

# American Health Information Community Workgroup on Electronic Health Records

## Summary of the Web Conference Held Tuesday, September 19, 2006 (9th Web Conference of This Workaroup)

### PURPOSE OF MEETING

The purpose of the September 19, 2006, meeting of the Electronic Health Record Workgroup (EHR WG) was to advance progress on the workplan for the workgroup's 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.*

The primary objectives of the present EHR WG meeting, chaired by Ms. Lillie Gelinas and Dr. Jonathan Perlin, were the following:

1. Discuss adding a new Department of Veterans Affairs (VA) member to EHR WG given that Dr. Perlin has moved from the VA to the private sector.
2. Begin to prioritize elements in the *state of the technology domain* of the EHR WG's workplan for accomplishing its broad charge.
3. Prioritize the four domains of the EHR WG's workplan for accomplishing its broad charge: (1) *state of the technology*; (2) *financial*; (3) *organizational*; and (4) *legal/regulatory*.
4. Hear testimony on legal/regulatory domain issues from Professor Nicolas Terry, a law professor at St. Louis University, and from Mr. Tom Leonard, McKesson Corp.

### KEY TOPICS

#### **Adding a New Member to the EHR WG from the VA**

Ms. Gelinas explained that the EHR WG needed a new representative from the VA, because Dr. Perlin had recently left the VA to join the private sector. EHR WG members agreed that Ms. Linda Fischetti, a nationally recognized nurse informaticist from the VA, would be a great asset as the VA's new representative to the workgroup. Ms. Fischetti reported that the VA was considering a potential representative and would present names by the EHR WG's October meeting.

#### **Prioritizing Elements in the State of the Technology Critical Component of the EHR WG's Plan for Achieving its Broad Charge**

EHR WG members were asked to begin prioritizing a draft list of elements pertaining to the *state of the technology* critical component of the EHR WG's plan for achieving its broad charge. In response to a comment that the draft list of elements pertaining to the state of the technology seemed to be "mixing apples and oranges," the EHR WG decided to cluster the elements in two buckets: (1) one with the critical data elements that health

care providers want in an EHR; and (2) one with key policy considerations related to developing the architecture and framework to provide that information (which might be considered with the financial or regulatory domains) (see table below).

<b>Elements Related to the State of the Technology for EHRs</b>	
<b>1. Clinical Data Elements Providers Want in an EHR</b>	
<i>Element</i>	Related policy or technical issues
1. Information that identifies the patient	Need policy ensuring standard and interoperable mechanisms for reliable and valid identification of patients.
2. Medication list & medication allergies	
3. Lab results	
4. Problem list	
5. Clinical encounters/notes	
6. Anatomic pathology results	
7. Vital signs	
8. Radiology text reports (NOTE: eventually would hope to have images)	
9. Family history and health factors	
10. Immunizations (?)	
11. Data needed by emergency responders (prehospital emergency responders and hospital emergency departments) [Add]	
<b>2. Policy Considerations</b> (consider these with Financial or Legal/Regulatory Domain?)	
<ol style="list-style-type: none"> <li>1. Pay for use</li> <li>2. Pay for performance</li> <li>3. Stark/anti-kickback</li> </ol>	

Referring to the list of data elements that health care providers want, Dr. Perlin noted that effective and secure identification of patients was a necessary first priority. Ms. Gelinas emphasized that the data needs identified by emergency responders at the EHR WG's May 2, 2006, meeting, should be considered a priority.

EHR WG members agreed to resume their discussion of the prioritization of data elements that physicians want in an EHR at the October 13, 2006, meeting. They will also identify specific policies needed to ensure the availability of specific data elements. In the meantime, ONC staff will ensure that the list includes all the elements in the VA/Department of Defense list presented by Col. Harmon at the EHR WG's August meeting.

**Staff Action Item #1: The EHR WG will resume its discussion of the state of the technology at its October meeting. ONC staff will ensure that the list of data elements that physicians want encompasses the VA/Department of Defense list presented by Col. Harmon at the August meeting. They will also ensure that the list also includes data previously identified as being needed by first responders in disasters**

(prehospital emergency responders and hospital emergency departments).

### **Prioritizing the Four Critical Components of the EHR WG's Plan for Achieving its Broad Charge**

EHR WG members were asked to prioritize the four domains related to achieving the EHR WG's broad charge: (1) *state of the technology*; (2) *financial*; (3) *organizational*; and (4) *legal/regulatory*.

