

# **American Health Information Community**

## **Workgroup on Electronic Health Records**

**Summary of the Web Conference Held Wednesday, April 26, 2006  
(4<sup>th</sup> 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**

Lillee Smith Gelinas welcomed everyone to the Web conference and noted that the meeting would go from 10 a.m. to noon. She said that Dr. Robert Kolodner would fill in for Dr. Jonathan Perlin for the first 30 minutes of the meeting.

### **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. The EHR Workgroup is a committee subject to the requirements of the Federal Advisory Committee Act (FACA), and Dr. Bell noted that input from members of the public would be permitted at the end of the meeting.

### **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 March 21 Meeting – Ms. Gelinas**

The minutes of March 21, 2006, Web conference of the EHR Workgroup, which were mailed to Workgroup members on April 6, 2006, were accepted as presented.

### **\*New charge for the EHR Workgroup from the Department of Health and Human Services (DHHS) Secretary**

Ms. Gelinas asked Dr. Bell to describe the additional task that DHHS Secretary Leavitt had added to the EHR Workgroup's broad and specific charges. Dr. Bell explained that Secretary Leavitt had requested that the EHR Workgroup develop recommendations on how to ensure that first responders responding to a disaster or emergency situation, such as Hurricane Katrina, can obtain the critical health information they need electronically. The EHR Workgroup should have recommendations on its general approach and direction with respect to this charge at the May 16 meeting of the Community.

## 5. Review and Discussion of the EHR Workgroup's Draft Recommendations for the Workgroup's Specific Charge Related to Electronic Lab Results – Dr. Bell

One of the most important goals of this Web conference, Ms. Gelinas said, was for the EHR Workgroup to develop a consensus around the content and wording of the Workgroup's recommendations related to the Workgroup's specific charge – the deployment within 1 year of “standardized, widely available, and secure solutions for accessing current and historical laboratory results and interpretations.”

EHR Workgroup members were given a copy of a letter to Secretary Leavitt with draft recommendations from the EHR Workgroup to review. Ms. Gelinas noted that an effort should be made at this meeting to do the following:

- Refine the EHR Workgroup's recommendations to be very clear and concise. Consider feasibility and inclusiveness.
- Pay particular attention to “whom,” both public and private entities, the recommendations are calling to action.
- Ensure recommendation and responsible entity alignment. Merge similar/supporting recommendations to eliminate redundancy. (Ms. Gelinas suggested including a one-page executive summary.)
- Prioritize recommendations for the Community's consideration.

Dr. Bell said she hoped that the discussion at this Web conference would go fairly smoothly because of the many hours of work and effort to develop the draft recommendations. She noted that the ONC staff would modify the recommendations to incorporate the suggestions made at this conference and would continue to revise and seek EHR Workgroup members' comments over the next several days leading up to the EHR Workgroup's next Web conference on May 2.

**ACTION:** The ONC staff will send the modified versions of the recommendations to the Community with EHR Workgroup members for review and comment and additional revisions prior to the EHR Workgroup's next meeting on May 2, 2006.

### A. Recommendations for Reporting Lab Results: Central Focus

**Recommendation 1.0:** The ultimate goal, “pure vision” is patient-centered electronic laboratory results, with a recognition that there is an evolutionary path from current business practices toward that goal. ONC, in addressing the specific charge to the EHR/Lab Workgroup, shall ensure that electronic laboratory data is transmissible in a patient-centric environment, permitting all laboratory results on a specific patient to be available to all authorized providers of care.

#### Questions for discussion:

1. What other stakeholders in addition to ONC can ensure lab result data are available in a patient-centric manner?
2. How can we broaden the “who” responsible for achieving the breakthrough?

#### Discussion

Mr. Houston said that Recommendation 1.0 seemed more like the charge of the EHR Workgroup than a recommendation. Dr. Bell explained that the EHR Workgroup's specific charge is to ensure that historical lab results and interpretations are available and that, in order for ONC to ensure that attention to the flow of historical lab information is a top priority for contractors so the work can be done in the first year, there must be a recommendation to the Community and then to the Secretary.

Mr. DuBois, although agreeing that the “pure vision” of patient-centric electronic lab results is the end goal, stated that getting this recommendation fully implemented as part of the EHR Workgroup’s specific charge in a year is unrealistic. Although a couple of commercial labs might be able to get patient-centric results, provided the resources were available, these labs are the exception. With no agreement on standards, test names, descriptors, etc., it is going to be complex and expensive to get to patient-centric electronic lab results.

