

Meeting Report

American Health Information Committee

November 13, 2007

The American Health Information Community (AHIC), a federally chartered commission formed to help advance President Bush's call for most Americans to have electronic health records (EHRs) within 10 years, held its 17th meeting on November 13, 2007, at the Sheraton Chicago Hotel & Towers/Cityfront Center, Ballroom 6, 301 East North Water Street, Chicago, IL 60611.

The purpose of the meeting was to bring together Community members to continue discussion of steps toward ways to achieve its mission of providing input and recommendations to DHHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected in a smooth, market-led way. The meeting focused on an update on the NHIN (National Health Information) Trial Implementation, on e-prescribing, and on defining and strengthening health data stewardship.

DHHS Secretary Michael O. Leavitt chairs the Community. The remaining 16 members, selected by Secretary Leavitt, are key leaders in the public and private sectors who represent stakeholder interests in advancing the mission of the Community and who have strong peer support. Members serve 2-year terms.

A summary of the discussion and events of that meeting follow.

Call to Order

Joining Secretary Leavitt around the table were:

Robert Kolodner, MD, National Coordinator for Health Information Technology

Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, and Vice-Chair, AHIC

Scott Serota, President and CEO of the Blue Cross Blue Shield Association

Charles N. (Chip) Kahn III, President of the American Federation of Hospitals

Julie Gerberding, MD, Director of the Centers for Disease Control and Prevention

Gail Graham, Director of Health Data at the Department of Veterans Affairs, Veterans Health Administration

Kevin Hutchinson, CEO of Surescripts

Craig Barrett, PhD, Chairman of the Board, Intel

Lillee Gelinas, RN, MSN, FAAN, Vice President and Chief Nursing Officer of VHA, Inc.

Dan Green, Deputy Associate Director, Office of Personnel Management (Mr. Green represented Linda Springer, Director of the Office of Personnel Management)

Steve Lampkin, Vice President, Benefits, Compliance, and Planning, Wal-Mart (Mr. Lampkin represented John Menzer, Vice Chairman, Wal-Mart)

S. Ward Casscells, MD, Assistant Secretary for Health Affairs, Department of Defense

Nancy Davenport-Ennis, founder of both the National Patient Advocate Foundation and the Patient Advocate Foundation

E. Mitchell (Mitch) Roob, Secretary of the Indiana Family and Social Services Administration

Jason Mitchell, Title (Mr. Mitchell represented Douglas Henley, MD, Executive Vice President, American Academy of Family Physicians)

Bettjoyce Lide, Scientific Advisor for Health Information Technology, National Institute of Standards and Technology's Information Technology Laboratory (Ms. Lide represented Robert Cresanti, Under Secretary of Commerce for Technology, U.S. Department of Commerce)

Secretary Leavitt's Introductory Comments

Secretary Leavitt opened the meeting by thanking participants for coming to Chicago. He said he hoped everyone had had a chance to see the displays that were part of the American Medical Informatics Association convention, which was being held in the same hotel, concurrent with this AHIC Community meeting.

Secretary Leavitt announced that today, November 13, through the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (HHS) put forth a proposal to adopt new standards for aspects of e-prescribing under Medicare prescription drug benefit. This development, he said, is an important piece of the equation that that AHIC is building.

The Secretary noted that the Community began implementing the first set of e-prescribing standards last year. At the same time, they launched a pilot to involve providers and pharmacies and plans to test these standards. Through the pilot, the Community learned the strengths and weaknesses of that first set of standards, and incorporated all they learned into this new proposed set of e-prescribing standards. All providers and pharmacies transmitting prescriptions electrically for Medicare will have to comply with these new CMS standards. Adapting this rule, he said, will move AHIC considerably closer to the connective system that they are all working for, and it will be an improvement in the safety and quality of healthcare that all of patients receive.

Next the Secretary stated that two weeks ago, a new Medicare demonstration program was announced that promotes adoption of health IT. The demonstration will award providers who use certified Electronic Health Records (EHRs) to develop high quality care in small to medium sized practices across the country. This is where most Americans get their healthcare, and it is also where there are the lowest adoption rates in health IT.

Under the demonstration, Medicare will pay higher rates of reimbursement to physicians who use certified EHRs. The demonstration will involve 1,200 small to medium sized physician practices and reach as many as 3.6 million patients, making this a significant step forward.

Secretary Leavitt said that many private insurance companies have, since the announcement, indicated that they are going to take similar, parallel actions.

The Secretary thanked the Certification Commission for Health Information Technology (CCHIT) for their work in creating the standards for certified EHRs. This is the designation that will be used to determine those practices that are qualified for this demonstration. Last year, CCHIT certified roughly 75 percent of the EHR products that are now being used by doctors. Secretary Leavitt said that the products CCHIT has already certified account for about 25 percent of those in hospitals. He said it is clear that that percentage of certified hospital EHR systems will increase fairly quickly, just as the percentage of outpatient systems has. So the momentum is growing.

Secretary Leavitt stated that he would not be announcing the AHIC 2.0 award at this meeting as he had hoped. Agreements are still being finalized, and the Secretary intends to announce the award before the next AHIC meeting. He said they have created a broad coalition of significant players, and that this will come together into a very aggressive effort to make certain the AHIC 2.0 deadline is met.

Secretary Leavitt informed the Community that 434 days remain on the AHIC “clock,” and he is feeling an increasing sense of urgency to bring the system together, while he also acknowledged the great progress that has been made so far.

Then Secretary Leavitt introduced the chairman of the Federal Communications Commission, Kevin Martin. He explained that the FCC is working to fund the delivery of broadband connectivity to rural and underserved communities, placing a particular emphasis on healthcare providers. The Secretary thanked Chairman Martin for attending, and said that there is not another part of our economy where we could invest in the development of this kind of infrastructure that will have more rapid or lasting social and economic benefits.

Chairman Martin’s Introductory Comments

Chairman Martin acknowledged the importance of the role that the FCC is playing in its efforts to deploy the infrastructure that can make some of AHIC’s goals possible. He also acknowledged that the work that AHIC is doing is not only important for healthcare, but also for the overall economy.

Since becoming chairman, Chairman Martin said he has made broadband deployment the FCC’s top priority, given that broadband technology is a key driver of economic growth, productivity, innovation, and, of relevance here, it is changing the way healthcare is delivered and received.

In April of 2004, the president issued his executive order to provide leadership for the development of nationwide implementation of an interoperable health information technology infrastructure, and a key goal of AHIC is to help Americans obtain access to electronic medical records.

In order to receive the benefits of EHRs, Chairman Martin explained, healthcare providers must have access to underlying broadband infrastructure. Without this underlying infrastructure, efforts to implement electronic healthcare records, for example, cannot succeed. That is why a key element in the

national health IT agenda is the creation of a nationwide health information network. The Chairman announced that the FCC will try to help in that effort.

It is the FCC's vision to see that every healthcare facility in the nation is connected to each other with broadband. To that end, on September 26 of 2006, they launched the rural healthcare pilot program to provide funding for up to 85 percent of an applicant's cost of deploying a dedicated broadband network connecting healthcare providers in rural and urban areas with the state or region. It also provides for funding of up to 85 percent of the applicant's cost of connecting the state or regional network to Internet2 and/or National LambdaRail, the dedicated national backbones, as well as the public Internet.

In an overwhelming response, eighty-one regional and state health networks across the country have submitted applications. The FCC is preparing to dedicate a significant funding to spur the deployment of these broadband networks for these healthcare facilities.

Chairman Martin proposes dedicating more than \$400 million over the next three years to the construction of broadband networks for statewide and regional healthcare networks in 42 states and three US territories, all connected to the national backbone providers. The FCC, through this funding, will connect over 6,000 healthcare providers across the country, including hospitals, clinics, public health agencies, universities and research facilities, behavior health sites, community health centers and others.

These networks will support telehealth, telemedicine, clinical care, consumer and professional health education, public health, health administration, research, and electronic medical health records. The pilot program is structured to encourage applicants to aggregate the needs of healthcare providers in both rural and urban areas and select the most efficient technology based upon their network needs. For example, the pilot program encourages multiple healthcare providers in a state or region to join together, allows flexibility and network designs that will be able to meet the specific needs of healthcare providers, encourages the creation of self-sustaining networks, and encourages broadband connections particularly for rural healthcare providers.

Chairman Martin said this program aligns with the goals of the Department of Health and Human Services and the Health Community, which is why he feels it is important that the organizations participating in this pilot program use their resources in a manner consistent with the health IT initiatives being promoted by HHS. This includes the implementation of interoperable health IT systems and the use of certified health IT products. Additionally, the participants are expected to coordinate with HHS and CDC during public health emergencies such as pandemics and bioterrorism events.