The EHR WG agreed to make financial factors related to the achievement of its broad charge the next priority. Members emphasized that financial factors include factors hindering the adoption of EHRs (e.g., lack of a business case for EHR adoption, lack of a business case for performance) and factors providing incentives for adoption (e.g., pay for performance, pay for use of EHRs, performance standards, grants or loans). Financial factors for physicians (including up-front costs of acquisition, costs of practice transformation, loss of productivity, sustaining over time, etc.) were discussed at the EHR WG's August meeting, but financial factors for hospitals and other entities also need to be considered.

Ms. Kelly Cronin suggested that two sources of background information would be useful for EHR WG members: whatever evidence there is of successes in building in pay-for-performance and other types of incentives for EHR adoption and use; and ONC policy options papers with levers to help change the business case for EHR adoption. Ms. Cronin and Dr. John Tooker also volunteered to help identify individuals to make presentations pertaining to financial factors at the EHR WG's October meeting. These presentations would serve to help members understand this domain better so that they can craft the EHR WG's recommendations to The Community.

**Staff Action Item #2: Financial factors related to the widespread adoption of EHRs will be a priority topic for discussion at the EHR WG's October meeting. ONC staff will prepare relevant background materials and will work with Dr. Tooker and other EHR WG members to identify people to make presentations that will help inform the EHR WG about the topic.**

### **Testimony on Legal/Regulatory Factors Related to the EHR WG's Plan for Achieving its Broad Charge**

#### ***A. Legal Factors That May Inhibit the Adoption of EHRs—Professor Nicolas Terry, St. Louis University***

Professor Terry discussed the “medical-legal issues” that pose challenges to the widespread adoption and use of EHRs. Despite these issues, Dr. Terry pointed out that he strongly supports the rapid introduction of health information technology (HIT) into

the U.S. health care system to reduce errors, improve efficiency, and better involve patients in the healthcare process.

Professor Terry first addressed four clusters of medical-legal issues related to EHRs: (1) issues related to architecture; (2) issues related to state records laws; (3) issues related to adoption transition; and (4) issues related to general liability. In each of these realms, he raised numerous examples of the types of issues that pose challenges to the adoption and use of EHRs.

Professor Terry then addressed the more complex privacy, confidentiality, and security issues related to EHRs. He explained that interoperable EHRs differ from paper medical records in that paper records are in locked filing cabinets in individual silos; in contrast, interoperable EHRs are premised on the aggregation of these silos, and common data standards. These highly sophisticated data mining tools are designed to improve usability and maximize the return on EHR investments. The intent is to make EHRs available to all health care providers, even those tangentially related; security will be equivalent to the weakest link. Furthermore, the data in EHRs will be coveted by commercial aggregators and secondary users. Professor Terry believes that the Health Insurance Portability and Accountability Act (HIPAA) is entirely inadequate to deal with current privacy issues, let alone those that come up with interoperable EHR.

In 2005, Professor Terry testified before the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Privacy and Confidentiality in San Francisco. He and a colleague subsequently wrote an article with specific proposals about what they think is an appropriate privacy/confidentiality model for interoperable EHRs. Professor Terry said he would be happy to make that article, soon to be published in the *University of Illinois Law Review*, available to the EHR WG, as well as to the newly formed Confidentiality, Privacy, and Security Workgroup.

**Staff Action Item #3: ONC staff will obtain the article “Ensuring the Privacy and Confidentiality of Electronic Health Records” by Nicholas Terry and Leslie Francis that is soon to be published in the *University of Illinois Law Review* and make it available to members of the EHR WG and the newly formed Confidentiality, Privacy, and Security Workgroup.**

### Questions & Comments.

Following Professor Terry’s presentation about the legal disincentives or barriers to the adoption and use of EHRs by health care providers, Dr. Perlin asked: Are the liabilities of the incomplete information and sharing of information in its paper form not greater in terms of cumulative liability than EHR? Is the problem insurmountable? Professor Terry replied that he believes that improvements in patient safety that come out of HIT will eventually overwhelm any new issue arising from new technologies, but in the short term, there are some additional risks. And in the case of privacy risks, the stakes go up both because of the vast amount of data that will be available in interoperable EHRs and because of the fact that the data are coveted by many entities other than physicians.

To move forward on the HIT front, given all these challenges, Professor Terry recommended two steps: (1) minimize potential perceptions of harm (e.g. reassure patients that making it clear as a matter of law that data can only be distributed to medical care professionals who are involved in the circle of care for that patient; reassure health care providers by saying that as a matter of law health care providers may not provide data to, for example, drug companies); and (2) maximize legal protections (e.g., vastly expand HIPAA to make it a national protective device; empower patients to secure information that they do not want spread around).

