The Community

American Health Information Community

May 16, 2006
8:30 a.m. - 3:00 p.m.

PowerPoint Presentations

U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 800
Washington, DC 20201

American Health Information Community

Electronic Health Records Workgroup

EHR WORKGROUP MEMBERSHIP

- **Co-chairs:**
  - Lillee Gelinas — VHA Inc.
  - Jonathan Perlin — Department of Veterans Affairs
- **Members:**
  - Carolyn Clancy — Agency for Healthcare Research and Quality
  - Bart Harmon — Department of Defense
  - John Houston — NCVHS
  - Charles Kahn — Federation of American Hospitals
  - Mark Lewis — EMC Corporation
  - George Lynn — American Hospital Association
  - Alan Mertz — American Clinical Lab Association
  - Blackford Middleton — HIMSS
  - Pam Pure — McKesson
  - Barry Straube — Centers for Medicare and Medicaid Services
  - John Tooker — American College of Physicians
- **Office of the National Coordinator:**
  - Karen Bell

EHR WORKGROUP CHARGES

- **Broad Charge for the Workgroup:**
  - Make recommendations to the Community on ways to achieve widespread adoption of certified EHRs, minimizing gaps in adoption among providers.

- **Specific Charge for the Workgroup:**
  - Make recommendations to the Community so that within one year, standardized, widely available, and secure solutions for accessing current and historical laboratory results and interpretations are deployed for clinical care by authorized parties.

BACKGROUND

- President's charge for the widespread adoption of interoperable EHRs
- Despite the benefits, only 17% of physicians have adopted
- Barriers identified that contribute to this low adoption:
  - High cost to purchase and implement
  - Costly custom interfaces to the most needed systems such as laboratory information systems
- Because lab results are a component in 70% of clinical decisions, timely and easy access to comprehensive laboratory information is of high value to clinicians

How can lab results be shared to meet provider and patient needs?

RECOMMENDATION 1.0:

HHS should take immediate steps to facilitate the adoption and use of endorsed standards and incentives needed for interoperability of lab results within the current provider-centric environment. ONC shall work with multiple stakeholders to develop a detailed workplan to achieve patient-centric information flow of laboratory data by 3/31/07.

DISCUSSION:

Evolutionary path

- Patient-centric focus
- Plan with stakeholders

X	**Accept**		**Table**		**Reject**

How can standards be identified?

RECOMMENDATION 2.0: (cross-cutting recommendation)

HITSP should identify and endorse vocabulary, messaging, and implementation standards for reporting the most commonly used laboratory test results by 9/30/06, so as to be included in the CCHIT interoperability criteria for March 2007 certification. HITSP should consider CLIA and HIPAA regulatory requirements as appropriate.

DISCUSSION:

- Barrier: lack of standards
- HITSP and CCHIT

X	**Accept**		**Table**		**Reject**

How can standards be put into use?

RECOMMENDATION 2.1:

Federal healthcare delivery systems (those which provide direct patient care) should develop a plan to adopt the HITSP-endorsed standards for laboratory data interoperability by 12/31/06.

DISCUSSION:

- Healthcare Delivery Systems
- Federal Plan

X	**Accept**		**Table**		**Reject**

How can standards be put into use?

RECOMMENDATION 2.2:

Federal Agencies and Departments with health lines of business should include/incentivize the use of HITSP-approved standards in their contracting vehicles where applicable.

DISCUSSION:

- Health lines of Business
- Federal Plan

X	**Accept**		**Table**		**Reject**

How can regulatory barriers be removed?

RECOMMENDATION 3.0:

By 9/30/06, ONC should review the possible models for the exchange of both current and historical lab information and determine which would require CLIA / HIPAA guidance, regulatory change, and/or statute change.

DISCUSSION:

- Models of data exchange
- HIPAA Privacy
- CLIA

X	**Accept** w/ Modification		**Table**		**Reject**

How can regulatory barriers be removed?

RECOMMENDATION 3.1:

Based of the findings from Recommendation 3.0, by 12/31/06, ONC should engage the National Governors Association and other State-based organizations to resolve variations in “authorized persons” under the various State statutes, regulations, policies, and practices as a resource for clinical laboratories seeking to define access rights to electronic laboratory data.

DISCUSSION:

- Stakeholder engagement

X	**Accept**		**Table**		**Reject**

How can privacy protections be designed?