Discussion Highlights

“Certainly since becoming chairman, I've made the broadband deployment the commission's top priority. And broadband technology is a key driver of economic growth. The ability to share increasing amounts of information at greater and greater speeds increases productivity, facilitates interstate commerce and helps drive innovation. But perhaps most important, broadband has the potential to affect almost every aspect of our lives from where and when we work, to how we'll educate our children, and of most relevance to our discussion today, it is increasingly changing the way healthcare is delivered and received.”—Chairman Martin

“It's our vision to see that every healthcare facility in the nation is connected to each other with broadband. This is especially important in rural areas of the nation that may lack the breadth of medical expertise available in urban areas. To make such connectivity a reality, we need to continue to encourage the deployment of broadband facilities that can connect network of networks of rural and non rural, public

and not for profit healthcare providers within a state and a region, and as well as connect such state-wide and regional healthcare networks to each other across the nation.”—Chairman Martin

“So specifically, I propose dedicating more than \$400 million over the next three years to the construction of broadband networks for statewide and regional healthcare networks in 42 states and three US territories, all connected to the national backbone providers.”—Chairman Martin

“I think the broadband deployment at the core of the FCC’s program blends perfectly with the work of AHIC and HHS to accelerate the development of adoption of health information technology and to advance the president’s goal for widespread adoption of electronic medical records. I hope to continue to work with the healthcare community, to help deliver the broadband infrastructure that is going to be at the core of all these missions.”—Chairman Martin

“This is a potentially powerful energizing opportunity for the creation of our network. Obviously, there are network standards that are becoming well defined with respect to the Internet. As you allude on slide 11, there is a need for us to make certain that the standards that we’re developing for health information technology records are incorporated. How do we actually go about assuring that those standards are built in? Would there be opportunities for these grants to be conditioned upon their acceptance of those standards? I mentioned the demonstration project that we are funding at CMS. One of the criteria is that they’re using CCHIT certified records. Could you give me some reaction to that?”—Secretary Leavitt

“I don’t think that we’re able to explicitly condition it on having ... the records, but we have conditioned it on trying to coordinate with HHS and CDC, and [applicants] actually are required to having meetings to understand both the process and opportunities, and the best way that we could end up coordinating them. Now, the grants, themselves: because they are through the telecommunications act, which has a different standard, we can’t explicitly condition on the grant of coming into compliance with the work of another agency, but I think that we’re going to be able to accomplish the same goals by the close coordination and requiring them to at least go through the processes of meeting with HHS.”—Chairman Martin

“it was a challenge for the Commission in the past to ... more fully utilize some of what we were doing on the healthcare side. We had a very effective program to connect schools and libraries throughout the country using broadband, but on the healthcare side, we’ve actually had a significant amount of money that’s gone underutilized or not fully utilized. And I think the key to trying to unlock that was actually to try to think about this in terms of networks of networks, where we’re trying to connect rural healthcare facilities back to the urban facilities, and paying for that—for those regional networks as opposed to just individual grant applications.”—Chairman Martin

“[VHA has] over 600 small and rural hospitals in our network. And I’m curious, just as a practical application, how we could be supportive of the implementation of the pilot. We can perhaps take it offline, but I have to tell you, this is really exciting for our rural providers.”—Ms. Gelinas

“I appreciate it, and we should end up following up on how you can end up being most supportive and seeing which ones of those clinics that you’re talking about may actually already be implemented in one of the different networks that we’re trying to provide.”—Chairman Martin

Mr. Kerry Weems’ Comments

Mr. Weems announced that this morning the proposed standards for e-prescribing, and the proposed standards for formulary and benefits and medication history were put on display in the federal register.

The availability of a standard for formulary and benefits will enable the prescriber to see upfront which drugs are covered under a beneficiary's drug plan—in this case, Medicare—as well as a list of alternative drugs that would allow the provider to substitute a generic drug.

This type of information, Mr. Weems said, will streamline prescriber workflows, eliminating calls to the plans, as well as call backs from pharmacies. Although e-prescribing is voluntary under Medicare, if prescribers and pharmacies transmit subscriptions for Medicare covered drugs electronically, they are required to comply with any standards that are in effect. Four more standards are still being considered, and Mr. Weems hopes the normal commenting process will happen quickly so that these rules can be in place soon.

At the Secretary's suggestion, Mr. Weems also said a few words about the Medicare demonstration project. The focus over the next several months is going to be on recruiting a dozen communities; then CMS will work with those communities to recruit one hundred participating physicians. By early winter, Mr. Weems hopes that the criteria will be in place for "wired for wellness" communities.

Bonuses will be paid to physicians who use an electronic health record: initially for reporting on quality standards, and then later, on pay for performance. What this demonstration serves to remind us is that an electronic health record isn't an end in itself. The end is patient safety and overall performance of the healthcare system, Mr. Weems said.

Following Mr. Weems' comments, Secretary Leavitt asked Dr. Kolodner to lead the Community through the meeting's agenda.

Approval of September 18, 2007, Meeting Minutes

Minutes from the September 18, 2007, AHIC meeting were distributed, reviewed by Community members, and approved unanimously with no changes.

Dr. Kolodner's Comments

Dr. Kolodner welcomed a new member of the AHIC, Department of Commerce's Cita Furlani. She is the director of the Information Technology Laboratory at NIST, and has a master's degree in electronics and computer engineering, and in the past, has served as CIO at NIST, and director of the national coordination officer for IT research. Also, he announced that Dr. Chuck Friedman has joined the Office of the National Coordinator as the new deputy national coordinator. Dr. Friedman is a member of the College of the Medical Informaticists, and an active member at AMIA and throughout the community.

Dr. Kolodner noted that the Community did receive the requested report from the Institute of Medicine. They evaluated AHIC's standard setting activity, and brought up some points about pacing, depending on some of the complexity of the standards, which the Community will be considering. In their report, the IOM recognized that ONC and HHS have advanced the national health IT agenda over the last three years, and accelerated the development and advancement of standards. They acknowledge that we've launched several standards related to organizations, and established a process that didn't exist before for harmonizing and identifying those standards, and that we have taken a full cycle of standards development into the implementation process—a process that Secretary Leavitt refers to "turning the crank."

Dr. Kolodner announced that, related to that, Secretary Leavitt is scheduled to recognize the first set of interoperability standards in December of 2007, before the next meeting of the AHIC. These standards

will then be incorporated into the ambulatory and the inpatient certification criteria starting in mid 2008, and applying to that round of certification.

In addition, the IOM recommended that the ONC develop a strategic plan to guide the national health IT agenda, and also develop a security and privacy framework. Both of those recommendations are now under way.

Finally, Dr. Kolodner announced that the Community received a report in September from the Population Health Workgroup with some recommendations that are still being considered, and will be discussed at the AHIC meeting in January, 2008.

NHIN Trial Implementation Update

Dr. Loonsk reported that the National Health Information Network (NHIN) has made announcements for the awards for the first NHIIEs, nationwide health information network exchanges, that will be participating in the NHIN cooperative. He introduced Maggie Gunter from the Lovelace Clinic Foundation, and Liesa Jenkins with the CareSpark Health Information Exchange in eastern Tennessee and southwest Virginia, each participating NHIIEs. Then Dr. Loonsk announced the other health information exchanges that have been awarded to participate in this process:

- New York E-health Collaborative, representing the State of New York,
- West Virginia Health Information Network, representing the State of West Virginia
- North Carolina Health Information and Communication Alliance, representing the State of North Carolina
- MedVirginia Health Information Exchange representing areas of central Virginia
- Delaware Health Information Network representing the State of Delaware
- Long Beach Network for Health, representing Long Beach and areas of Los Angeles
- Federal NHIIE (DoD, VA, HHS, others including participating Indian Health Service regions)

Others have indicated an interest in participating, Dr. Loonsk said.

The NHIN is currently identifying the specific core services, that minimal set of national standards that need to be advanced to have a network of networks. They have identified, through the course of the prototype work from last year, four basic standards that need to be advanced to support networks working together.

Dr. Loonsk explained that many of the health information exchanges have rightfully been thinking about activities in their own jurisdictions. So NHIN is trying to create a single set of standards that would do the following:

1. identify the services for looking up patient data across health information exchanges
2. support the retrieval and delivery of that data
3. Standardize consumer access controls, so the consumer can have a say in who can access their personal health information, and whether they choose to or not choose to participate in the electronic network exchange
4. Create guidelines for reporting and other uses of electronic data

Dr. Loonsk stressed that this is a network of networks, not a central infrastructure. He said that by the end of this first year's performance, they will have essentially removed the technical obstacles for health information exchange between the participating HIEs.

To do that, he said, some critical leadership roles for the health information exchanges have been identified. The activities here in the spirit of the local control are being led by the health information exchanges, so the Core Content Working Group is being led by the representatives from the Lovelace Clinic as well as the New York Healthcare Information Collaborative. The Core Technical and Security Working Group has co-chairs from West Virginia and from the federal health NHIE. The Data Use Working Group is being led by representatives from the North Carolina Health Information and Communications alliance in MedVirginia. Testing is being advanced in conjunction with representatives from NIST, as well as the Indiana University and the Indianapolis Health Information Exchange.

Dr. Loonsk said that the Centers for Disease Control (CDC) is another partner in the project who will help advance the vision of a reusable foundation, an infrastructure that can be used to advance public health needs even beyond creating a method for provider information exchange in individual health information access.

Lisa Jenkins thanked the AHIC community, and explained that CareSpark was begun about four years ago, and was one of the early participants in the e-health initiative. The goals that we had already defined for our community and our region, which is multi-state, aligned very closely with the e-health initiative goals that were defined at that time: engaging the clinicians, engaging the patients, working on public health, and aligning financial incentives. It has been important for CareSpark to kind of stay in sync with the things going on at the federal level, because it straddles state lines of not only Tennessee and Virginia, which is where the bulk of their providers are, but also North Carolina, West Virginia, and Kentucky. That is why CareSpark participated in the first round of the NHIN prototypes. Jenkins said it was not an easy experience for many their many small, entrepreneurial organizations with few resources, to learn how to work with a large corporation and federal contracts. It was a learning experience, but everyone survived and they were successful in our demonstration.

Jenkins said the process was valuable because they would never have otherwise had, in CareSpark's region, the ability to kind of stay on top of the standards that were being defined, much less have a voice in them and contribute in any way to what those would be. Secondly, it allowed CareSpark to connect with other communities who are trying to do similar things, which allowed them to build not just a technical network, but the human infrastructure and connections between people that Jenkins believes are the real key to success.

Third, the initiative brought awareness and education about health information technology to their region. Jenkins has seen an increase in adoption of EMRs among physicians in CareSpark's rural area, and a growing awareness about issues of privacy and security among citizens in the community.

The initiative has educated the local elected officials, Jenkins said, and noted that CareSpark worked with Virginia and Tennessee, and that the governor of Tennessee is serving as the co-chair of the National Governor's Association State Alliance for E-health. Their involvement in NHIN1 and now NHIN2 has helped them to be a conduit for those state officials to align what they're doing, what CareSpark is doing, and what's happening at the national level.

Jenkins noted that CareSpark is very interested in how they connect with their regional VA medical center in our region, which is an important partner.

Dr. Loonsk next introduced Maggie Gunter, CEO of the Lovelace Clinic Foundation in New Mexico, a new health information exchange.

