The Certification Commission for Healthcare Information Technology (CCHIT) -- Overview and Perspective --

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Medical Director, HI MSS

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United Health Group

Presented at:
HI MSS Summit: Achieving National Healthcare Transformation
New York, NY -- June 6, 2005
Today’s Talk

- CCHIT Overview - Mark Leavitt, MD, PhD
  - Origins, mission
  - Organization, scope, timeline
  - Progress and plans
- CCHIT in Perspective - Reed V. Tuckson, MD
  - Guiding principles
  - Value proposition
  - Summing up

Q & A
CCHIT Overview

Mark Leavitt, MD, PhD, FHI MSS
Chair, CCHIT
Medical Director, HI MSS
Origins of CCHIT

Goals and Strategies of HHS’s Framework for Strategic Action

<table>
<thead>
<tr>
<th>Goals</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1:</strong> Inform clinical practice with the use of electronic health records (EHR)</td>
<td>1. Incentivize EHR adoption</td>
</tr>
<tr>
<td></td>
<td>2. Reduce risk of EHR investment</td>
</tr>
<tr>
<td></td>
<td>3. Promote EHR diffusion in rural and underserved areas</td>
</tr>
<tr>
<td><strong>Goal 2:</strong> Interconnect clinicians so that they can exchange health information using advanced and secure electronic communication</td>
<td>1. Foster regional collaboration</td>
</tr>
<tr>
<td></td>
<td>2. Develop a national health information network</td>
</tr>
<tr>
<td></td>
<td>3. Coordinate federal health information systems</td>
</tr>
<tr>
<td><strong>Goal 3:</strong> Personalize care with consumer-based health records and better information for consumers</td>
<td>1. Encourage use of personal health records</td>
</tr>
<tr>
<td></td>
<td>2. Enhance informed consumer choice</td>
</tr>
<tr>
<td></td>
<td>3. Promote use of telehealth systems</td>
</tr>
<tr>
<td><strong>Goal 4:</strong> Improve public health through advanced biosurveillance methods and streamlined collection of data for quality measurement and research</td>
<td>1. Unify public health surveillance architectures</td>
</tr>
<tr>
<td></td>
<td>2. Streamline quality and health status monitoring</td>
</tr>
<tr>
<td></td>
<td>3. Accelerate research and dissemination of evidence</td>
</tr>
</tbody>
</table>

Source: HHS.

* Phase I strategies are shown in bold type.

Private sector certification of HIT products – a **key action** in the Framework
Origins of CCHIT

- Founded by three HIT organizations:
  - American Health Information Management Assoc (AHIMA)
  - Healthcare Information and Management Systems Society (HIMSS)
  - The National Alliance for Health Information Technology (Alliance)
- Formed panel to nominate first Commissioners
- Provided seed funding for launch
- First official meeting Sept 14, 2004
Mission of CCHIT

To accelerate the adoption of robust, interoperable HIT throughout the US healthcare system, by creating an efficient, credible, sustainable mechanism for the certification of HIT products.
How Product Certification Can Accelerate HIT Adoption

- Increase the confidence of providers to invest in and adopt HIT
- Facilitate interoperability of HIT products within the emerging health information infrastructure
- Enhance the availability of HIT adoption incentives from public and private purchasers/payers
CCHIT Organization

Business Operations Committee

Program Management Team

CCHIT Commissioners

Work Group: Functionality

Work Group: Interoperability

Work Group: Security & Reliability

Work Group: Certification Process

Advisory Councils and Liaisons:
- Vendor Associations
- Provider Organizations
- Payer/Purchaser Organizations
- Standards Development Organizations
Stakeholder Balance and Diversity

Commission

- **2 – 4 from each key stakeholder group:**
  - Providers
  - Vendors
  - Purchasers/payers/coalitions
- **2 – 4 total drawn from other stakeholders:**
  - Government (ex-officio, nonvoting)
  - Standards development organizations (e.g. HL7)
  - Others, e.g. healthcare consumer advocates, etc.