Ms. Pure added that even if all the recommendations in the letter to the Secretary Leavitt were implemented, nothing would change in a year. Recommendation 1.0, as written, could be interpreted only as patient centric. She thought the EHR Workgroup was going to try to chunk things up within a year. She believes that the effort will have to begin with a provider-centric focus and that it will take years to get to a patient-centric focus. She does not want to focus so much on the end state that opportunities for some short-term progress are missed.

Dr. Jim Sorace observed that Recommendation 1.0 as written did attempt to recognize an evolutionary path. He believes it is important to state the ultimate goal so that we know that incremental steps to foster adoption and lower costs of interfaces will feed into something that is patient centric.

Mr. Dubois recommended adding the following as stakeholders other than ONC that can ensure that lab result data are available in a patient-centric manner: ONC contractors, the Healthcare Information Technology Standards Panel (HITSP), the Centers for Medicare and Medicaid Services (CMS), Congress, and State governments. He noted that each of these has a role to play to make this recommendation a reality, because of the barriers posed by the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and State privacy laws and regulations that present a barrier to the exchange of information by labs.

**DECISION/ACTION:** The ONC staff and EHR Workgroup members will wordsmith Recommendation 1.0 to make it clearer that patient-centric electronic laboratory results is a goal rather than something that can be fully realized in a year. ONC contractors, HITSP, CMS, Congress, and State governments will be identified as stakeholders in implementing the recommendation.

## **B. Recommendations for Reporting Lab Results: Standards**

**Recommendation 2.0:** HITSP should identify and endorse vocabulary, messaging, and implementation standards for reporting the most commonly used laboratory test results by September of 2006 so as to be included in the Certification Commission for Healthcare Information Technology (CCHIT) interoperability certification.

**Recommendation 2.1:** ONC, in addressing the role of standards to facilitate the exchange of electronic laboratory data, HITSP should recognize and actively promote adoption of those standards endorsed by HITSP as the basis for vocabulary, messaging, and implementation guidance for electronic transmission of laboratory test results.

**Recommendation 2.2:** In carrying out their work, HITSP must consider CLIA options and Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements.

### **Questions for discussion:**

1. Can Recommendation 2.2 be included in 2.0?
2. For Recommendation 2.1, which stakeholders would be targeted for the promoted standards use: laboratories, purchasers, CCHIT?
3. Who are the responsible entities for achieving the breakthrough?

## Discussion

Dr. Kolodner made the following comments with respect to the questions posed:

- Recommendations 2.0 and 2.2, both of which address HITSP's selection of standards for electronic lab information could be combined.
- In Recommendation 2.1, the following additional implementers should be added: payers, providers, patients, and commercial labs.

Ms. Laubenthal made the following comments with respect to the questions posed:

- Recommendations 2.0 and 2.2 could be combined.
- In Recommendation 2.1, include EHR vendors as entities targeted for use of HITSP standards, because not just the senders of electronic lab results but also the receivers of such results will have to adopt the standards.

Mr. DuBois made the following comments:

- Recommendations 2.0 and 2.2 could be combined.
- In Recommendation 2.1, include hospital, commercial, and physician office laboratories as entities targeted for use of HITSP standards.
- One question is how HISTP standards will be implemented. CCHIT, which certifies vendor products, is an important promoter, and once standards are recommended by HITSP, the two parties might marry their standards. The Federal Government might encourage the adoption of standards through the Consolidated Health Informatics initiative. Having the Department of Veterans Affairs (VA), the DHHS, etc. adopt the standards could encourage adoption within the private market. Howard Isenstein agreed that having a huge swath of the Federal Government adopt HITSP standards would encourage adoption and that this should be included in the recommendations. Dr. Bell suggested that perhaps the language about procurement powers and purchasing powers of the Federal Government in the introductory language for this set of recommendations could be moved into the recommendations themselves.

Mr. Isenstein asked whether the Workgroup's recommendations should say that ONC needs to talk to State legislators or governors. Mr. Houston suggested that perhaps Recommendation 2.2 could be deleted, because it is already addressed in Sections 3 and 4. Dr. Bell noted that Recommendation 4.1 addresses legal constraints in State and Federal laws, so some combining might be possible. Ms. Laubenthal emphasized that HITSP must consider currently existing laws and regulations when approving standards. Dr. Sorace added that HITSP should also consider CLIA and Federal standards when approving standards.