Ms. Gunter explained that, through her work leading a nonprofit applied health research institute she helped to devise solutions that would improve healthcare quality, cost effectiveness, and efficiency. As

part of that work, she said, they were pioneering the sort of disease management that is integrated into every day practice in a group practice. Gunter said in the course of this work, she realized what a difference it would make if they just had health information technology tools to integrate their research into everyday practice of physicians so that it was seamless with their workflow, and sustainable.

She knew that even as they developed electronic health record systems, they already a lot of electronic data that they used as applied researchers, including lab results, claims data, and ICD 9 codes. This data was imperfect, but valuable for looking at patterns of care.

So they applied for the AHRQ health information technology implementation funding in order to create a means for sharing this information across their community. Gunter expressed her appreciation that the grant was in the form of matching funds, so that the community was required to support and participate in the project. Intel participated, demonstrating that the Lovelace Clinic Foundation felt that employers had a critical role to play, not just healthcare organizations.

Gunter said that after three years of effort, the Lovelace Clinic Foundation has made significant progress in establishing the community governance and trust necessary because the field of providers are in some cases competing with each other and have diverse points of view and motivations.

They have established the basic technology infrastructure, and done some pilot information exchange programs. They have worked with the Department of Health, and with Governor Richardson, who is trying to pass legislation to reform healthcare in New Mexico and increase uninsured coverage, as well as working on privacy legislation. Gunter said the state is putting a plan together to require participation in electronic health records and health information exchange as a way to increase efficiency and to cover more uninsured patients. She noted that New Mexico is one of the poorest states and has one of the highest level of uninsured and Medicaid recipients.

Gunter said they had hoped for even more progress by now. The community collaboration and matching funding have not been as supportive as they had hoped for. Their plans called for a community wide disease management system and a fully operational exchange to provide comprehensive information across various health settings, available to the physician at the point of care. They had also hoped to have a patient portal by now, especially for patients with asthma and with chronic diseases like diabetes, so that they could better self-manage their own illness. Gunter said they have not given up on accomplishing those aims, and on the importance of a health information exchange. But they acknowledge that building a health information exchange is more about the sociology than the technology, and that innovation is messy, especially when it requires reaching consensus among many different community organizations with diverse and sometimes competing interests.

Ms. Gunter noted that RHIOs across the country are taking longer than expected to develop into fully operational systems with solid business cases. She stated that federal grants and contracts alone are not the answer, but because of the expense involved and the technology required, federal support is critical for getting RHIOs to the place where there is a solid business model.

Ms. Gunter characterized the project's aggressive one-year timeline as both scary and wonderful. She said the aggressive timeline allows participants to show the nation that a health information exchange both within and across states is feasible; it also requires them to quickly come into compliance with standards. This timeline is only achievable through a very collaborative Workgroup that allows participants to share their expertise, which is helpful because each individual participating practice limitations and constraints in personnel and expertise.

Another significant strength in the project's model is that each site is required to create its own business model depending on the needs of its community, which will ensure that the interoperability that has been created is sustainable after the project's grant funding is over. Gunter stressed that is essential for to engage both large national employers and local employers in these projects, given that how much US employers have at stake as healthcare costs continue to escalate. She said some companies are unable to compete in the global market because of the enormous amounts of money that they must spend on healthcare. Corporate participation is also important because corporations have expertise in the area of business models.

Secretary Leavitt noted that Google and Microsoft, among others, are beginning to develop platforms for personal health records. He asked Dr. Loonsk for an update on the progress in the ability to send data for health exchanges like the ones being created through the NHIN projects to such private platforms. Dr. Loonsk said this has been part of the NHIN vision from the start. With the connectivity and the single set of standards being created through the NHIN projects, the private "health vaults" will have access (with the appropriate controls) to all the networked hospital and ambulatory care data. Without that access, the health vaults will not be as valuable a tool, and Loonsk said that the importance of the standards being developed will become self-evident to companies like Google and Microsoft.

Discussion Highlights

"It has educated our elected officials, quite frankly. We worked very closely with Virginia and Tennessee, and with our governor of Tennessee serving as the co-chair of the National Governor's Association State Alliance for E-health. That's something that he's been very interested in. So our involvement in NHIN1 and now NHIN2 has really helped us kind of be a conduit for those state officials to stay involved with, to stay abreast of, and to kind of align what they're doing, what CareSpark is doing, and what's happening at the national level."—Ms. Jenkins

"We did not get into this project in the first place because of a grant. Our community started this because we know we've got major issues. Probably more urgent than many other communities do. We have significant disparities in the Appalachian area. We have huge challenges to face in broadband access, in health outcomes, in patient involvement. And we recognized, about the year 2000, that our community is going to have to step up to the plate and do something. We would have done it with or without NHIN, but it's a lot easier to do it with you guys."—Ms. Jenkins

"I am a medical sociologist, and I have to tell you that every single sociological skill I've ever developed has been tested in working on health information exchange."—Ms. Gunter

"One of the things about the NHIN project that I think is both scary and wonderful is it has a very aggressive timeline of one year for demonstrating and testing interoperable exchange across our nine sites. I think, as scary as it is, that an aggressive timeline is exactly what we need, because we must show the nation that health information exchange both within and across states and communities is feasible. I think we'll also expedite and facilitate the compliance with standards in each of our sites. These are hard things to do, and sometimes this is exactly the kind of catalyst that we need to do that."—Ms. Gunter

"When I talk to legislators and citizens about this, they kind of nod and say, that's really important. I know how frustrated I am. I can never get all my records wherever I go, and mostly, they're surprised and dismayed that this doesn't already occur. [They say] 'Well, I just supposed that we already had this kind of linkage across places. We have it with Jiffy Lube. Why don't we have it with our healthcare data?' And we cannot afford to lose the momentum and the enthusiasm that has been built in so many communities. That's my biggest fear."—Ms. Gunter

“If the health records bank is the model, our region is quite likely to fall even farther behind than we are now, because we have a lot of folks who really don’t have the education, the income level, the computer access, and all the other things it would take to manage that. So we’re literally building on the relationship between the clinician and the patient to figure out how to integrate that information from the patient and the clinical setting.”—Ms. Jenkins

“What are you doing, within your programs, to engage consumers as you’re building the networks, and in trying to measure with consumers and patients, what are they looking for specifically at the end of the day so that they do want to become engaged, and they do feel comfortable with the process?”—Ms. Nancy Davenport-Ennis

“That was a softball tossed to me, wasn’t it, Nancy? Our region has done quite a bit of work, again. We have been very publicly now, for almost five years, talking to this about our community in the media, in presentations to everything from civic clubs to seniors groups to Sunday school classes, I mean you name it. We have actually done questionnaires. We’ve done fairs and focus groups, and solicited input from people in our community, just regular citizens, about, you know, what benefits would this bring to you, what risks do you perceive, what kind of information would you be willing to share, with whom, for what purpose. You know, who’s responsible for the security, and all that kind of stuff. So we have been very, very public in about what we’re doing. And literally invite people through our website, and every time we do, to get feedback to us.”—Ms. Jenkins

“We have taken a much more active consumer role in the last year, as we have understood that the concerns nationally about privacy are very substantial, that you cannot—it is not only what you can do from a HIPAA standpoint, but what is wise to do from a consumer standpoint. So we have changed a great deal. We’re working with lots of different stakeholder groups, consumers, about privacy; but trying to find a way to balance the needs of privacy—and all of us, we’re all patients. Every one of us. And every one of us in our family has somebody that probably has a mental illness or AIDS or something of that sort, where there is a great concern that they have about having their data shared.”—Ms. Gunter

“There were a lot of comments made by other networks and RHIOs and HIEs about the value of NHIN2 in moving their own strategies forward, and whether or not they could be supportive of participating in the trial implementations in the next phase, given the pressures they’re under from a business perspective, as well as the demonstrations and the implementation of the standards that they feel they need to move forward with. I think the question that I would ask is, what made these two organizations or other organizations feel differently to participate in these implementations, which we all feel are very important?”—Mr. Kevin Hutchinson

“So I’ve already expressed to you our attitude, I guess, about being a part of the solution, and feeling that citizens need to speak up and participate in governance, and that was very much a part of our decision. I think we also have a philosophy of collaboration, and we know that it takes work at various levels, but even more importantly for us are really kind of two things. Number one was probably timing. Had we been an organization that had a technical infrastructure in place for several years, and it was designed like this, and, you know, we wanted to keep that, that would -- that was different. But we were sort of at the sweet spot of having done a lot of the planning and tracking along pretty closely, so the timing for us was a good match with what NHIN2 was proposing. The other thing was, and we made this very clear to John, our board—my board and volunteers and partner organizations were very adamant about this, too: only if it meets the needs and priorities for our community. The outcomes that we know we need to get in health improvement and cost savings, those use cases have to line up with our needs. If they don’t, it’s just a distraction for us to work on something that’s not that important to us. Those were really the criteria.”—Ms. Jenkins

CCHIT Update

Mark Leavitt of the Certification Commission for Healthcare Information Technology (CCHIT) announced that one week ago the first inpatient EHR products were certified. Last year, he said, CCHIT worked on ambulatory products for doctors offices, and this year they have started working on products for hospitals. Certifications are announced on a quarterly basis, and six hospital EHRs have now been certified. Four are full certifications, meaning it was an existing product already in use in the market. Two of them are what we call pre-market certifications, which means it's a new product. CCHIT will wait until these new products have been in use with at least one customer for 45 days who will verify it. Then CCHIT will issue a full certification.

Leavitt said that in speaking to the vendors, CCHIT learned that this certification initiative was a primary driver in the decision to invest in new product development. So CCHIT is actually encouraging capital investment in health information technology.

In the ambulatory sector, in the first four quarters, CCHIT certified 44 percent of the vendors who deliver the product used by over 75 percent of the doctors using EHRs. There were about 200 vendors of ambulatory care EHR products.