Work Groups

- **Open Call for Participation**
  - 275 applicants
  - Commissioners ranked by qualifications then adjusted for stakeholder balance
- **Co-Chairs**
  - Two Co-Chairs
  - Must represent two different stakeholders
- **Members**
  - 8 – 10 members
  - Qualified experts
  - Diversity of backgrounds
Scope, Timeline, and Deliverables

- **Initial scope**
  - Certify EHR products for physician offices

- **Timeline**
  - Pilot process ready in September 2005

- **Deliverables:**
  - Operational capability for certification
  - Roadmap forecasting future certification plans 1 and 2 years ahead
Timeline: Project Phases

- Organizational Phase
- Phase I - Data Gathering
- Phase I - Public Comment period
- Phase II - Draft Requirements and Certification Test Plans
- Phase II - Public Comment period
- Finalize Requirements/ Begin Pilot Test
- Publish Final Requirements and Roadmap
- Launch product certification
**Timeline**  
(Dates approximate and subject to adjustment)

**2005**

- **April 18** -- Publish Phase I interim work product for comment
  - Phase I Public Comment Period April 18 – May 18
  - “Town Calls” April 21-27
- **July 11** – Publish Phase II interim work product for comment
  - Phase II Public Comment Period July 11 – Aug 11
  - “Town Calls” July 11 - 25
- **Sept** -- Publish 2005 pilot reqm’ts
  - Pilot test of certification process
- **Publish final requirements and roadmap. Begin certifying products**
# Certification Roadmap Concept

## Ambulatory EHR Product Attributes

<table>
<thead>
<tr>
<th>Functionality</th>
<th>Current Year</th>
<th>1 Year Ahead</th>
<th>2 Years Ahead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final 2005 Requirements</td>
<td>Forecast 2006 Requirements</td>
<td>Forecast 2007 Requirements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interoperability</th>
<th>Current Year</th>
<th>1 Year Ahead</th>
<th>2 Years Ahead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final 2005 Requirements</td>
<td>Forecast 2006 Requirements</td>
<td>Forecast 2007 Requirements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Security &amp; Reliability</th>
<th>Current Year</th>
<th>1 Year Ahead</th>
<th>2 Years Ahead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final 2005 Requirements</td>
<td>Forecast 2006 Requirements</td>
<td>Forecast 2007 Requirements</td>
<td></td>
</tr>
</tbody>
</table>
Work Group Process

Phase I: Gather Data

- Available Standards Framework
  - Element X

- Priority as seen by stakeholders
- Availability in the marketplace
- Practicality of certification

Phase II: Finalize Requirements

Certification Reqm’ts for 2005
- Requirement X

Certification Roadmap 2006-2007
- 2006
- 2007
- Future X
- Do not certify X

Element Decision Process (see next slide)
<table>
<thead>
<tr>
<th>Priority</th>
<th>Availability</th>
<th>2006-07 Roadmap</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>Widely Available</td>
<td>Certify in 2005</td>
<td>Do not certify</td>
</tr>
<tr>
<td>Essential in the Future</td>
<td>Available in 2006 or 2007</td>
<td>Consider for 2006-07 roadmap</td>
<td>Do not certify</td>
</tr>
<tr>
<td>Optional</td>
<td>Available Uncertain</td>
<td>Do not certify</td>
<td>Do not certify</td>
</tr>
</tbody>
</table>
Phase I Work Products and Public Comment Period
## Phase I Work Products Example: Functionality Work Group

### CCHIT Functionality Work Group Phase I

<table>
<thead>
<tr>
<th>Line</th>
<th>Criteria Name</th>
<th>WG</th>
<th>Criterion Description</th>
<th>Source (map to Standard source)</th>
<th>Priorities (L,M,H)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify &amp; maintain a patient record</td>
<td>Funct</td>
<td>Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.</td>
<td>DC.1.1.1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Manage patient demographics</td>
<td>Funct</td>
<td>Contact information including addresses &amp; phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored &amp; maintained for reporting purposes and for the provision of care.</td>
<td>DC.1.1.2</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9</td>
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<td>10</td>
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<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Manage summary lists</td>
<td>Funct</td>
<td>Patient summary lists can be created from patient specific data and displayed and maintained in a summary format. The functions below are important.</td>
<td>DC.1.1.3</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Functions from HL7 EHR TC DSTU (Subset)**

**Evidence on Priorities**

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The Certification Commission for Healthcare Information Technology
## Phase I Work Products Example:
**Functionality Work Group**

