 outcomes by the end of February.

10. Next Steps

Referring to the timeline presented by Dr. Bell (agenda item #6 above), Ms. Gelinis said she and Dr. Perlin had talked about the need to reach some consensus about how to achieve those types of deliverables, so that a first draft of high-level recommendations from the EHR Workgroup would be ready by April 17th; and final recommendations from the EHR Workgroup would be available for distribution to the Community by May 1st. She noted that there were no planned meetings of the EHR Workgroup and no conference calls meeting in April, so it was important to give adequate guidance to ONC staff for meeting the Workgroup's very aggressive time frames.

Dr. Bell suggested that perhaps people from the EHR Workgroup could work with ONC to flesh out the first draft, and then the Workgroup could schedule a full EHR Workgroup meeting the last week of April. Most of the other Workgroups are doing this. There is a Community meeting on April 21st, so perhaps it could be held then; another possibility might be April 24th. Then the EHR Workgroup could proceed with its previously scheduled meeting in May.

Action Item: ONC staff will poll EHR Workgroup members about the possibility of holding another full EHR Workgroup meeting the last week in April to see if one day is better than another.

Update: Meeting scheduled for April 26th, 10:00 am - 12:00 pm EST

Action Item: Following the timeline for recommendations, ONC will work with the EHR Workgroup to develop a letter with the EHR Workgroup's final recommendations for delivery to the Secretary and the Community by May 1, 2006. As a start, ONC staff will do some work off line and use the work of Ms. Yost on CLIA and Ms. McAndrew on HIPAA to develop a draft of high-level recommendations, then run the draft by EHR Workgroup members on e-mail or the Web site until they can be pulled together for a robust discussion.

Update: work has started

11. Public Input

There was only one public comment. A representative from Deloitte and Touche said that they are a major player in the industry and favor the patient-centric model.

**Workgroup on Electronic Workgroup Members
and Designees Participating in the Web Conference**

Dr. Jonathan B. Perlin Co-chair	VA
Lillee Smith Gelinias Co-chair	VHA, Inc.
Kelly Cronin Dr. Karen Bell	ONC/DHHS – Staff Co-chair ONC/DHHS – Staff Co-chair
Dr. David Brailer	ONC/DHHS
Connie Laubenthal (for John Tooker) Dr. Chantal Worzala (for George Lynn) Dr. Carolyn Clancy Jason DuBois (for Alan Mertz) Alan Mertz Howard Isenstein (for Chip Kahn) Dr. Jim Sorace (for Dr. Barry Straube) Col. Bart Harmon John Houston	ACP American Hospital Association AHRQ ACLA ACLA American Federation of Hospitals Centers for Medicare and Medicaid Services DoD National Center for Vital and Health Statistics/ University of Pittsburgh Medical Center
Dr. Rob Kolodner (for Dr. Perlin) Linda Fischetti (for Dr. Perlin) Dr. Blackford Middleton	VA VA Partners HealthCare System/Brigham and Women's Hospital, Harvard Medical School

PRESENTERS

Dr. Scott Young Susan McAndrew Judith Yost Dr. Mark Frisse Dr. Marc Overhage	Agency for Healthcare Quality and Research Office for Civil Rights, DHHS Centers for Medicare and Medicaid Services Vanderbilt University, TN AHRQ grantee Indiana University School of Medicine, Regenstrief Institute, Inc.; IN AHRQ grantee
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