Dr. Scott Young reported that the Agency for Healthcare Research and Quality (AHRQ) and ONC are doing some work to try to identify what State laws, regulations, and practices are to inform the discussion. Right now, there is little understanding of how State laws interact with each other and Federal privacy law, CLIA, Patriot Act, etc. Ms. Gelinis asked whether this lack of understanding would preclude action in terms of implementing EHRs. Dr. Sorace said probably not, because even though State laws are very diverse, there could be interstate compacts. He added, though, that there might be specific State laws that would make it difficult to implement lab EHRs in specific States.

Ms. Gelinis suggested the possibility of involving the Southern Governors' Association in helping to address any issues related to State laws. The governors of those States are eager to help, because they recognize that the hurricane season is only 40 days away, and the issue of not being able to exchange information across State lines is going to arise once again if there is a bad hurricane season.

Dr. Bell brought the discussion back to the recommendations on technical standards of vocabulary, messaging, and implementation standards. She said what she had heard so far is that we need to ensure that HITSP is aware of CLIA, HIPAA, and any State laws that affect the technology when doing the standards work. Mr. DuBois agreed that the issue of Federal and State laws would be addressed in the discussion of the next set of recommendations.

Dr. Blackford Middleton suggested that the recommendations specify the year that interoperability standards for patient health information should be available, namely 2007. Dr. Bell concurred that it would be good to add language referring to the interoperability certification process for 2007, noting that a roadmap that includes laboratory interoperability for 2007 had been agreed upon by HITSP in just the past week. Mr. Dubois reported that the implementation guide for EHR-Lab Interoperability and Connectivity Standards (ELINCS) approved, as part of CCHIT, EHR ambulatory certification. Once HITSP gets up and says same thing, the recommendation will come to fruition. Ms. Gelinas asked for ONC to post the information about the roadmap mentioned by Dr. Bell.

**ACTION:** ONC will post the information about the HITSP roadmap that includes laboratory interoperability for 2007 for EHR Workgroup members.

**DECISION:** ONC staff and Workgroup members will combine Recommendations 2.0 and 2.2. In Recommendation 2.1, several additional entities will be added as stakeholders targeted for promoted standards use. Language regarding ways that the Federal Government can help incentivize adoption of HITSP-endorsed standards in the private sector will be moved from the introductory language preceding the recommendations into the body of a recommendation.

### **C. Recommendations for Reporting Lab Results: CLIA/HIPAA Options**

**Recommendation 3.0:** ONC, in addressing the specific charge to the EHR/Lab Workgroup, will seek to address barriers to the flow of laboratory result information from laboratories to persons or entities other than the clinician ordering the test, when access to laboratory results is needed by such persons or entities for legitimate purposes such as disease management or chronic care improvement. Specifically, ONC should seek to resolve those hurdles currently created by CLIA, HIPAA, and State laws.

**Recommendation 3.1:** ONC should work with the National Governors Association and other State-based organizations to resolve variations in “authorized persons” under various State clinical laboratory laws, as a resource for clinical laboratories seeking to define access rights to electronic laboratory data.

**Recommendation 3.2:** CMS should publish CLIA guidance that clarifies the broad definition of authorized parties.

#### **Questions for discussion:**

1. How is Recommendation 3.0 different from Recommendations 3.1 and 3.2?
2. Should we consider broadening/redefining the stakeholders responsible for carrying out these recommendations?

### **Discussion**

Dr. Perlin joined the Web conference and suggested that perhaps Recommendations 3.0, 3.1, and 3.2 might be merged. Mr. Houston agreed. Mr. DuBois, on the other hand, said thought the recommendations addressed different issues.

Mr. DuBois also said he thought that Recommendation 3.2, in relation to CLIA, was a short-term solution to a long-term problem and that it would be unlikely to resolve the barrier. He recommended including a stronger statement about the needs of Federal preemption of the various State privacy laws. Mr. Houston disagreed, stating that preemption is a much longer-term issue and not practical to think about at this juncture. Mr. DuBois countered that including a statement about the need for Federal preemption would be analogous to including a patient-centric focus in the first set of recommendations to help set the direction for future efforts. Mr. Houston stated that if we do what we can regarding authorizations and dealing with authorized parties, we avoid even having to go down the preemption road.