In the hospital market, Hutchinson said, there are only about 25 vendors, so the six certified vendors represents 24 percent of the total. So in the first quarter, CCHIT is ahead of the pace set in ambulatory, in terms of the percentage of vendors involved. Applications were being accepted for the next round until November 14, 2007. Several applications had already been received.

In the ambulatory sector, CCHIT updated the criteria in 2007. In particular, standards based e-prescribing is required. Nine products have been certified, and about half dozen more are in process. The total number of ambulatory products now certified is nearly 100, Hutchinson said.

Hutchinson then updated the Community on the development work for 2008 standards. In e-prescribing, standards will also include medication history and formulary checking beginning in July 2008.

CCHIT is adding four new domains this year: the health information exchanges or networks, plus three areas which the marketplace requested of CCHI: emergency department systems, child health care, and cardiovascular medicine. The first step,

CCHIT received about 1,000 public comments to the Environmental Scans, which is the first step in drafting the criteria. Hutchinson expects the first draft to be released November 21st, and it will have a 30-day comment period.

In order to ensure that interoperability testing is done thoroughly, CCHIT announced a collaboration with the MITRE Corporation, is a nonprofit, federally funded research and development organization, to be the technical leaders on this project to develop testing tools in open source code. A kickoff teleconference announcing this was scheduled on November 15th.

Hutchinson summed up the progress in accelerating Health IT adoption by pointing to the financial incentives that are starting to emerge from both public and private payers—particularly the announcement made earlier from CMS about their pilot project. States and regions are working with CCHIT to develop their initiatives. Finally, CCHIT is working with Karen Bell at ONC to look at the possibility of malpractice premium discounts for physicians using EHRs.

Discussion Highlights

“Mark, tell us about volunteer fatigue. How are we doing on that?”—Secretary Leavitt

“We’re actually doing okay on it. We became aware of the issue fairly early on, because so many initiatives started and they all depended on volunteers. So what we did is we added staff this year, last July, so that the volunteers didn’t have to do quite as much homework. And we also added new areas so that people could focus on what they cared about most. A new privacy and compliance group, for example. Volunteers are the key resource of CCHIT, and you really have to monitor how happy they are. It’s just like your employees. How are they feeling, what’s the morale, how well are they coordinated? It’s not easy, but we’re not hearing that they’re fatigued. What you’ll be hearing is that there is lots of debate, and it will bounce out into the press sometimes. I think that’s perfectly healthy. Because that’s actually what keeps them engaged, is that they heard there is an open process, and then when you’re finished, you’re having an impact. So last year, we had twice as many applications as we could accept for volunteers. So I’m hoping that we’ll see something similar next April when we go to refresh the group.”—Mr. Leavitt

“Years ago I used to watch my grandmother take certain materials and she’d put it in the top of a thing and she would turn this crank and it would all get ground through this process. And that’s where we came up with the analogy of turns of the crank. Our goal has been to get through three complete turns of the crank from use case all the way to your place where it comes together. Could you give us an assessment of where you think we are right now? Can we get the three turns of the crank if we just keep turning? Are we pushing too much material through it? What about our pace and productivity?”—Secretary Leavitt

“I think actually the pace now is right. The start was lumpy, because we tried to start things in parallel that people thought should be sequential, but you couldn’t make them sequential. But actually it’s lined up very much now. So the use cases coming out of the community now are the ones that are real practical things that we can drive a standard into the HIT systems about. And so I think that 2008 is the year that you’ll actually see all the pieces.”—Mr. Leavitt

“I asked the NHIN panel about the number of new large technology players who are seeing an opportunity in the personal health records space. In my judgment, that will be the energy that ultimately drives this whole thing. But they have to have the ability to populate those electronic health records, or personal health records with data coming from the 98 systems that you have now certified. Could you elaborate some on just how much work are you seeing between those systems and those large technology providers, and the extent to which this system of standards is necessary to enable that?”—Secretary Leavitt

“That’s a really good question. The system of standards is needed, not only to enable it, but to make sure that patients have freedom of choice. So we wanted to actually energize competition between providers for not just quality and safety, but could I mention convenience? And so you really want it now. You really want those standards now, because you don’t want it to evolve into a proprietary world, where it’s not as competitive. So I think we need them very much.”—Mr. Leavitt

“I heard a lot this morning about the safety and well being of our patients as our highest priority. And Kerry, if I understood what CMS is doing about electronic prescriptions, it’s [that] you’re creating a standard without requiring usage. And I’m still looking at all of the data that suggests that thousands or tens of thousands of people in this country are impacted each year because we don’t have 100 percent e-prescription. And so my question is, this is the 17th meeting of this august body. We’ve discussed this at

meeting number one, two, three, four, then we went dark, and now we're back at 17. Where are we?"—Mr. Craig Barrett

"There may come a time when we require—right now we don't require it as a condition of writing a prescription, but if you write an electronic prescription, then you must use our standards. And certainly, there is a considerable push out there to do that. I believe Mr. Serota wrote us last week or the week before about that. We are not, you know, completely deaf to those exhortations, but we're not yet in a position to require it."—Mr. Leavitt

"You ought to talk to your friends in the IRS or the EPA. They don't seem to hesitate to put requirements in without the necessary base involved. I'm just—I go back continually to the issue of patient safety as our highest priority. This is an obvious issue, and we seem to just be moving ever so cautiously and slowly on it when we could make a giant leap and perhaps facilitate the movement of the infrastructure and the capability."—Mr. Barrett

"One of the things, Craig, for those of us who have been in healthcare systems, especially large healthcare systems, what we found is that as good as something might be as an idea, that until you have a base in there that in some cases may be up at the 30 or 40 percent range, you haven't worked through all the issues. And if you put an arbitrary date in before having that, at least in the healthcare arena, it has sometimes caused a problem. Now, the question is how you put incentives in, so you can get to that more quickly rather than starting with the stick."—Dr. Kolodner

"I'd just like to reinforce what Craig said. I think in the case of an institution like a hospital, where you've got computerized prescription order entry, you have an institution that can bring people along. And I agree with ... reaching the 40 percent. But I think in terms of individual physicians, you're not going to get to 40 percent in this century unless you require it, frankly. You're not going to get to 50 percent. You're not going to get to 20 percent. So I think it's really the only way to go. You're going to have some use, but it's not going to happen until you just tell people. And I think this is one area where if you tell them, I think they're going to have to do it."—Mr. Kahn

"I just don't think there is anything happening out there that's going to get you to the tipping point. Having standards is great, important, it sends a signal. But there is not anything sort of promoting—pushing you to the tipping point. There are some vendors out there that are pushing products, but it's not going to happen, I don't think. I mean in the hospital situation, whether it's leap frog or some payers are compelling hospitals, and so the hospitals are beginning to work with the doctors; but in terms of individual practices—you know, just look at the numbers. They're pitiful, and they're not growing that rapidly. They're growing by the hundreds. They're not growing by the thousands. And so I just think if you look at the trend line, it ain't going to happen unless something forces it."—Mr. Kahn

"I will tell you that, you know, we stand today with 40,000 of the 55,000 pharmacies in the United States, are live on the network and ready to do electronic prescribing, and that continues to grow. There are an average of about 100 physicians a day that are logging on to the network and registering to get the network to do electronic prescribing. That's 100 per business day. But we're not seeing the utilization that we would expect to see. It's still very much in a pilot mode. Even those physicians that are coming onto the network are processing maybe 10 to 15 percent of their total prescriptions electrically, and still picking up the pad. And we go back to this issue of the DEA. We have to solve this DEA issue. It's only one of the issues. There is a lot that we have solved over the last several years with your help, but we need to solve this DEA issue on controlled substances for schedule two through fives, because it causes physicians confusion and concern about when they can write electrically and when they can't."—Mr. Hutchinson

“The one number I would remind everyone, and I’ve said this in meetings past, but when we get to the tipping point, it is about, you know, a 30 or 40 percent range, but it’s not about 30, 40 percent of physicians. It’s about 30, 40 percent of the volume. And 30 percent of the physicians of the United States write 80 percent of the prescriptions. So if you’ve automated 80 percent of the prescriptions of the United States going electrically, you have, in fact, improved enormously patient safety, and it’s those 30 percent of physicians writing 80 percent of the volume that we really need to get to.”—Mr. Hutchinson

Health IT Physician Adoption Survey

Dr. Jane Sisk presented the current statistics about EHR adoption in physician’s offices, gleaned from the National Ambulatory Medical Care survey and the National Hospital Ambulatory Medical Care surveys. These surveys reach 3,350 office-based physicians, which will grow in 2008 to an additional 2,000 when a mail survey is added. Additionally, the surveys include 500 hospitals. In both surveys, representatives conducted in-person interviews, followed by medical record abstractions. There was about a 63 percent response rate in offices, and a 92 percent response rate among hospitals. For 2006, EHR usage has been on the increase, and in 2006, an estimated 29 percent of physicians who reported using either full or partial electronic medical record systems, up significantly from 2005.

Sisk showed that the survey defined the percentage of office-based physicians using various EMR features, and also showed how these features correspond with the features that were identified in another study as being necessary for minimally functional systems: clinician notes, prescription orders, test orders, and imaging results. About 12 percent of the physicians surveyed reported that they had those minimally functional selected features in their EHRs.

The study found that the more physicians were in a practice, the greater the adoption rate was reported to be. Physicians in health maintenance organizations reported a significantly higher rate. Physicians in the west reported a significantly higher rate than those in other regions of the country. About 34 percent of all physicians in this country are solo physicians, accounting for about two-thirds of the practices. Their reported rate of any use is 24 percent, and of the minimally functional features, about seven percent.

2005 data shows that patients having access to practices using EHR systems in urban areas was significantly higher than rural. Privately insured patients are more likely to have them than Medicaid or Medicare. Hispanic patients were significantly less likely to be visiting practices with EHRs than non Hispanic black or non Hispanic white. There was no significant difference between the two non Hispanic categories, whether black or white.