<table>
<thead>
<tr>
<th>Availability</th>
<th>Test Method</th>
<th>Test Specification</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. The system <strong>SHALL</strong> create a single patient record for each patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>2. The system <strong>SHALL</strong> associate (store/link) key identifier information with each patient record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>3. The system <strong>SHALL</strong> store multiple identifiers for each patient record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>4. Using the key identifying information, the system <strong>SHALL</strong> identify (look up) the unique patient record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>5. The system <strong>SHALL</strong> maintain and make available dynamic data elements for each patient record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>6. The data in the patient record and the integrity of the record itself <strong>SHALL</strong> be maintained until specifically deleted based on local policies, procedures and/or applicable laws and regulations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>1. The system <strong>SHALL</strong> capture and maintain demographic information as part of the patient record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>2. The system <strong>SHALL</strong> provide ability to report demographic information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3. The system <strong>SHALL</strong> keep track of demographic information over time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>4. The system <strong>SHALL</strong> allow a user to modify demographic information about the patient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**To be developed (Phase II):**

- 2005 Criteria and 2006-07 Roadmap

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**Evidence on Availability**

**Conformance Criteria and Test Specifications**

**The Certification Commission for Healthcare Information Technology**
### Interoperability Use Cases – Priority cases highlighted

<table>
<thead>
<tr>
<th>Line Num.</th>
<th>ID</th>
<th>Use Case Component</th>
<th>Description</th>
<th>Priorities</th>
<th>Discussion / Barriers to Market Availability</th>
<th>Source Standard or Vocabulary</th>
<th>Implementation Guide</th>
<th>Source Available Today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>L.1</td>
<td>Receive results</td>
<td>Results using common vocabulary with inbound interface modality removed</td>
<td>H M</td>
<td>(1) Interface modality; (2) lack of standard result and result values vocabularies; (3) non-standard handling of microbiology; (4) Coding standards (once defined) must be kept current. Process must be efficient and fast to keep up with the addition of new tests; (5) Need to provide discrete data and laboratory specific reports. This is especially true for anatomical pathology and esoteric reporting. (6) Myriad of communication architectures increases costs to support send and receipt of results. (7) What is business model to support real-time results feeds? Who will pay? (6) Potential for innovation (technological and clinical) to be throttled by standards bodies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>L.2</td>
<td>Result values naming</td>
<td>SNOMED</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>L.3</td>
<td>Result values naming</td>
<td>LOINC result naming</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>L.4</td>
<td>Result values naming</td>
<td>HL7 v3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>L.5</td>
<td>Result values naming</td>
<td>LOINC result naming</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>L.6</td>
<td>Result values naming</td>
<td>HL7 v2.4</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evidence on standards, vocabularies, barriers, and availability

- **Phase I Work Products Example:** Security & Reliability Work Group

- **CChI Interoperability Workgroup Phase I:** Collection of Data and Assessment of the Industry

- **Use Cases – Priority cases highlighted**

- **Evidence on standards, vocabularies, barriers, and availability**

- **To be developed (Phase II):** 2005 criteria and 2006-07 roadmap
# Phase I Work Products Example: Interoperability Work Group

The table below provides an example of the security criteria with references and rationale for inclusion/exclusion, priorities and market availability, and preliminary recommendations (to be refined in Phase II).

### Security Criteria with references and rationale for inclusion/exclusion

<table>
<thead>
<tr>
<th>Security Criteria</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>Relevance to patient safety</td>
</tr>
<tr>
<td>Priority 2</td>
<td>Compliance with regulatory requirements</td>
</tr>
</tbody>
</table>

### Priorities and market availability

<table>
<thead>
<tr>
<th>Priority</th>
<th>Market Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Yes</td>
</tr>
<tr>
<td>Medium</td>
<td>No</td>
</tr>
<tr>
<td>Low</td>
<td>No</td>
</tr>
</tbody>
</table>

### Preliminary recommendations (to be refined in Phase II)

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High priority for inclusion</td>
</tr>
</tbody>
</table>

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The Certification Commission for Healthcare Information Technology
I. Introduction

The Certification Process Work Group (CPWG) is pleased to present its Phase I report on its progress towards identifying the essential elements of a certification process for ambulatory electronic health records. The CPWG is actively seeking feedback on this Phase I deliverable in order to develop a consensus-based model that will serve the needs of the various stakeholders within the process. The goal of Phase I was to develop an assessment of current and potential testing methodologies and then provide a summary for public comment.