Dr. Bell asked whether there was enough difference between ONC working with the National Governors Association and other State-based organizations, and Federal law or guidance around Federal laws, that the EHR Workgroup could at least break this set of recommendations down into two separate recommendations – one recommendation specific to CLIA guidance and HIPAA, and a second recommendation more specific to State law. Dr. Houston said that he would need to see the language. Dr. Bell said that ONC could work on this internally and get back to EHR Workgroup members that evening with some alternatives for them to provide feedback.

**ACTION:** The ONC staff will reword this set of three recommendations to two new draft recommendations – one recommendation specific to CLIA guidance and HIPAA, and a second recommendation more specific to State law – for the EHR Workgroup’s review later in the day.

Dr. Houston, referring to Recommendation 3.0, asked whether “disease management or chronic care improvement” activities were intended to be specific for individual patients or more generally for population health. He noted that there is substantial concern among patients’ rights advocates about the generalized uses of information absent patient authorization, so if it is for individual patients, that should be noted to defuse potential opposition from patient’s rights advocates that could impede implementation of this recommendation. Dr. Perlin said that he would not want to preclude broader uses of data for public health purposes such as detecting emerging pathogens. Mr. Isenstein suggested putting a period after “for legitimate purposes” and omitting the words “disease management or chronic care improvement.” His suggestion was accepted.

**DECISION:** In Recommendation 3.0, put a period after “for legitimate purposes.”

In Recommendation 3.1, Ms. Laubenthal suggested an editorial change of “State clinical laboratory laws” to “State laws.” This change is needed because a number of authorized persons are actually defined in the medical licensing laws.

**DECISION:** In Recommendation 3.1, change “State clinical laboratory laws” to State laws.”

#### **D. Recommendations for Reporting Lab Results: Privacy and Security**

**Recommendation 4.0:** ONC shall support the development of a national authorization and authentication infrastructure for both patients and health information technology systems users. At a minimum, this system should allow patients to opt in or out of data sharing and to designate a surrogate who could authorize access to their data.

**Recommendation 4.1:** The Workgroup has noted that legal constraints in HIPAA and State laws specify that labs can release data on patients only to the provider who has ordered the test. To address these constraints, the Workgroup recommends that ONC review State and Federal laws

so that policies can be developed to make them more consistent and compatible with sharing laboratory data in a patient-centric manner.

**Recommendation 4.2:** ONC should include in its contract with HITSP incentives to develop or endorse a methodology to match an individual patient to his or her information across multiple systems.

**Questions for discussion:**

1. For Recommendation 4.1, who should be the primary responsible party for carrying out this recommendation?
2. Which groups should carry out Recommendation 4.2: HITSP, the Health Information Security and Privacy Collaboration, others?

**Discussion**

Dr. Bell began the discussion by introducing two people who had joined the Web conference: Jodie Daniel, the Director of the Office of Policy and Research in ONC, with a strong background in HIPAA, and Katy Barr, the new Executive Director of the American Health Information Community.

Noting that all four Workgroups were focusing on the same issues of privacy and security, Dr. Bell proposed establishing a short-term ad hoc Workgroup made up of members of the four existing Workgroups and experts in privacy and security to develop recommendations to take the place of separate recommendations on these topics by the four Workgroups (EHR, Consumer Empowerment, Chronic Care, and Biosurveillance). The purpose of the ad hoc workgroup on Privacy and Security would be to ensure that the approaches to privacy and security issues recommended to the Community and ultimately to Secretary Leavitt are harmonized and unambiguous.

Dr. Houston said he thought establishing an ad hoc workgroup on Privacy and Security such as that proposed by Dr. Bell would be beneficial. He also agreed to serve on such a Workgroup. In addition, he noted that the National Committee on Vital and Health Statistics (NCVHS) is about to release a document related to privacy in the national health information network that will be of value to this proposed workgroup.

Mr. Isenstein said he supported Dr. Bell's proposal and agreed to serve on an ad hoc workgroup on Privacy and Security. He suggested coming up with the language for the recommendation and then holding a conference call with all the Workgroups to review that language. Dr. Bell said that the ONC staff could work through the logistics.

Dr. Perlin indicated that he supported Dr. Bell's proposal because it would help to cross-fertilize and coordinate some of the recommendations of the four Workgroups, thereby accomplishing one of the metatasks of the Workgroups.