Dr. David Blumenthal discussed a survey in progress. This survey about health information technology was mailed to about 5,000 currently practicing physicians randomly selected from the American Medical Association master file. They expect to get responses from about 3,000, which would be a target response rate of about 60 percent. The results presented today are taken from only about 400 of the expected 3,000, and may not be typical of the final numbers.

Dr. Blumenthal presented the definitions of an EHR. The historical definition has allowed providers to define an EHR (excluding billing records). Then there is the minimally functional, or selective EHR, which encompasses a set of minimal functionalities. Finally, there is a functional electronic health record, which fully encompasses the basic functionalities that should characterize an electronic health record, according to the Expert Consensus Panel.

The minimally functional EHR has six of the 17 functionalities that a fully functional EHR would have. About 39 percent of physicians answer positively to the historical NAMCS definition. They say they have

an electronic health record, without the surveyors defining it for them. About 14 percent have minimally functional EHRs. About five percent have functional EHRs.

Barriers to ERH adoption are

- Lack of capital (70%)
- Finding a system that meets their needs (56%)
- Uncertainty of the return on investment (55%)
- Systems becoming obsolete (47%)
- Loss of productivity (39%)
- Capacity to implement (37%)
- Physician resistance (33%)

Discussion Highlights

“I think that the best information available suggests that there are some gains to physicians, but they are very small compared to the gains that are realized by other parties that participate in the healthcare system. And the parties that gain most are insurers and ultimately, employers. And payers of all kinds. And so there are some things that physicians, once they get really well working EHRs, can gain. But if you’re looking for rapid adoption, the major incentives will be felt by groups that have internalized the financial gains.”—Dr. Blumenthal

“I prefer to be on the positive side of the equation, and that’s around the incentives. And we’ve said, at least in our Workgroup and here more than once, that monetary incentives are pay for adoption, is clearly a key component, and I would just like to hear a little bit about that, why it’s not a part of this conversation here. I’ve got hours and hours of transcript for you, if you’d like to read through it. But this notion of incentive for adoption—and Mitch, what you brought up is a slightly different angle than what we’ve talked about in our Workgroup meetings. And that is that benefit goes to those that would not adopt. We’ve got to overcome this. We absolutely have to overcome this particular aspect, so I would love to hear what the survey said in terms around incentives, and what this work might be able to do to recommend to the Secretary. You know, this meeting so far has been great. Excellence is breaking out everywhere, as we say. So how do we get these incentives where they need to be to get going in a rapid way? I’m struck with the fact that we’re not going to be around here much longer, I don’t think. The new successor will come in and the work that we’ve begun, we want to see come to fruition before the next turn of the crank, so to speak. So where were the incentives in the report?”—Ms. Gelinas

“Well, we have some information that wasn’t presented here that looks at incentives reported by physicians that we queried. And the top two are financial. One is the availability of capital. The other is compensation—additional compensation for care rendered. So it’s pay for performance or pay for use of the electronic health record. And a third, which has also come to light here, and been mentioned, is relief from fear of liability. It’s not quite discount. It’s concerns that something about the use of the record will make physicians more vulnerable to legal—to torts about the care they provide.”—Dr. Blumenthal

“My only comment on the access to capital issue is it’s not as clear as it appears on this issue, because we, in the blues, have tried on numerous occasions to give away practice management technology to physicians, and they won’t take it. So it’s not simply that they can’t afford to pay for it, it’s more like they don’t want to change the practice—the pattern of practice that they have in order to adopt the technologies that are required. And I also raise a little bit of concern, as you might expect, to the comment that insurers and employers are the ultimate beneficiaries. Patients are the ultimate beneficiaries of this. The objective of the electronic health record is to improve the quality of care. The economics will follow, because high quality care is more cost effective. So the economics will follow, but the ultimate

beneficiary of an electronic record will be the patient who will get a more integrated care experience. And so, you know, I think we need to kind of put it in that context. If we build the model of an electronic health record around economics, around “it will be less expensive,” I think two things will occur. One, it will never get adopted. Because it won’t be less expensive to the practicing physician, initially. It will be over time, but there is a hurdle. And second, we’ll be missing a lot of uses of that electronic record, because it will focus on the wrong things. We will not focus on informatics. We will not focus on gathering data and information. And it will miss a whole big piece of that puzzle”—Mr. Scott Serota

“Simple question. Was it a hard copy a mail survey?”—Mr. Barrett

“Yes.”—Dr. Blumenthal

“That has got to be the biggest statement about what we’re talking about here. When was the last time anybody in this room filled out a hard copy survey on any topic?”—Mr. Barrett

“This whole discussion really is about, how do you motivate change? Do we motivate change by paying more for process or do we motivate change by paying more for results? And we’ve just announced this new electronic health record demo, where we’re going to take 12 different regions and we’re going to engage in this discussion, in a very practical way, with a hundred practices in each region. 1,200 practices. 3.6 million patients. This is exactly what we need to find out, is how do we construct a business model that will motivate change, or at least complement our need to change in other ways? I mean, we may have to say society demands this occur, and we’re going to demand that it occur in the following ways. But somehow we’ve got to make this business model transition so that some of the savings that comes from quality finds its way into the pocket of the physician.”—Secretary Leavitt

“I know that at some point, we need to use the purchasing power of the federal government. And I expect that it’s at a point where it’s done, that the private insurers will begin to do the same thing, where we say it’s now an expectation: if you’re going to do business with us, that you use these. Where we are on this process of tipping is an important thing that this group could give me some advice on. I don’t expect that your advice would be conclusive, but I would like to have you follow on the conversation.”—Secretary Leavitt

“One thing they have in common is the challenge of speed and everybody finds these current systems, all the commercial available systems still frustratingly slow. It still interrupts the doctor/patient relationship. And you’ve mentioned that in productivity, I think, here, but I want to mention it. The speed of the systems is still frustrating.”—Dr. Ward Casscells

“The second thing that comes up, if you really have a second cup of coffee with the person, or know them well, is that it’s challenging to your ego, when the system gives you unsolicited advice or corrects you, and that’s not so hard to take, if you think it through cerebrally, you know that—and maybe you have some deeper knowledge about this, Dr. Blumenthal, but you know that it’s going to improve your quality of care, and the patient is going to benefit, and you, as the doctor, are going to look better and [have] less chance for a malpractice lawsuit. But somehow, it just still grates on doctors to have a machine telling them—questioning their judgment.”—Dr. Casscells

“Talking to my brother about this the other day, who is in private practice. He’s had several turnovers in electronic systems over the past decade, maybe 18 or so, a lot. He says one of the big problems is that when you document things, which we all—you and I think is critical for quality of care. I know Dr. Kolodner agrees: you ought to be immunizing yourself against some of the risks. But the fact is that the legal risk—the malpractice risk is still overwhelmingly weighted towards things that you do, rather than things that you fail to do. So a lot of these people just feel safer by not documenting—the less they put

down, the better they feel. And it's going to take the kinds of—I think Secretary Leavitt had his finger right on it. You have to be reimbursed, you know, that week for the notation that the colonoscopy was, you know, scheduled or was declined, because we still are so underpaying for preventive care and paying for procedures to a large extent.”—Dr. Casscells

“What I'm saying, Dr. Blumenthal, is if you have more data on physician resistance, and on this question of loss of productivity, if you can give us more breakdown, maybe not today, maybe at another session, that would be very helpful. Because we're redrafting policies for our 10 million beneficiaries now in defense. And that alone would be a big service to us.”—Dr. Casscells

“If I can take my research hat off and put on my practitioner's hat, I converted to an electronic record when I tried to prescribe a sulfa drug to a patient who was allergic to it, and the record said, you can't. And that was, to me, a kind of seminal moment in my use of the record. It didn't endear the record to me when it also prevented me from ordering a stress test on a patient who wanted it, because it said the indications weren't there, but I think you take the good with the bad in these things.”—Dr. Blumenthal

“We will be able to get you additional data, perhaps not all the data you'd like in terms of motivation, and psychology, and physician attitudes, but we will be able to get you more data about some of these barriers and incentives in our next presentation.”—Dr. Blumenthal

“There may be some parallels in some other aspects of business. For example, Congress, in its infinite wisdom, passed something called Sarbanes-Oxley. Every public corporation in the United States had to immediately change the way it did business, had somebody looking over its shoulder, public auditors, public reports about how you did this, how you did not do it. It cost us all millions of dollars. I think it cost my corporation something like 25 or \$30 million a year for the first three years or so. And documenting every aspect of our doing business, and every decision we made. And how every internal control operated. This is not a new issue. Every other business in the United States has done this. As I keep trying to remind this audience, I know that medical care is different. Everybody says their industry is different, but there are innumerable instances where massive changes have taken place almost overnight in the way we do business. Somehow, we're more resistant in this area than every other business that I know of.”—Mr. Craig Barrett

“We don't need any more studies. There's plenty of data out there that suggests the value and the benefit that comes out. Most recent ones that came out from Henry Ford Medical Center that spent well over a year looking at this issue, and where the benefit lies. And the fact is, all the participants in the prescribing process benefit by automating this process. Physicians benefit because they're not reimbursed for their time to manage medications, to take phone calls for refill requests, to handle patient calls for those refill requests and pharmacy calls for illegible scripts and things like that. But they have to take the time to do it, and they lose money through that process. The patients obviously benefit from a safety standpoint and from a convenience standpoint of having those medications ready when they show up at the pharmacy, and from a safety standpoint, obviously, of avoiding drug interactions and avoiding contraindications of medications. Pharmacies benefit because now the recent studies show that they're actually dispensing more new medications when sent electronically, because there is more compliance with physician's orders on initial medications that are ordered electronically versus ones that are handed to the patient that actually never make it to the pharmacy, but they only make it to the glove box of the car. And the employers and plans benefit because what Henry Ford has seen, and we all assume this is the case, there is more generic utilization when prescriptions are written electronically. They've even analyzed and they look at how many drug interaction avoidance they had last year with over 1 million medications that were ordered electronically and analyzed, and the percentage of those medications that because they were written electronically, found drug to drug interaction issue problems or allergic problems. It ended up saving them a lot of money, because they're obviously the health plan as well, in avoidance of emergency

room visits and hospitalizations. So all of the data is there that suggests that all of the parties that are participants in this process benefit from it. Some would say, well, then why are the physicians bearing all of the cost of this? And that's not true. The physicians aren't bearing all the cost of this. The pharmacies have borne a lot of cost in implementing and upgrading all of their systems to support these standards that have been required by HHS with NCPDP script standards."—Kevin Hutchinson

