

American Health Information Community
Workgroup on Electronic Health Records
Summary of the Web Conference Held Tuesday, July 25, 2006
(7th Web Conference of This Workgroup)

PURPOSE OF MEETING

The July 25, 2006, meeting of the Electronic Health Record (EHR) Workgroup (EHRWG) chaired by Jonathan Perlin and Lillie Gelinias had three major objectives:

1. Approve an EHRWG recommendation related to first-responder EHRs for presentation to the American Health Information Community (the Community) at its meeting on August 1, 2006.
2. Get updates on the current status of activities in several important health information technology infrastructure realms.
3. Prioritize components of the workplan for accomplishing the EHRWG's broad charge related to achieving broad adoption of certified EHRs. Identify actions/tactics for achieving them. Lay out an agenda for future public hearings and start identifying potential speakers.

Dr. Perlin reported that he had resigned as under secretary for health at the U.S. Department of Veterans Affairs (VA) and therefore would be resigning as Co-chair of the EHRWG. Ms. Gelinias and Dr. Karen Bell thanked Dr. Perlin for his contributions. Ms. Gelinias informed the group that a new Co-chair would be appointed shortly. Judith Sparrow, the newly appointed executive director of the Community, was introduced and noted that she would e-mail EHRWG members a four-page summary of Federal Advisory Committee Act (FACA) requirements after the meeting.

KEY TOPICS

1. EHRWG's Emergency Responder EHR Recommendation

The EHRWG's charge for emergency responder EHRs is as follows: *Make recommendations to ensure that the critical health information that first responders need when attending to people in a disaster or emergency situation can be made available electronically.*

The EHRWG had agreed at its previous meeting that the Office of the National Coordinator for Health Information Technology (ONC) staff would develop a draft recommendation to the Community with respect to the Health Information Technology Standards Panel's (HITSP) development of a harmonized set of standards for emergency responders, so that the EHRWG could come to consensus on the recommendation and present it to the Community on August 1, 2006. John Loonsk from ONC presented the following draft recommendation to the EHRWG:

Draft Emergency Responder Use Case Recommendation: Under the leadership of the Office of the National Coordinator for Health Information Technology (ONC), an emergency responder use case should be developed and prioritized for the attention of HITSP and the other ONC initiatives. The use case should describe the role for emergency responder EHRs, including a patient summary record that can be used to support emergency and routine health care activities.

Ms. Gelinas expressed concern that the EHRWG had not made enough progress in advancing its emergency responder EHR charge during the past 6 months. John Houston recommended adding specific milestones to the recommendation to specify the time frame for implementation. Dr. Carolyn Clancy recommended that the phrase “patient summary record” should be replaced, so that it would not seem so broad. Dr. Perlin noted that the EHRWG had received testimony that critical elements to include in an emergency responder EHR are demographic information, medications, allergies, and principal diagnoses. The following action item was agreed upon:

Staff Action Item #1: The ONC staff will redraft the EHRWG’s emergency responder EHR recommendation shortly after the meeting and will send the revised draft to all EHRWG members for review, comment, and signoff, so that the EHRWG Co-chairs can present the final recommendation to the Community at its meeting on August 1, 2006. The new recommendation will include a timeline and specific elements discussed as critical factors of an emergency responder EHR.

2. Updates on Important Health Information Technology (HIT) Infrastructure Activities

In 2005, David Brailer, the National Coordinator for Health Information Technology, indicated that advances in the following five areas should complement breakthroughs in the areas of biosurveillance, consumer empowerment, chronic care, and EHRs (the areas covered by the four workgroups of the Community): (1) HIT adoption, (2) the National Health Information Network (NHIN), (3) certification of EHR products, (4) privacy/security, and (5) standards harmonization. Updates on developments in the first four of these infrastructure areas were presented to EHRWG members and are summarized below.

A. HIT Adoption Studies for ONC

David Blumenthal and Sarah Rosenbaum reported that they have produced the following for ONC: (1) a simple conceptual model of factors that influence HIT adoption; and (2) an environmental scan of the literature on rates and levels of HIT adoption, the results of which have been submitted as a paper for publication.

Conceptual Model of Factors That Influence HIT Adoption. The conceptual model posits that the factors that influence HIT adoption are of four general types:

- ***Financial factors:*** (a) factors hindering adoption (lack of business case for performance, lack of business case for EHR adoption) and (b) incentives for adoption (pay for performance, public reporting of performance, pay for use of EHR, small

grants or low-interest loans, in-kind assistance, performance standards).