**DECISION:** The EHR Workgroup supports the idea of establishing an ad hoc workgroup on Privacy and Security, with members from all four workgroups and experts in privacy and security, to harmonize and coordinate privacy and security recommendations to the Community and to Secretary Leavitt. Dr. Houston and Mr. Isenstein will represent the EHR Workgroup on the new ad hoc workgroup.

**ACTION:** The ONC staff will work on the logistics of establishing the ad hoc workgroup on privacy and security.

Mr. Dubois identified two issues, with associated liability concerns, that he would like the ad hoc workgroup on Privacy and Security to address. First is the potential, in the absence of a unique patient

identifier, for mismatching patients with misspelled names, maiden names, etc. The other is the idea of allowing patients to opt-in or opt-out of data sharing; the reality is that patients may need to be able to opt-in and opt-out on a treatment-by-treatment basis to protect their privacy. Dr. Bell said that by the end of the day, she would have a list of all the privacy and security issues that have come out of all four of the Workgroups. She would share that list with members of the EHR Workgroup so that they could see whether it captured all of the issues they wanted addressed.

**ACTION:** By the end of the day, the ONC staff will share a list of privacy and security issues that have come out of all four Workgroups so that they can review it for accuracy and completeness before it is given to the Ad Hoc Workgroup on Privacy and Security.

## **E. Recommendations for Reporting Lab Results: Assessment, Monitoring, and Research**

**Recommendation 5.0:** AHRQ should develop a proposed study methodology to measure the extent and effectiveness of the adoption of the first stage of HITSP standards, as well as the adoption and utilization of aggregated patient-centric data as they become available.

**Recommendation 5.1:** AHRQ should research best practices in the implementation and utilization of patient-centric laboratory data stores and how to disseminate this knowledge.

### **Question for discussion:**

1. Are there additional areas that need to be assessed, monitored, or studied to achieve the goal of patient-centered laboratory results data availability?

### **Discussion**

Dr. Bell had noted that Dr. Young and Dr. Middleton had to leave the Web conference early and suggested that the EHR Workgroup consider the fifth set of recommendations related to assessment, monitoring, and research, but by the time the Workgroup got to these items, Dr. Young and Dr. Middleton already had left. Dr. Bell said she would work with them offline and share the results with Workgroup members online in the next few days.

**ACTION:** The ONC staff and EHR Workgroup members will consult with Dr. Middleton and Dr. Young offline on the issues and recommendations pertaining to assessment, monitoring, and research and share the results with Workgroup members online prior to the next EHR Workgroup meeting.

## **6. Timeline Discussion**

The timeline for the EHR Workgroup is as follows:

- Today: Finalize recommendations
- Week of April 24: Workgroup completes and reviews recommendation letter
- No later than May 1: Finalized recommendations available for distribution.

## **7. Review and Discuss Outstanding Issues and the Workgroup's New Charge**

Ms. Gelinas introduced this session by explaining that the EHR Workgroup should consider three outstanding issues that came up in comments from EHR Workgroup members during the process of vetting the draft letter and recommendations to the DHHS Secretary pertaining to the Workgroup's specific charge:

- Whether standardization of laboratory test ordering is necessary
- How to address physician office lab equipment

- What, if any, incentives are needed
- The DHHS Secretary's new charge for the Workgroup to ensure that critical information needed by first responders to people in a disaster or emergency situation is electronically available.

**Need for standardization of laboratory test ordering?** Dr. Bell explained that the question is whether the EHR Workgroup needs to craft a separate recommendation on the standardization of lab test ordering (as opposed to reporting). Mr. DuBois reported that for ELINCS, a decision was made to focus on standardizing lab results information and to get that done right before moving on to standardizing lab test ordering information. Dr. Bell asked whether the lack of standards for lab test ordering would be a barrier to realizing the EHR Workgroup's specific charge. Mr. Dubois said this would not be a barrier for the realization of the specific charge, although the standardization of lab test ordering would be part of the overall evolutionary efforts toward the EHR Workgroup's broader charge. Dr. Bell said that she would not include the standardization of lab test ordering in the EHR Workgroup's recommendations to the Secretary Leavitt in May but would mention this issue as part of the overall evolutionary process in the draft letter to the Secretary.