"But I guess the point I want to make is before we go too far down the road and say, well, let's go analyze it or look at it, I don't think we need to do that. I think there is recognition that all parties benefit from the process. The question becomes, how we should incentivize the physicians to adopt, whether it be through positive incentives or negative?"—Kevin Hutchinson

"I was intrigued when Kevin said that 30 percent of physicians represent 80 percent of the prescriptions. Did I hear that right? Okay. So if 30 percent have the large majority, what's the cost to get the 30 percent automated? And I don't think we've ever approached it that way before, because then you're really reaching the tipping point. Do we have a handle on that number or not?"—Ms. Lilee Gelinis

"Let me bring us to a close at this point. I think there are a couple of things that we know of. First of all, the Secretary wanted us to engage in a further conversation about e-prescribing, and we, I think, don't have the energy to do that today. But what I would like to do is to, in fact, make sure that we do that in January. Lilee, maybe the EHR Workgroup can spend a little time helping to frame that. It will align with David coming back with the full report, and not based on 400, but based on 3,000 responses."—Dr. Kolodner

"We've discussed this on and off for 17 meetings. The issue is, if you believe Kevin's numbers, and he's quoted those numbers every damn time, they haven't changed. I have to believe they're right. Thirty percent of the doctors do 80 percent of the work. You want a tipping point. Go up to 30 percent of the doctors. By the way, what we do here means nothing. It's what you guys do that means something. You have the purchasing power. You have the control to say -- not these are the standards, but these are the standards and you will be reimbursed if you do it this way. Period. I mean seems to me this is the simplest possible decision that somebody has to make. It's not a discussion topic. We've discussed this painfully several times. If I sound like I'm frustrated, yeah, I'm frustrated. In the business world, this would have been a done deal 17 meetings ago. Slam dunk. Get on with it. Falls in your guys' court."—Mr. Barrett

"I think Craig Barrett's comment deserves a real answer. I share his frustration. I'm looking for ideas for a kind of demo we can do: it may be that a year from now, the Navy doctor or Air Force doctor doesn't get their check on time, until they get their certain percent of prescriptions done electronically. I don't know what we're going to do, but we have a dutiful bunch, and we have really complete control. I don't want to suggest anything we do is really going to be very instructive to the larger group of physicians. But I do think a clear demonstration of these kinds of microeconomic incentives that the Secretary mentioned is necessary, and I don't want to put Kerry Weems on the spot, but gosh, this is the place to discuss this. And the Secretary's posited some things, and Mr. Barrett has expressed the frustration that the business community feels. I know the hour is late, but can't we do something?"—Dr. Casscells

"I did take the liberty of checking with counsel and that points to one of the great differences between business and government, and why we have government and why we have business. And that is that it would require a change in the statute for us to compel this. So it's not within our means. Certainly it is within our means to ask the legislature for that change, but it's not within our means just to do the slam dunk."—Mr. Weems

"But I want to support Craig's position. I don't need to see any more data. I've got data everywhere. I don't need to have people waste more time, doing more research, doing more surveys. We know the

answer. And maybe we, as AHIC, need to collectively put pressure on Congress through a letter to the Secretary, through a letter to the leadership and Congress to say look, we have studied this until we're blue in the face, and there is only one solution, and that is to mandate compliance with electronic prescribing."—Mr. Serota

"I mean the data is overwhelming. Our blue data, a third of the prescriptions—when people get electronic, a third of them have drug interactions. You'd save the money alone, forget generic substitution. I mean if you don't want to get into the dollars, just talk about the quality implications. It doesn't matter what measure you look at. The case is compelling."—Mr. Serota

"And I am very sensitive to the physician's practice disruptions. I resisted e-mail and all those things, too, but eventually you got to do it. And now I don't know how I existed without it. And I suspect once we get over the hump of 'I didn't really want to do it,' once the practices go electronic, they'll wonder how the heck they ever operated with paper and pencil before."—Mr. Serota

Advancing the National Framework for Uses of Health Data

Dr. Don Detmer thanked Secretary Leavitt for addressing the American Medical Informatics Association meeting earlier in the day. He explained that AMIA's goal is to make IT work well for health professionals. It has approximately 4,000 members from 53 nations. Two-thirds of the members are involved in clinical healthcare and in informatics. About a quarter of the members are in public health or population health, and the rest are in translational bioinformatics, taking the human genome data and moving it toward patient care. AMIA started with some colleagues from Pfizer Pharmaceuticals in 1985 with the support from a variety of corporate supporters. They convened their first conference in 2006 with about 30 experts.

Dr. Detmer said he will discuss the uses of clinical data and its importance, then outline the studies that AMIA has done, and then talk about next steps.

Dr. Charles Safran explained that AMIA's research starts from the premise that use of health data is a good thing, and that more of it would be better, under appropriate conditions. So when they discuss the secondary uses of health data, he would begin by reminding everyone that AMIA wants to facilitate more and better use of this information in order to enhance experiences for individual citizens, to expand the knowledge about disease and treatment, to strengthen the understanding and effectiveness and efficiency of our health system or health sector, to support public health and homeland security, and to help businesses meet the needs of their customers.

AMIA published the framework which Dr. Safran believes was provided to AHIC in January of 2007, and convened a second conference in June of this year. They have presented to the Consumer Empowerment Working Group of AHIC, of which Safran is a member. They have testified before the NCVHS in July, and submitted our taxonomy to NCVHS in September. They have also submitted a consumer checklist to Dr. Kolodner and the Office of the National Coordinator.

AMIA has dropped the term "secondary" as being not productive to the discussions, the further discussion of the issues before us. But at the time of the study, we defined primary as being for reasons of patient care, so information that was collected in the context of a clinician patient relationship. And secondary was everything else. Today we believe that it's appropriate just to talk about uses of healthcare data in an appropriate framework.

What they found was, first, that the uses of health data were very widespread, sometimes beyond the existing policy and legal framework. Secondly, they found that issues of privacy dominate the public policy to date. Third, they came to understand that the pace of development outpaced the pace of policy and practice. They uncovered businesses whose fundamental business case was that they were operating beyond the HIPAA framework. AMIA was concerned at the time that the emerging RHIOs would eventually discover, as a business case, that perhaps they might be able to resell their data, that that might be a part of their evolving business model. Fourth, they felt that it was not productive to talk about data ownership, and that to forward a policy discussion, that it was perhaps important to put forward the idea of stewardship. They had an intuitive sense of what data stewardship was, but no precise definition. They have since added further definition to the term “stewardship.” Finally, AMIA identified in 2006 the need for more leadership at the national and state levels. Dr. Safran commended the Secretary, Dr. Kolodner, Dr. Gerberding, Dr. Lenert, and Dr. Solomon at CDC, for putting forward on a national basis this issue.

Dr. Safran reiterated that when he talk about the reuse of health data today, for purposes of this discussion he includes the term “secondary” just for anchoring effect. He is talking about data that’s collected for or used for reasons for other than those for which they were originally collected. This data is valuable for reasons of quality, safety, public health, payment, business operations, research, provider certification, accreditation, post marketing surveillance, and a variety of appropriate business uses. Which opens the question, what are questionable or inappropriate uses of data?

AMIA’s work proceeded to define a framework for reuse of health data in six dimensions, as follows:

Accountability. That is, the levels of sanctions or penalties for disclosure or inappropriate use of patient health data, transparency, the extent to which the practices governing the use of patient’s health data are known and understood by those who disclose or use patient data, and to the patients whose data are subject to use.

Patient consent notification. The opportunity offered to patients to allow or permit the use of their health data. Notification refers to the mechanism by which patients are informed of their right to consent.

The cost and complexity of re-identification. Dr. Safran explained that there is some scientific work which led them to believe that data can be reidentified by publicly available databases. If reidentification is not possible today, the group felt that technology and data available tomorrow might allow for the reidentification of an anonymized database.

Oversight. The extent to which the entity is subject to governance or supervision, including the ability to impose remedies for breaches.

Regularity/law. The framework for regulations and law that governs the use of health data, including penalties and enforcement guidelines.

Within that framework AMIA created a consumer checklist for awareness about personal health information, how it was being used, and how policy might be devised, particularly for non-HIPAA covered entities:

A Data Reuse Policy should:

- Be prominently posted, with an effective date
 - Written in clear understandable language
 - Identify contact to resolve privacy issues
 - Describe any & all uses of health data & any sharing of data with other organizations, whether you can be identified or not
 - Describe how personal data are protected

- Describe how to receive a free report of who has accessed your data, & when
- Describe how your permission is obtained to share data with others
 - Decisions to opt-out of data sharing should not result in denial of services
 - Provide advance notification of any changes
 - Allow termination, without penalty, if you do not agree with the changes
- Describe whether, upon termination of the agreement, you can remove your data & prevent further disclosure, whether identifiable as yours or as part of a group
- Describe how your data are handled if the organization is sold, merges with another organization, or files for bankruptcy

Dr. Detmer said they thought it was important to define the language that is used when discussing issues and creating policy. To that end, AMIA created a taxonomy that identifies possible uses of personal health information to clarify societal, public policy, legal and technical dimensions. They acknowledge that the words used are dynamic, and the taxonomy will need to evolve and be maintained.

AMIA is proposing the concept of “data stewardship.” Dr. Detmer said the idea is that if you’re a certified data steward (however that gets defined), that you can transact with other certified data stewards under the same umbrella, and that a citizen would trust that the person or the entity that you are handing the data to would abide by the same rules and understandings and philosophy and policy of the original entity to which they contributed their data.