- ***Factors related to the state of technology (ease of use and standardization):*** (a) factors hindering adoption (lack of interoperability, lack of interconnectedness even within organizations) and (b) incentives for adoption (standards for interoperability, product certifications, and support for Regional Health Information Organizations).
- ***Organizational factors:*** (a) factors hindering adoption (lack of accountability for quality, lack of trained workforce in many organizations, timidity among leaders, lack of size, availability of surplus or capital) and (b) incentives for adoption (internal reporting requirements, workforce training certification, training of health care leaders, assistance to small providers, assistance to safety net providers).
- ***Legal and regulatory factors that weigh on providers following HIT adoption:*** (a) factors hindering adoption: (legal questions related to the adoption process such as “Stark” and related fraud considerations, antitrust; legal consequences that come from information transparency and broader information use; and legal consequences related to custodial control of large volumes of data – privacy and security, liability considerations) and (b) incentives for adoption (Stark law modifications, Health Insurance Portability and Accountability Act clarifications).

Literature on Rates and Levels of EHR Adoption. Understanding EHR adoption levels and rates is critical, but efforts to develop good estimates are limited by the quality of available survey data and by the lack of a single definition of what constitutes an EHR. Dr. Blumenthal and Ms. Rosenbaum identified all of the published and unpublished surveys on the rates and levels of EHR adoption since 1995. Using a rating scheme developed with the assistance of an expert consensus panel, they then assessed the quality of the surveys’ methods and content. Their results have been submitted for publication. One of their findings is that the percentage of physicians reporting a minimum set of required features are using an electronic medical record with a minimum set of required features is much higher among physicians in groups of 11 or more (21 percent) than among solo practitioners (4 percent).

B. Functional Requirements for the NHIN

Dr. Loonsk reported that in late June 2006, ONC held the first public NHIN Forum to identify and catalogue the list of functional requirements for the NHIN. Functional requirements for network systems are brief, verifiable, declarative statements of what a system and its components must do or the actions they must take (e.g., locate, transmit, retrieve). A combined list of more than 1,100 functional requirements developed by the four consortia working on prototype architectures for the NHIN was discussed at the June meeting. A working group of the National Center for Vital and Health Statistics is going to produce a harmonized list of these functional requirements and identify architectural variations by September 2006. The next public forum for the NHIN will be held in mid-October and will focus on security and systems issues. A third NHIN forum is tentatively scheduled for mid-January, where prototype architectures for the NHIN developed by the four consortia will likely be presented.

C. Certification of the First Batch of Ambulatory EHR Products

Dr. Bell reported that Secretary Leavitt recently announced that the Certification Commission for Healthcare Information Technology (CCHIT) had certified the first batch of

ambulatory EHR products. EHR products must comply with more than 280 different criteria for functionality, interoperability, and security to gain CCHIT certification. Thus, CCHIT certification offers purchasers of certified EHR products assurance that the products include a baseline of critical features. The list of EHR products that are certified is available on the CCHIT Web site: www.CCHIT.org. More certified EHR products will be named at the end of July, and as more interoperability standards become available, they will be incorporated in future certifications. Although ease of use of EHRs for physicians and implementation issues raised by Mr. Houston and other physicians still need to be addressed, Dr. Bell said the certification of the first batch of EHR products is a huge step forward for ONC, physicians, and the industry.

D. Establishment of a New Confidentiality and Security Workgroup

Kelly Cronin from ONC explained that the new Confidentiality and Security Workgroup, which will be a full subcommittee under the Community whose work will crosscut that of the four existing workgroups, is in the process of being formed. ONC expects to have the members (many of whom come from existing workgroups) and Co-chairs of the new workgroup finalized by the end of the first week of August 2006. The ONC staff will work closely with the Co-chairs to determine what specific issues the new workgroup will tackle and in what order. Many of the issues the workgroup will address are contentious and complicated. The plan is to have full-day public meetings with ample testimony from key stakeholders including clinicians, consumers, and technology experts. The first public meeting will be held in August or September.

5. Prioritization of Components in the Workplan for Accomplishing the EHRWG's Broad Charge

The EHRWG's broad charge is as follows: *Make recommendations to the Community on ways to achieve widespread adoption of certified EHRs, minimizing gaps in adoption among providers.* Dr. Bell asked for discussion from EHRWG members on how best to move forward on two deliverables due in December 2006:

- A prioritized list of elements on which HITSP and ONC contractors should focus
- Objectives, tactics, and strategies to remove barriers to EHR adoption or provide incentives for EHR adoption.