Dr. Houston reported that NCVHS had written a thoughtful letter on privacy to HHS Secretary Leavitt in June 2006 that incorporated much of testimony NCVHS had heard over a year and a half. Dr. Houston recommended that ONC staff make the letter available to members of the EHR WG and newly formed Confidentiality, Privacy, and Security Workgroup. The letter is available on the NCVHS Web site ([www.ncvhs.hhs.gov/060622lt.htm](http://www.ncvhs.hhs.gov/060622lt.htm)).

**Staff Action Item #4: ONC staff will obtain the NCVHS letter on privacy and confidentiality in the Nationwide Health Information Network to HHS Secretary Leavitt in June 2006 from NCVHS Web site ([www.ncvhs.hhs.gov/060622lt.htm](http://www.ncvhs.hhs.gov/060622lt.htm)) and make it available to members of the EHR WG and the Confidentiality, Privacy, and Security Workgroup.**

***B. Report on a Survey of Physicians' Attitudes About Working With Local Hospitals To Adopt EHRs—Tom Leonard, McKesson Corp.***

Mr. Leonard reported on a national survey of physician attitudes about working with hospitals in the implementation of EHRs. The survey, commissioned by McKesson and conducted by Harris Interactive, was conducted in June 2006. A document about the survey entitled "Thought Leadership Survey: Physician Alignment through IT" was distributed to EHR WG members.

Mr. Leonard noted that purchasing HIT is often financially and technologically daunting. The current level of EHR adoption among physicians is less than 10-15 percent. Ninety-six percent of physicians work in practices of 10 physicians or fewer; the median physician practice has only 2 physicians. McKesson's hospital customers have put millions of dollars of investment into implementing clinical, financial, and IT infrastructure and see strong benefits in leveraging their current investment. They also see benefits in aligning more closely with physicians in their community by extending that clinical and financial investment by hosting an EHR for the physicians in their community.

The primary purpose of the McKesson/Harris Interactive survey was to gauge the interest of physicians to leverage a hospital's information technology (IT) infrastructure to deploy an ambulatory EHR. In addition, it sought to validate hospital CEOs' overall interest level in deploying an ambulatory EHR to physicians affiliated with the hospital. An EHR

was defined as “technology deployed within the physician practice to automate clinical processes, including encounter documentation, electronic prescribing, orders and results, and workflow management.”

The 428 physicians responding to the McKesson/Harris Interactive survey included 249 primary care physicians and 179 specialists in community-based practice. On average, physician respondents: admit patients to 2.5 hospitals, were age 45.7, had 14.8 years in practice, saw 129 patients a week. Eighty-four percent of respondents were male; 16 percent were female. Twenty CEOs and presidents of hospitals throughout the country were interviewed as part of the study, as well.

The survey of physicians had four areas of focus: (1) attitudes regarding IT services currently provided by their hospital; (2) attitudes regarding implementing an ambulatory EHR in their practice; (3) attitudes toward working with hospitals to deploy an EHR in their practice; and (4) overall attitude toward the value of an EHR. Major findings included the following. First, the physicians surveyed value the IT services currently provided by their hospital (e.g., discharge summaries, review/sign off on patient charts, lab results, medical images, surgical notes, scheduling, patient financial data). Second, about 74 percent of the physicians said they are likely to purchase an ambulatory EHR over the next 3 years. Generally, physicians ranked the clinical benefits of EHRs higher than financial factors. Eighty percent ranked “coordination of care across care settings as the primary benefit. Third, *about 74 percent of the primary care physicians and specialists surveyed are receptive to working with an affiliated hospital to deploy an ambulatory EHR in their practice.* Using a variety of means to assign a quantitative value led to the conclusion that physicians would be willing to pay an average \$550 per physician per month for a vendor-hosted EHR and an average \$531 for a hospital-hosted EHR. Finally, physicians believe that deploying a hospital-sponsored EHR will produce closer alignment with the sponsoring hospital.

### **Questions & Comments.**

Dr. Perlin asked whether there was any breakdown in terms of enthusiasm of the physician community for EHRs with respect to age. Ms. Dawn Bates from Harris Interactive said that younger physicians are the most enthusiastic about HIT; many older physicians are struggling and begrudgingly adopting EHRs if at all; some middle-aged physicians will adopt EHRs once they see their peers adopting them just because they want to remain competitive.