There is a need for data analytic principles for the following reasons:

- A statistically sound approach is necessary for analysis of large clinical practice data sets
- Random analysis or unstructured data mining could yield associative conclusions & potentially introduce false positive associations
- Standard data analysis principles provide a framework for sound studies with credible and reproducible results, & for minimizing errors possibly introduced during analysis
- Data analysis principles mitigate the risk of false positives that could cause misidentification of a safety problem
- Provides a grounding for multiple parties such that analyses can be more readily compared

Next it will be necessary to refine the data stewardship principles, which we have discussed in their broader framework. These principles include

- Accountability (including governance, oversight, & extent & level of applicable regulations)
- Openness & transparency (including structure, processing & delivery of data, plus business processes & practices)
- Notification to patients
- Privacy & security (including data quality, de-identification, & costs of re-identification)
- Granularity of consent
- Permitted uses & disclosures (including data aggregation & analyses)
- Data analysis principles
- Enforcement & remedies

Dr. Detmer then addressed the work that AMIA will do next, which is as follows:

- Differentiate appropriate & inappropriate use of data
 - Provide additional granularity for the commercial use category
- Develop recommendations to assure maintenance of Use Taxonomy

- Refine Stewardship Principles included Data Analysis principles
- Publish white papers
- Participate with AHIC, NCVHS, IOM & others, particularly with respect to negative impact on biomedical & health-related research

Discussion Highlights

“How would you ascertain industry alignment of other major groups, in getting behind this work and endorsing it, and vetting it, so that we know that it’s one voice, one work, you know, multiple recipients?”—Lillee Gelinias

“We’re in process of trying to think about how to drill down on the one very hard part that we had—I shouldn’t say the one very hard part, but the part that was hardest for us, was getting any sort of alignment around what was a use of data where there was an exchange of money. So we sort of abandoned the term “commercial” use of data, because what it meant to be a commercial entity was a sticking point. But if you look at the uses of data around where there is an exchange of money, so sometimes companies, for profit companies do work for the government to develop quality databases, for instance. And so we are needing to sort of refine the framework as it might apply to that specific area. So I think that, you know, of the area that perhaps—our next iteration of this, after we finish further defining the principles of stewardship, I think, then, we need to test this framework and the stewardship principles in this one very important area where we seem to get the most lively discussion, which is when data moves from one entity to another, and there is an exchange of money as a part of the transaction.”—Dr. Safran

“I might take a follow on to that, and try my own words, and see if that may help. I think your question is really a good one, and I think as we got into it, it was more, what’s an appropriate use and what’s an inappropriate use. Because in fact, if you’re running business operations or quality, in a lot of these circumstances, some of those are done in a not for profit, or some of them in a for profit. But again, the use and the rules, if you will, guiding the work, are totally appropriate and already safeguarded, if you will, according to the principles. The issue is, when is it inappropriate, is particularly I think—now, again, how do you reach those communities and deal with that? If you have ideas for us, we would be open to it, because I think in our kind of really complex, huge complicated society, it’s really important, but it’s also not a simple answer to give.”—Dr. Detmer

“But as you’re looking at your framework and stewardship principles that you were trying to develop, and when we look on slide number two, and we talk about the dimensions of use of framework, and we talk about accountability, and it begs the question that perhaps within the principles, there needs to be some identification of what relief would be available to consumers if, indeed, the secondary use of data did become a matter of public information concerning them.

So as we look at principles, I read throughout the notes here, there is a lot of patient consent and patient will be notified and informed, but I’d like to challenge you to look a bit at what is going to be available to patients in the event that their information is breached and becomes public. The second observation I’d like to share with you concerning patients and the public, is the issue of opting out with any denial of services. I’m so delighted to hear that that is an issue that you’re looking at, and one that continues to probably need discussion and review. I think it is also the final point I would like to make relative to the principles, and what can be done to ensure some form of safety for consumers, if there is a breach, is the definition of how is the data going to be used correctly? How does that happen? And what will the definition look like? And the final question that I would have that you may need to answer at a later date, but what are the steps that data stewards will go through in order to become certified, so that as we move

to assist them, where perhaps we don't own data, but we become stewards of data, there is an accountability.”—Ms. Nancy Davenport-Ennis

“Needless to say, that’s really the heart of the debate, which is in order to build a system where there is a chain of trust, we clearly need to bring the citizen—the citizen needs to believe that the steward is, in fact, doing the things, as you suggest, that will protect the citizen, and at the same time, that there is remedy and recourse. I think on the other hand, there is a concern among health service researchers and others about issues of opt in versus opt out, and the quality of data, and what we’re going to be able to do to protect the public health and a variety of other issues. If the data are basically censored for certain kinds of uses, meaning that the citizen has control and decides that I just don’t want my data to be used for any purpose. So it’s a really important part of that issue of stewardship and our attempt, at least, to address that in the slightly less controversial way, to move the dialogue forward, was to put forward this consumer awareness checklist, which is, at a minimum, ‘where should we start educating the citizens around the use of their health data?’ So we think until citizens are better informed, it’s going to be hard to really find the right set point is for policy along several of these dimensions. And so at least in that—I don’t know whether I’m really answering your question. I think part of the answer is that we need to begin to address consumer awareness, before we get to, you know, regulatory or punitive or other environment. We ought to spend some effort to make people part—citizens more broadly part of the dialogue that you’ve invited us here to talk about today.

“It’s possible that actually the Office of National Coordinator, or perhaps somebody else should be actually asking the Institute of Medicine to take on some of these. These are very, very tough issues, and there is not necessarily a clean right answer, particularly. But you do need the best legal minds, I think, and the data minds, as well as the society more broadly. And really, the Institute of Medicine is probably in the best position to take on some of those kinds of questions. I think we still can go a ways. But as I’m saying, I think you really have touched on some things that have been challenges, actually, for us.”—Dr. Detmer

Further Discussion of e-prescribing

Mr. Scott Serota then moved that AHIC adopt a resolution requesting that the Secretary, recommend to Congress that Congress grant CMS the statutory authority to mandate e-prescribing through the Medicare program.

Mr. Weems said he had spoken to the Secretary in anticipation of such a motion. Mr. Weems said the Secretary would be anxious to receive that recommendation, and he suggested that the EHR Workgroup of AHIC, under the guidance of Ms. Gelinas, very quickly draft the recommendation. As quickly as the rules of public notice allow, a voice meeting of the AHIC would then be scheduled.

Dr. Kolodner requested that the record show that all hands went up in support of Mr. Serota’s motion.

Enhanced Protections for Uses of Health Data Recommendations to HHS on a Data Stewardship Framework

Dr. Simon Cohn, associate executive director for Health Information Policy for Kaiser Permanente, and Chair of the National Committee on Vital and Health Statistics, introduced Justine Carr, senior director for Clinical Resource Management for Beth Israel Deaconess Medical Center in Boston; and Harry Reynolds, vice-president for Blue Cross and Blue Shield of North Carolina. They are both members of the NCVHS and have co-vice chaired the ad hoc Workgroup that will be discussed.

Dr. Cohn explained that the NCVHS is a statutory public advisory committee to the US Department of Health and Human Services, and the Secretary. For 58 years the committee has advised on a variety of health information policy areas and issues, including health data, health statistics, and health information privacy.

Dr. Cohn also noted the trouble with the use of the term “secondary” use. There is no universally accepted standard definition, nor is it always clear whether primary is always more important than secondary. The group concluded that it is best to avoid the uses of such terms as “secondary” or “reuse” or the like, and instead try to be very precise about the use being discussed: direct patient care, data for submission to public health and communicable diseases, information for quality improvement, et cetera.

Dr. Carr framed the conversation by listing the reasons why it is important to address the uses of health data now:

- Electronically available health data are no longer just claims data, but include more clinically rich data
- Electronic data can be linked more readily with other databases
- Sources of electronic health information are expanding beyond HIPAA protections of covered entities and their business associates
- Electronic solutions to protect and secure data continue to evolve, including approaches to allow individual consent to follow data

She said the recurring themes heard in the testimony basically boil down to two. The first recognized the great benefit that can be achieved by using electronic health data: an increase in the ability of use health data to benefit health care; enhancements of quality measurement and reporting with a more real-time quality improvement cycle; support in public health surveillance and responsiveness; and an acceleration of accrual of cases for timely identification of complications that may occur from new medications or new procedures, technologies and devices.

The other theme is the concern about the potential for harm. One part of this is that there can be erosion of trust in the healthcare system with potential compromise to healthcare, when individuals don't trust that their privacy can be protected. Another piece of this concern is the potential or actual discrimination, or confidentiality violations that occur with increased ability to collect longitudinal data, coupled with sophisticated methods to reidentify data.

Next Dr. Carr defined HIPAA and discussed where their group perceives gaps to be. She said HIPAA's focus was the promotion of electronic exchange of data for administrative simplification. Therefore, HIPAA regulates entities that electronically transmit health information, and this includes healthcare payers, providers and clearing houses. HIPAA also regulates business associates and their agents.

A key concern is the fact that there are a growing number of entities that are not covered by HIPAA, some vendors of personal health records. Another concern is the lack of detail on the expectations of HIPAA-covered business associations and their agents with regard to the ongoing uses of health information.

As part of HIPAA, Congress required HHS to adopt regulations safeguarding the privacy of individually identifiable health information, and this is called the HIPAA privacy rule. This covers individual identifiable health information in any form; paper, electronic, spoken, any form held or transmitted by the covered entity. So this is protected health information, but it does not cover personal health information held by any organization outside of HIPAA.

HIPAA requires authorization for disclosures of protected health information except for uses for treatment, payment or healthcare operations, or when required by law, as in public health. So healthcare operations include an array of activities, such as quality assessment, competence and review, compliance activities, business planning, et cetera.