EHRWG members began the prioritization process using the "Goals, Objectives, and Strategies" document prepared by the ONC staff. The discussion and decisions that were made are summarized below. Because time ran out, it was decided to continue the EHRWG's discussion of priorities at the workgroup's next meeting. Colonel Bart Harmon offered to begin the subsequent discussion with a presentation about the approach employed by the Department of Defense (DOD) and VA to get users to prioritize their information needs.

Staff Action Item #2: The agenda for the August 15, 2006, EHRWG meeting will include (a) continued discussion of how to prioritize elements of the EHRWG's plan to achieve its broad charge and (b) testimony from Colonel Harmon about how DOD and the VA have involved users in prioritizing their information needs.

The EHRWG discussed the following goals and objectives:

GOAL #1: INFORM HEALTH CARE PROFESSIONALS

Objective 1.1: High-value EHRs: It was agreed that one priority related to this objective should be addressing the needs of clinicians and making EHRs valuable, useful, and easy to use.

Objective 1.2: Low-cost and Low-risk EHRs: It was agreed that priority should be placed on developing a business model for EHRs, including clinicians' initial capitalization needs and a system for reimbursement from public and private payers. In addition, it was agreed that the EHRWG would obtain some public testimony on current concerns about some of legal issues discussed as barriers to HIT adoption during the presentation by Ms. Rosenbaum and Dr. Blumenthal.

Staff Action Item #3: For the EHRWG's September 2006 meeting, the ONC staff will line up testimony on the following topics: (a) how to make EHRs valuable to clinicians, (b) developing a business model for EHRs for health care professionals, and (c) addressing legal/liability barriers to EHR adoption by physicians. If it makes sense to the ONC staff, they will use the four categories of barriers and incentives in Dr. Blumenthal and Ms. Rosenbaum's presentation to structure the testimony.

GOAL #4: IMPROVE POPULATION HEALTH

Objective 4.4: Health Information Support in Disasters and Crises: Although EHRWG members previously agreed that Goal #4: Improve Population Health is not a critical component of the EHR Workgroup's plan for accomplishing its broad charge, Ms. Gelinas pointed out that Objective 4.4: *Health Information Support in Disasters and Crises* is closely linked to the EHRWG's charge related to emergency responder EHRs. For that reason, it was agreed that the ONC staff also would solicit public testimony pertaining to this objective for the EHRWG's August and September meetings.

Staff Action Item #4: For the EHRWG's September 19, 2006, meeting, the ONC staff will line up testimony related to Objective 4.4: Health Information Support in Disasters and Crises.

C. SUMMARY OF ACTION ITEMS

Staff Action Item #1: The ONC staff will redraft the EHRWG's emergency responder EHR recommendation shortly after the meeting and will send the revised draft to all EHRWG members for review, comment, and signoff, so that the EHRWG Co-chairs can present the final recommendation to the Community at its meeting on August 1, 2006. The new recommendation will include a timeline and specific elements discussed as critical factors of an emergency responder EHR.

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Staff Action Item #4: For the EHRWG's September 19, 2006, meeting, the ONC staff will line up testimony related to Objective 4.4: Health Information Support in Disasters and Crises.

Workgroup on Chronic Care
Members and Designees Participating in the Web Conference

Dr. Jonathan B. Perlin <i>Co-chair</i>	Department of Veterans Affairs
Lillee Smith Gelinas <i>Co-chair</i>	VHA, Inc.
Dr. Karen Bell <i>Staff Co-chair</i>	ONC/DHHS
Dr. Carolyn Clancy	Agency for Healthcare Research and Quality
Jason DuBois (for Alan Mertz)	American Clinical Laboratory Association
Lt. Col. Bart Harmon	Department of Defense
John Houston	National Committee on Vital and Health Statistics
Howard Isenstein (for Chip Kahn)	American Federation of Hospitals
Dr. Blackford Middleton	Health Information and Management Systems Society
Daniel Morreale (for George Lynn)	American Hospital Association
Pam Pure	McKesson Provider Technologies
Dr. John Tooker	American College of Physicians
Ken Waldbillig (for Mark Lewis)	EMC Corporation

ONC Staff

Kelly Cronin, Director, Office of Programs and Coordination
Dr. John Loonsk, Director, Office of Interoperability Standards
Judith Sparrow, Executive Director, American Health Information Community
LCDR Alicia Bradford, Office of HIT Adoption

Presenters:

David Blumenthal, Institute of Health Policy, Mass General Hospital, Harvard Medical School
Sarah Rosenbaum, George Washington University

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