**DECISION/ACTION:** The ONC staff will characterize the standardization of lab test ordering as being part of evolutionary process toward broader goals within the context of the EHR Workgroup's letter to the Secretary Leavitt. There will not be a specific recommendation on this topic from the EHR Workgroup at this time.

**Need to address physician office laboratory equipment?** Ms. Laubenthal explained that there is a wide variety of physician offices – from 160-physician group practices that have complex, hospital-like labs to solo practitioners that do everything manually and use only test “kits” or systems (like pregnancy or occult blood kits). The question is whether this issue should be addressed in the EHR Workgroup's recommendations. Dr. Perlin said that if we reflect on what is doable in a year, this is a place to make inroads by coming to some degree of standardization and then approaching people to offer them consistency. Dr. Sorace stated that the first thing is to get standards for reporting a test to an EHR at all; the second thing is to think about how to roll out LOINC and other codes by working with manufacturers. These are longer-term issues, not issues that can be addressed in a year. Mr. DuBois concurred. Dr. Bell said she would address this issue as part of the evolutionary process in the letter to the DHHS Secretary.

**DECISION/ACTION:** The ONC staff will characterize the issue of physician lab equipment as being part of evolutionary process toward broader goals within the context of the of the EHR Workgroup's letter to the Secretary Leavitt. There will not be a specific recommendation on this topic from the EHR Workgroup at this time.

**Need for incentives?** Dr. Bell noted that one of the suggestions that arose in the vetting process was that incentives be provided for labs, providers, and patients. She asked, “Do Workgroup members think that incentives are absolutely necessary for the adoption process to be successful?” Several Workgroup members answered that incentives are necessary. Ms. Gelinas said that if the EHR Workgroup makes recommendations without incentives and adoption strategies, they are not going to go anywhere. Ms. Laubenthal and Mr. DuBois agreed.

Dr. Perlin suggested that incentives should be provided for labs, providers, and payers (rather than patients, as originally had been suggested). Other Workgroup members agreed that this change was appropriate.

Mr. DuBois noted that he previously had commented that there should be incentives to both physicians and labs related to lab test ordering (e.g., an add-on payment for physicians whose health requisition is

transmitted using ambulatory EHRs that incorporate HITSP-identified standards – labs would benefit indirectly from more accurate test requisition, reduced administrative burdens, etc.). He suggested that incentives might be similarly offered for lab test results (e.g., reimbursement to labs for sending information electronically to Medicare disease management projects).

Dr. Bell explained that one of the suggestions that arose in the vetting process that was listed in the materials handed out to EHR Workgroup members was the following: “CMS should charter a group to do a full analysis of the capital expenditure mapped to the market segment that will reap the financial benefits.” She suggested changing this to a recommendation that somewhere within the DHHS, a full analysis be done of the business case associated with the proposal. Then the EHR Workgroup could recommend that the incentives related to adoption be based on what is learned in the business case analysis. Workgroup members agreed that this was a good idea. Dr. Bell said that the ONC staff would draft a preliminary recommendation from the EHR Workgroup on incentives and circulate it for review.

**DECISION/ACTION:** The ONC staff will draft a preliminary recommendation from the EHR Workgroup on incentives for labs, providers, and payers and circulate it for review. The recommendation will suggest that the DHHS do a full analysis of the business case associated with the EHR Workgroup’s proposal for realizing its specific charge and that incentives related to adoption be based on what is learned in the business case analysis.

Finally, Mr. DuBois made a comment about the draft letter to Secretary Leavitt from the EHR Workgroup that had been circulated. Noting that without physician authorization or a law, labs are not permitted to provide results to other entities, Mr. DuBois recommended rephrasing the sentence in the second paragraph on page 3 (in bold italics) that says, “Labs will only provide results to the ordering clinician” to say “labs are legally obligated to provide results to the ordering clinician.” Dr. Bell agreed to fix this sentence and asked anyone else with comments on the basic text to let ONC know, please.

**ACTION:** The ONC staff will modify the second paragraph of page 3 of the letter to the DHHS Secretary to say, “Labs are legally obligated to provide results to the ordering clinician.”

**How should the EHR Workgroup approach its new charge related to electronic health information for first responders?** Finally, the EHR Workgroup discussed the new charge for the Workgroup from the DHHS Secretary to ensure that the necessary health information that first responders need when attending to people in a disaster or emergency situation can be made available electronically.