Dr. Tooker asked: What is quid pro quo from the hospital for EHRs? And are hospitals considering giving “free EHRs” to primary care physicians that do not admit their own patients to hospitals but refer patients to hospitals? Mr. Leonard said that an unspoken but likely quid pro quo is that the EHR will make it easier for physicians to do business with the hospital, and in turn will likely result in a higher rate of referrals of patient and of high-margin lab and medical imaging business. He explained that the newly relaxed Stark regulations do not allow hospitals to discriminate on the basis of referral relationships in offering EHRs and noted that the EHRs from hospitals will not be

entirely free to physicians. ONC staff agreed to send Mr. Leonard's slides by e-mail to EHR WG members.

**Staff Action Item #5: ONC staff will e-mail Mr. Leonard's slides on the McKesson/Harris Interactive survey of physician attitudes about working with hospitals to deploy EHRs to interested EHR WG members.**

## **OTHER MATTERS**

### **Executive Order on Prompting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs.**

An Aug. 22, 2006, Executive Order directing Federal agencies that administer or sponsor Federal health insurance programs to increase transparency in pricing and quality, encourage the adoption of HIT standards, and develop and identify approaches that facilitate high-quality and efficient care was included in the materials sent to EHR WG members. Dr. Bell explained that this Executive Order came out of the recommendations of the EHR WG and other workgroups.

### **Update on Emergency Responder Use Case Development.**

Dr. Loonsk gave an update on the development of the Emergency Responder Use Case recommended by the EHR WG. ONC staff will e-mail a draft use case synopsis to EHR WG members the week of September 24<sup>th</sup> and would like to get comments back by early October, so that a detailed use case will be ready for the EHR WG's mid-October meeting. The target end date for the final Emergency Responder Use Case is the end of October.

**Staff Action Item #6: ONC staff will e-mail a synopsis of the Emergency Responder Use Case to EHR WG members the week of September 24<sup>th</sup> and would like to get comments back by early October, so that the use case can be reviewed at the EHR WG's mid-October meeting and completed by the end of October.**

### **Help in Developing the EHR WG's Vision of the Future.**

Dr. Bell invited members of the EHR WG to participate in a 1-hour meeting over the course of the next few weeks to help to develop a strawman version of the EHR WG's vision of the future. Dr. Perlin and Ms. Gelinis said they would help, and it was agreed that ONC staff would send out an e-mail about this inviting other EHR WG members to participate.

**Staff Action Item #7: ONC staff will send an e-mail to EHR WG members asking them to participate in developing a strawman version of the workgroup's visioning document.**

There were no public comments. The next EHR WG meeting is scheduled for Friday, October 13, 2006, at 1 p.m., EST.

## **SUMMARY OF ACTION ITEMS**

**Staff Action Item #1:** The EHR WG will resume its discussion of the state of the technology at its October meeting. ONC staff will ensure that the list of data elements that physicians want encompasses the VA/Department of Defense (DOD) list presented by Col. Harmon at the August meeting and that it also includes data previously identified as being needed by first responders in disasters (prehospital emergency responders and hospital emergency departments).

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**Staff Action Item #5:** ONC staff will e-mail Mr. Leonard's slides on the McKesson/Harris Interactive survey of physician attitudes about working with hospitals to deploy EHRs to EHR WG members who want them.

**Staff Action Item #6:** ONC staff will e-mail a synopsis of the Emergency Responder Use Case to EHR WG members the week of September 24th and would like to get comments back by early October, so that the use case can be reviewed at the EHR WG's mid-October meeting and completed by the end of October.

**Staff Action Item #7:** ONC staff will send an e-mail to EHR WG members asking them to participate in developing a strawman version of the workgroup's visioning document.

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

Dr. Jonathan B. Perlin <i>Co-chair</i>	HCA
Lillee Smith Gelinas <i>Co-chair</i>	VHA, Inc.
Dr. Karen Bell <i>Staff Co-chair</i>	ONC/Director, Office of HIT Adoption
Linda Fischetti Lieutenant Colonel Bart Harmon John Houston	Department of Veterans Affairs Department of Defense National Committee on Vital and Health Statistics
Daniel Morreale (for George Lynn) Dr. John Tooker	American Hospital Association American College of Physicians
Kelly Cronin, Director Dr. John Loonsk, Director Judith Sparrow, Executive Director LCDR Alicia Bradford	Office of Programs and Coordination Office of Interoperability Standards American Health Information Community ONC/ Office of HIT Adoption

**Presenters**

Nicholas Terry, J.D.	Chester A. Myers Professor of Law, and Co-director Center for Health Law Studies, St. Louis University, MO
Tom Leonard	Vice President and General Manager of Ambulatory Solutions, McKesson Provider Technologies, McKesson Corp.
Dawn Bates	Harris Interactive, Inc.

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