Phase I included the following deliverables:

- Research and examine a variety of current certification testing processes that had similar objectives to those of the CCHIT.
- Develop a summary of possible testing approaches.
- Research capabilities of current software testing laboratories.
- Construct a framework for an idealized certification process for electronic health records.

Phase II will commence once the initial public comment period has been completed. Phase II deliverables include the following:

- Details regarding the specific testing processes for certifying the individual criteria developed by the other Work Groups.
- Specific cost estimates will be developed once the fundamental decisions regarding the methods, location and sponsoring organization(s) are reached.

There are two levels to defining a certification process for electronic health records:

- The first level is outlining the macro level process. This includes everything from the application process to the
Phase I Public Comment: Response Volume and Timing

Total submissions: ~100
Total comments: ~1000
Phase I Public Comment: Responses by Source

Responses by Source

- Individual: 38%
- Organization: 62%
Phase I Public Comment: Responses by Category

- HIT Vendor: 29%
- Health System: 10%
- Physician Professional Association: 10%
- Physician: 7%
- Academic Health: 4%
- Other Association: 23%
- Consultant: 12%
- Consumer: 1%
- Government: 4%
Phase I Public Comment: General Responses for Commission (does not include comments for WGs)

TOTAL: 28

- General Support, 18%
- Constructive suggestions, 28%
- Request for Inclusion, 18%
- Format Issues, 18%
- Broad Concerns, 18%
News Today: Broadened Funding Support

- Unrestricted grants, >$100k total, from:
  - American Academy of Family Physicians (AAFP)
  - American College of Physicians (ACP)
  - Hospital Corporation of America
  - McKesson
  - Sutter Health
  - United Health Foundation
  - WellPoint Health Networks, Inc.

- In support of our continued work as an independent, private sector initiative to certify HIT products
CCHIT in Perspective

Reed V. Tuckson, M.D.
SVP, Consumer Health and Medical Care Advancement
UnitedHealth Group
Guiding Principles for CCHIT

- **Timeliness**
  - Need decisive private-sector action **now**

- **Value**

- **Integrity**
Making Electronic Medical Records Work in Private Practice

*Hundreds of products are available to help get organized and compete for contracts, but costs remain high*

*ACP Observer, copyright © June 1997 American College of Physicians*

"Outcomes are the major reason why you want an electronic record… Once you get this information, it's a snapshot of what you do every day, how good a doctor you are."

“Despite the advantages that electronic record software can bring, however, fewer than 5% of physicians currently use computerized record software in their daily practice.”

“One reason is cost. Implementing a computerized record system can run approximately $1 million for a 20-doctor group and $40,000 to $50,000 for a two- to three-doctor group. Physicians who have little experience with computers fear sinking so much money into a product they don't know much about.”
Timeliness: Physician’s Perspectives from 2002

For doctors, the pressure is on to computerize

*Regulations protecting patient information are giving new urgency to an old debate*

From the ACP-ASIM Observer, copyright © January 2002.

“While EMR vendors say there has never been a better time to buy, not everyone is convinced. Physicians remain leery about putting big money into technology that has been hyped for years. Most physicians concede that a shift to electronic clinical records is inevitable, but they remain sharply divided over whether now is the time to invest.”

“According to industry analysts, fewer than 5% of practicing physicians now use electronic clinical information systems.”

“When considering an EMR, doctors should weigh another big variable: the informatics plans of local hospitals. Are hospitals in your community installing clinical information systems, and does their software have ambulatory care components?”
# Timeliness: Seeking Meaningful Guidance in 2005

## How to Select an Electronic Health Record System

### KEYPONTS

- To reduce your list of potential vendors to a manageable length, consider only those systems that have already developed interfaces with the practice management software you use, that are marketed to practices the same size as yours and that are well rated in published surveys.
- How the EHR enables users to create and complete tasks, find information, view labs, manage health maintenance reminders and write prescriptions can be more important than how easily it creates a patient note.

### EHR FUNCTIONALITY

This list, which includes most of the capabilities of EHRs, is designed to help you organize your priorities. As you clarify your goals, you may want to rank each of these functionalities in order of need or divide the functions into three groups: must-have, want-to-have and not critical.