HIPAA privacy does not protect deidentified data. NCBHS heard concerns related to the sale of deidentified data. To begin to address this, the group has created a health data stewardship conceptual framework. This framework is intended to outline how an organization may approach evaluation of intended uses of data, and recognize where it may elect to enhance data stewardship processes. The framework looks like this:

- Health Data User and Use Profile
 - User: Provider, Payer, Clearinghouse, Business Associate or Agent, Researcher, Public Health, PHR Vendor, Other
 - Regulatory Status: HIPAA, State Data Statutes, IRB, FDA, VA, Privacy Board, Other State Laws, FTC, Other
 - Identity Status: Identifiable, HIPAA De-identified (Safe Harbor), HIPAA De-identified (Statistical), Limited Data Set, Anonymization, Pseudonymization, Other
- Analysis of Benefits and Potential Risks
 - Intended Use of Data: Treatment, Payment, Healthcare Operations, Research, Public Health, Other
 - Impact: Benefits to Individual & Society, Potential Risk for Harm
- Data Stewardship Considerations
- Accountability Chain of Trust, Transparency, Individual Participation & Control, HIPAA De-identification, Security Safeguards & Controls, Data Integrity/Quality, Oversight of Data Uses

For example, a business associate of a payer that is covered by HIPAA, who wishes to use identifiable data for quality measurement under healthcare operations, would describe the benefits of the use and consider the potential risks for harm, and then consider how it would address each of the data stewardship considerations. In some areas, the user may believe it provides appropriate stewardship, but in other areas, it might see an opportunity for improvement, such as improved transparency or stronger security controls.

Stewardship addresses not just data collection at transmission, but it also includes data aggregation and use of the data, Dr. Carr said. Focus is needed on completeness and accuracy of data, and processes to assure correct application of methodologic rules, as well as valid application of the rules related to statistical significance.

NCVHS has identified guiding principles, against which each of the recommendations on enhanced protections for uses of health data is evaluated. Protections should do the following:

- maintain or strengthen individual's health information privacy
- enable improvements in the health of Americans and the healthcare delivery system of the Nation
- facilitate uses of electronic health information
- not place an undue administrative burden on the healthcare industry
- increase the clarity and uniform understanding of laws and regulations pertaining to privacy and security of health information
- build upon existing legislation and regulations whenever possible

Mr. Harry Reynolds explained that their group's recommendations call for enhanced HIPAA protections and data stewardship for all uses of health data by all users, independent of whether an organization is covered by HIPAA. He said most of their recommendations don't require legislation, and take the form of such measures as inclusion and requirements for contractors, incentives, conditions of participation, and interagency collaboration.

Our four categories of recommendations are as follows:

- the principles of data stewardship, which will address the areas and the framework having to do with accountability and chain of trust, transparency, individual participation and control, deidentification, security, and data integrity, data quality.
- Enhanced oversight for specific uses of health data, since our recommendations are also to focus on uses of health data for quality measurement, reporting and improvement.
- An evaluation of new tools and technologies as the industry makes a transition to HIE and NHIN
- Additional legislation to broaden the scope of privacy coverage to all who may have access to personal health information, and to address antidiscrimination consequences that may arise out of the wrongful uses of health data, as we transition to this new world.

Mr. Reynolds then shared with the Community NCVHS's draft recommendations on principles of data stewardship. They are as follows:

- Accountability and chain of trust within HIPAA
 - Covered entities specify in business associate contracts terms that:
 - Clearly describe uses of:
 - identifiable health data
 - de-identified health data
 - Require contract between business associates and agents, and identification of all agents to covered entity
 - Include a yearly confirmation of compliance with contract
 - Business associates include all companies requiring access to protected health information during transmission
- Transparency
 - Enhancements to notice of privacy practices
 - Make information available, upon request, about specific uses and users
 - Make information available, upon request, about specific information disclosed to other organizations, such as public health
- FTC uses its authority to ensure that privacy policies fully inform and do not mislead the public
- Individual Participation and Control over Personal Health Data
 - Assure authorization for personal health information uses not protected under HIPAA
 - Evaluate technologies to manage individuals' authorization
- De-identification
 - HIPAA definition (safe harbor or statistical process) is the only currently recognized means to de-identify protected health information

- NCVHS will further investigate uses of de-identified data, and potentially offer recommendations for guidance
- Security Safeguards and Controls
 - Promote technical security measures and compliance with HIPAA Security Rule by all business associates and their agents
- Data Integrity and Quality
- Data for quality measurement, reporting, and improvement follow rules and guidelines to ensure precision and reliability of quality measures

With respect to oversight for specific uses of health data, NCVHS has two areas of recommendations:

- Quality Measurement, Reporting, and Improvement
 - Uses of health data for quality measurement, reporting, and improvement are within scope of HIPAA health care operations
 - Use a proactive oversight process accountable to senior management and governance to ensure compliance with HIPAA
 - Assess risk and apply further protections as appropriate when quality activities are conducted across different covered entities within an organized health care arrangement
- Research
 - Harmonize research regulations
 - Clarify definition of research and provide methodologies that help differentiate research from quality
 - Widely disseminate quality/research guidance
- Identify approaches to ensure that when a quality study becomes generalizable and evolves into research, that HIPAA Privacy and IRB requirements are respected

Mr. Reynolds walked the Community through the draft recommendations on transitioning to a NHIN:

- Adopt data stewardship principles in NHIN activities
- Use NHIN trial implementations to evaluate:
 - Individual choice applications
 - Data stewardship principles in comprehensive databases
 - Potential new de-identification techniques
 - Chain of trust enhancements
- Educational modalities to improve understanding

Finally, Mr. Reynolds said the group recommends additional privacy protections for health data, beyond data stewardship. NCVHS recommends that the need for more inclusive federal privacy legislation for health data be addressed; in absence of such legislation, an expanded definition of a “covered entity” under HIPAA is needed. He suggested promoting legislative or regulatory measures on anti-discrimination, and recommended that states be encouraged to map their data restrictions laws to one another in order to promote interoperability.

Next, NCVHS will address additional public comments to finalize recommendations (this AHIC meeting is part of that.) NCVHS has its full committee meeting November 27th and 28th, and all of these recommendations will be sent to the Secretary. An ongoing analysis and subsequent recommendations are anticipated, Mr. Reynolds said.

Discussion Highlights

“I’m always struck by parallels and other aspects of society, and it seems to me the scenario where a relatively small number of absolute principles trumps all else, and that you can worry infinitely about the process by which things happen. But if you have certain things which are illegal, like disclosing of information, discrimination, et cetera, et cetera. If you engage in any of those activities, you’re breaking the law and the law should be enforced, and that should be the ultimate guardian of the individual’s rights. The parallel I was thinking of is if you look at the Enron, WorldCom, those business scandals, it turns out that the executives involved broke existing law, which was not being enforced. And yet what we came down with was a complex set of new processes to try to control the behavior people, as opposed to monitoring the law and monitoring whether they were breaking the law or not. So I love the approach I think you’re taking which is here is a small number of absolute principles. Those should trump all else. And if you effectively implement the principles, then you don’t have to effectively go after every minute process within the system. Am I understanding correctly the direction you’re taking?”—Mr. Craig Barrett

“Yes. I think we’re all nodding our head yes, and we’re obviously trying to make this along the lines of best practices, model agreements, and contracts with the idea that hopefully it will lessen the administration burden. So thank you.”—Dr. Cohn

Public Input Session

Dr. Kolodner then invited public comment.

Dr. Alan Zuckerman, a pediatrician who also teaches informatics at Georgetown University, addressed the Community. He said he represents the American Academy of Pediatrics, with its 60,000 pediatricians, and he represents America’s children to the Health Information Standards Panel. Additionally, at CCHIT he co-chairs the interoperability expert panel with a representative from industry. Dr. Zuckerman said that he addressed the AHIC Community two years ago in order to mention the importance of reciprocal registration where providers would register with patients. He said this is the interoperability with personal health records that he is still seeking. He also mentioned the importance of including children, pointing out that the EHR pilot that the Community has so enthusiastically embraced will not include children. He said he can’t change the legislative mandate of CMS, but, of course, the groups he represents are going to address this issue with the state alliance.

He feels it’s important for the AHIC to make a statement on the importance of including children in health information technology so that there is not a repeat of what happened at the FDA regarding the certification of use of drugs for children.

Fortunately, the medication history and the formulary transactions I think will make it in. But when it comes to things like the registration summary and medication history, the over 200 comments we got on our environmental scan show that the industry isn’t quite ready to embrace some of the things we’ve put forward. In fact, he says they may propose some of these as provisional, so that people who fail to meet them this year won’t “fail,” but will need to be reviewed again next year.

Dr. Zuckerman emphasized the importance of building acceptance, adoption, and demonstration of things like a portable family history, and like immunization and response management.

He also addressed e-prescribing, pointing out that the use case that AHIC adopted two years ago, with the registration summary, could be a huge enabler of e-prescribing by facilitating work flow, enabling a patient’s usual pharmacy, their insurance, their existing medications to move seamlessly into physician’s

systems. Yet Dr. Zuckerman said there is very little awareness of this, and he thinks there needs to be a focus on that work flow facilitation.

Finally, he said that two years ago he raised the issue at the DEA of the importance of controlled substances to children with attention deficit disorder. He said that it remains a tremendous challenge to align standards with the needs of our system.

Hugh Zettel of GE Healthcare spoke in his role as the vice chair of the HIMSS EHR Vendor Association, a trade association of the over 40 EHR providers, both inpatient and ambulatory space.

Recognizing the benefits of interoperability in healthcare, the HIMSS EHRVA is pleased to announce that it has released a quick start guide for the ASTM HL7 continuity of care document standard. The association developed the guide which is available at no charge at www.HIMSSEHRVA.org on the EHRVA website, as a resource to help hasten interoperability in healthcare.

Finally, Mr. Jackie Jacamathan commented on the fact that there doesn't seem to be a focus on removing regulatory barriers for medical practice across states. He likened it to having a drivers license from West Virginia that only allowed him to drive in West Virginia and not in, say, California. This is the case for physicians wishing to practice in multiple states, he said.

Closing Remarks

Dr. Kolodner adjourned the 17th meeting of the AHIC, and said he looks forward to seeing everyone again in Washington in January.