Dr. Bell explained that the goal for the EHR Workgroup at this meeting was to agree on an approach for addressing the new charge. Addressing the charge, she suggested, involves two steps: (1) defining elements of information (e.g., medications) that are critical for first responders with appropriate input from public and professional societies, and (2) addressing the issues necessary to make that critical information electronically available to first responders. She noted that Alicia Bradford from ONC had put together a set of slides to facilitate the EHR Workgroup’s discussion of the topic.

Ms. Gelinas said she is particularly interested in this charge as a native New Orleanian. She emphasized that this issue is very big for the Gulf States, and with the next hurricane season nearly upon us, it is essential to act quickly.

Dr. Perlin agreed that the issue of preparedness for the upcoming hurricane season is very important and that the presentation from the Southern Governors’ Association had driven that point home. He also reported on the experience of the VA Medical Center and the Armed Forces Retirement Home in Washington, DC, both of which received Katrina evacuees from the Gulf Coast. Having electronic

records of health history, medications, etc., for VA patients was extremely helpful, but some of the veterans in the Armed Forces Retirement Home never had been to a VA medical center, so they did not have electronic records. He noted that a patient's prescription history gives a fair amount of insight into a patient's health needs.

Dr. Bell noted that the EHR Workgroup could devote quite a bit of time to this issue at the next Workgroup meeting on May 2 and come up with some recommendations for May 16 Community meeting. She suggested that the EHR Workgroup might invite representatives of first responders both within and external to the Federal Government (e.g., the American College of Emergency Room Physicians, the American Ambulance Association) to help specify what critical elements of information should be available to first responders in the event of a catastrophe or emergency. This would enable the Workgroup to present the critical elements of information to the Community on May 16 and to present recommendations on how to make them available to first responders at a subsequent meeting of The Community.

Ms. Gelinas said that in discussions in the private sector, the three critical elements that have been discussed are (1) medication history, (2) allergy history, and (3) major diseases (e.g., diabetes).

Dr. Perlin said that the elements laid out by Ms. Gelinas are probably the most salient, adding that he would hope that the EHR Workgroup would be able to get greater insight into and agreement on what medications, allergies, and diseases are really the most useful as core elements. The other piece of the charge, Dr. Perlin noted, is how to make the critical information available this summer in real time. Dr. Bell indicated that both these tasks should be addressed at the EHR Workgroup meeting on May 2.

**ACTION:** At its May 2, 2006, meeting, the EHR Workgroup will develop recommendations for the core elements of information that should be available to first responders and a process for making the critical information to first responders this summer.

## **8. Public Comments**

There were no public comments. The following e-mail address was left up for half an hour to enable members of the public to send in any comments they might have: [ehlthrecrods-wkg@hsrnet.com](mailto:ehlthrecrods-wkg@hsrnet.com).

## **9. Conclusion**

Dr. Perlin and Ms. Gelinas thanked EHR Workgroup members for their insights, recommendations, and hard work. They noted that Dr. David Brailer has resigned as the National Coordinator for Health Information Technology.. They thanked him for his leadership and said it was hard to imagine that anyone could have had better vision and focus in getting Workgroups together. Dr. Bell added that Dr. Brailer wanted very much to be part of the next EHR Workgroup's call on Tuesday, May 2, at which the Workgroup would sign off on the letter and recommendations to the Secretary Leavitt and focus on the Workgroup's new charge related to making critical health information electronically available to first responders in a disaster or emergency.

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

Dr. Jonathan B. Perlin  
Co-chair

VA

Lillee Smith Gelinias  
Co-chair

Veterans Health Administration, Inc.

Dr. Karen Bell  
Staff Co-chair

ONC/DHHS

**Members:**

Jason DuBois (for Alan Mertz)

American Clinical Laboratory Association

Linda Fischetti (Dr. Jonathan B. Perlin)

VA

John Houston

Howard Isenstein (for Chip Kahn)

American Federation of Hospitals

Dr. Rob Kolodner (Dr. Jonathan B. Perlin)

VA

Connie Laubenthal (for John Tooker)

American College of Physicians

Dr. Blackford Middleton

Health Information and Management Systems Society

Pam Pure

McKesson Provider Technologies

Dr. Jim Sorace (for Barry Straube)

CMS

Dr. Scott Young (for Carolyn Clancy)

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Kathryn Barr

ONC/DHHS

Alicia Bradford

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