<table>
<thead>
<tr>
<th>Must-Have</th>
<th>Want-To-Have</th>
<th>Not Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results reporting (lab, radiology, other)</td>
<td>Secure external e-mail for patients</td>
<td>Patient Web portal</td>
</tr>
<tr>
<td>Order entry (lab, radiology, other)</td>
<td>Patient education</td>
<td>Patient Web portal</td>
</tr>
<tr>
<td>Multiple note creation options (templates, macros, dictation, voice recognition, handwriting recognition)</td>
<td>Scanning</td>
<td>Patient education</td>
</tr>
<tr>
<td>Automated E/M coding advisor</td>
<td>Automated chart documentation (problem lists, medication lists, vital signs, health maintenance)</td>
<td>Scanning</td>
</tr>
<tr>
<td>Software interfaces with internal and outside labs</td>
<td>Automated charge entry</td>
<td>Scanning</td>
</tr>
<tr>
<td>Prescription writer and database (with online formularies and drug-interaction checking)</td>
<td>Inpatient reports (downloadable)</td>
<td>Scanning</td>
</tr>
<tr>
<td>Flow charting (labs, vital signs, growth parameters)</td>
<td>Electronic fax reports (dictation, lab, radiology) to outside specialists</td>
<td>Scanning</td>
</tr>
<tr>
<td>Remote access</td>
<td>Patient follow-up/health-maintenance deficiency alerts</td>
<td>Scanning</td>
</tr>
<tr>
<td>Referral ordering and tracking</td>
<td>Practice population analysis tools</td>
<td>Scanning</td>
</tr>
<tr>
<td>Patient registration information (master patient index)</td>
<td>Decision support tools</td>
<td>Scanning</td>
</tr>
<tr>
<td>Telephone message documentation and tasking</td>
<td>Security (audit trails, user access hierarchy, passwords)</td>
<td>Scanning</td>
</tr>
<tr>
<td>Internal e-mail</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Guiding Principles for CCHIT

- **Timeliness**

- **Value**
  - Deliver value for all key stakeholders and the larger healthcare community
  - Process must be efficient and not add net costs

- **Integrity**
Quality and Safety Concerns Are Apparent to Purchasers and Consumers

- 30% of all direct health care costs due to poor care
  - Misuse, under-use, overuse
  - Poor quality care costs between $1,900 and $2,250 per covered employee year.

Value: Clear expectations for technology to improve clinical care decisions, evaluate care quality, and communicate results
Value: Driving Electronic Adoption of Best Evidence at the Point of Care -- “Just in Time Access”

450,000 on-line sessions

48 Specialty Societies with 100,000 physician registrants
Value: Hospital and Physician Performance Assessment - A Priority For All Stakeholders
Significant Progress In Achieving An “Industry Standard” for Physician Performance Assessment: Electronic Records are Key

**Goal**
- Measuring performance
- Collecting and aggregating data
- Reporting to consumers, and other stakeholders

**Sponsors**
- Agency for Healthcare Research & Quality
- American College of Physicians
- American Academy of Family Physicians
- Americas Health Insurance Plans

**Key Stakeholders**
- CMS
- National Quality Forum
- Consumer/Purchaser Disclosure Project
- AARP
- Leapfrog
- Pacific Business Group on Health
- National Business Group on Health
- AMA Performance Measurement Consortium
- Rand
- Office of Personnel Management
- American Medical Association
- Health Plans
- Hospitals
- NCQA
- JCAHO
- Institute of Medicine
- Consulting Firms
### AQA Ambulatory Quality Measures: A Mix of Claims and Office Chart Data

<table>
<thead>
<tr>
<th>Prevention Measures</th>
<th>Coronary Artery Disease</th>
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<tbody>
<tr>
<td>• Breast cancer screening</td>
<td>• Drug therapy for lowering LDL</td>
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<tr>
<td>• Colorectal cancer screening</td>
<td>• Beta blocker immediately post discharge for MI</td>
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<tr>
<td>• Cervical cancer screening</td>
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<tr>
<td>• Tobacco use</td>
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<td>• Advising smokers to quit</td>
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<tr>
<td>• Influenza vaccination</td>
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<td>• Pneumonia vaccination</td>
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<th>Heart Failure</th>
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<tbody>
<tr>
<td>• Ace inhibitor/ARB for CHF and LVSD</td>
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<tr>
<td>• LVF assessment</td>
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<th>Diabetes</th>
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<tbody>
<tr>
<td>• HbA1C management</td>
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<tr>
<td>• HbA1C management control</td>
</tr>
<tr>
<td>• BP management</td>
</tr>
<tr>
<td>• Lipid measurement</td>
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<tr>
<td>• LDL &lt;130</td>
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<tr>
<td>• Eye Exam</td>
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AQA Ambulatory Quality Measures:
A Mix of Claims and Office Chart Data

- **Asthma**
  - Percent of people diagnosed with persistent asthma appropriately prescribed medications
  - Percent of people with persistent asthma prescribed the proper therapy

- **Depression**
  - Acute phase medication management
  - Continuation phase medication management

- **Prenatal Care**
  - Screening for HIV
  - Anti-D Immune Globulin for D(Rh) negative unsensitized patients

- **Overuse or Misuse**
  - Appropriate use of antibiotics for children with URI
  - Appropriate testing of children with Pharyngitis who were treated with antibiotics

- **Next Steps**
  - Efficiency measures: scheduled for September 2005
  - Specialty care measures
  - Patient experience with care assessment
  - Data aggregation!!!
Acting On The Value Equation: Financial Incentives for Physician Adoption

- GE
- Ford
- Proctor & Gamble
- UPS
- Verizon
- Raytheon
- Hannaford Brothers
- City of Cincinnati
Significant Progress In Achieving An “Industry Standard” for Hospital Performance Assessment: Electronic Records and Inter-connects Are Key

<table>
<thead>
<tr>
<th>CPOE</th>
<th>NQF 27 Safe Practices Criteria</th>
<th>NQF 10 Core Measures</th>
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<tbody>
<tr>
<td>ICU Specialists</td>
<td>Proper hand washing</td>
<td>Management of Acute Heart Attacks</td>
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<tr>
<td>Volume based referrals</td>
<td>Recorded verbal orders</td>
<td>Heart Failure</td>
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<td>Protocol for x-ray labeling</td>
<td>Pneumonia</td>
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- Protocol for wrong site and wrong patient surgery
- Standard methods for labeling medications
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- Etc

- Management of Acute Heart Attacks
- Heart Failure
- Pneumonia
Guiding Principles for CCHIT

- **Timeliness**

- **Value**

- **Integrity**
  - Operate in credible, objective, transparent manner
  - Certification must be objective, laboratory verified to the greatest extent practical
Stakeholders Must Have Confidence in the Scope, Specificity, and Integrity of the Process

Physicians’ Use of Electronic Medical Records: Barriers and Solutions
March/April 2004

Barriers
- High cost and uncertain financial benefit
- High initial time costs
- Usability
- Customization of standard products and inadequate technical support
- Inadequate electronic data exchange between EMR and other clinical data systems
  - Especially for solo/small group physicians
- Lack of incentives
- Physician attitudes

Solutions
- Community-wide data exchange
  - Lessens disruption, decreases time costs and increases financial benefits
  - Data exchange standards essential
- Support for customization
- Objective product comparative information on costs, use, and comparative features
- Performance incentives and mandates
The HIT Adoption Deadlock

Payers/Purchasers

Can’t offer incentives unless benefits and interoperability of EHRs are assured

HIT Vendors

Can’t bring down costs until provider adoption accelerates

Providers

Hesitant to buy HIT until costs and risks are lower and/or incentives higher
Breaking the Deadlock

Beneficial effects and interoperability assured, unlocking incentives

Payers/Purchasers

Growing market attracts investment, lowers costs

IT Vendors

Reduced risk and availability of incentives accelerates adoption

Providers

HIT Adoption
Key Points to Clarify

• **Product Certification is different from:**
  - Organizational Accreditation
  - Professional Certification

• **Certification is binary, i.e. “pass/ fail”**
  - Not a subjective, comparative rating system
  - Competition and innovation can thrive “above the line”

• **Voluntary process**
  - Initial requirements must be market reality-based
  - A forward-looking requirements roadmap provides the best means to influence market direction
Value Proposition for Stakeholders

- **HIT Customers (Medical Practices)**
  - Information on market & needs
  - Increase confidence in investment

- **HIT Vendors**
  - Information on current and future state of products
  - Accelerate market; roadmap of future expectations

- **Payers with Incentives for IT Adoption or IT-Enabled Quality**
  - Commitment to incentives for certified products
  - Assurance that certified products, properly deployed, can deliver results

- **HIT Standards Organizations**
  - Standards against which compliance can be tested
  - Feedback on current standards; drive development of new standards

Certification Commission
Q and A

For more information, or to download the presentation:

www.cchit.org