RECOMMENDATION 4.0: (cross-cutting recommendation)

The Community should create a consumer empowerment subgroup comprised of privacy, security, clinical, and technology experts from each Community Workgroup. The subgroup should frame the privacy and security policy issues relevant to all the Community charges and solicit broad public input and testimony to identify viable options or processes to address these issues that are agreeable to all key stakeholders.

(continued on next slide)

How can privacy protections be designed?

RECOMMENDATION 4.0: (continued from previous slide)

The recommendations developed should establish an initial policy framework & address issues including, but not limited to:

- Methods of patient identification
- Methods of authentication
- Mechanisms to ensure data integrity
- Methods for controlling access to personal health information
- Policies for breaches of personal health information confidentiality
- Guidelines & processes to determine appropriate secondary uses of data
- A scope of work for a long-term independent advisory body on privacy and security policies.

DISCUSSION:

- Sub-group formation
- Scope of work

X	**Accept** w/ Amendment		**Table**		**Reject**

How can adoption be advanced?

RECOMMENDATION 5.0:

HHS, in collaboration with all key stakeholders, should both assess the value proposition and develop the business case for current and historical laboratory results data sharing across all adoption models, considering the unique needs and alignment of incentives for all stakeholders.

DISCUSSION:

- Consideration of all stakeholders
- Business Case articulation

☐	**Accept**	X	**Table**	☐	**Reject**

How do we learn from early adopters?

RECOMMENDATION 6.0:

By 3/31/07, AHRQ, in collaboration with CDC and CMS, should develop a proposed study methodology to measure the extent and effectiveness of the adoption of the first stage of HITSP standards, as well as the adoption and utilization of aggregated patient-centric data as they become available.

DISCUSSION:

- Business Case
- Best practices, incl. standards adoption

☐	**Accept**	☒	**Table**	☐	**Reject**

How do we learn from early adopters?

RECOMMENDATION 6.1:

By 12/31/07, AHRQ, in collaboration with CDC and CMS, should research best practices in the implementation and utilization of patient-centric laboratory data stores and how to implement this knowledge.

DISCUSSION:

- RHIO experiences

☐	**Accept**	☒	**Table**	☐	**Reject**

First Responder EHR

Additional charge to EHR WG from Chairman Leavitt:

Ensure that first responders responding to a disaster or emergency situation can obtain the critical health information they need electronically.

Public Testimony from:

- American College of Emergency Physicians
- Department of Defense
- Louisiana Department of Health and Hospitals
- EMS Stakeholder Representative (5 groups)

Workgroup's Next Steps:

- Additional testimony and follow-up
- Coordination with Consumer Empowerment WG
- Coordination with other Federal efforts in Emergency Response Preparedness

American Health Information Community

Chronic Care Workgroup

CHRONIC CARE WORKGROUP MEMBERSHIP

- **Co-chairs:**
  - Craig Barrett — Intel
  - Mark McClellan — Centers for Medicare and Medicaid Services
- **Members:**
  - Madhulka Agarwal — Department of Veterans Affairs
  - Ed Cameron — U.S. Department of Agriculture
  - Mike Crist — Laboratory Corporation of America
  - Dan Jones — University of Mississippi Medical Center
  - Shaygan Kheradpir — Verizon
  - Herb Kuhn — Centers for Medicare and Medicaid Services
  - Eric Larson — Group Health of Puget Sound
  - Mohan Nair — Regence Group
  - Mary Naylor — University of Pennsylvania, School of Nursing
  - John Rother — AARP
  - Jeff Rideout — Cisco
  - Jay Sanders — Global Telemedicine Group
  - Tony Trenkle — Centers for Medicare and Medicaid Services
- **Office of the National Coordinator:**
  - Karen Bell

CHRONIC CARE WORKGROUP CHARGES

- **Broad Charge for the Workgroup:**
  - Make recommendations to the Community to deploy widely available, secure technology solutions for remote monitoring and assessment of patients and for communication between clinicians about patients.
- **Specific Charge for the Workgroup:**
  - Make recommendations to the Community so that within one year, widespread use of secure messaging, as appropriate, is fostered as a means of communication between clinicians and patients about care delivery.

BACKGROUND - CHRONIC ILLNESS

- 50 million Americans live stably with a chronic condition -- most have more than one
- 80% of chronic care management takes place outside of the practitioner's office in home, work, and school environments
- Secure messaging between patients and clinicians allows patients to receive clinical guidance outside of the office setting, at the time that it is needed

BACKGROUND - SECURE MESSAGING

- Secure patient-clinician messaging refers to communications between patients and the individual clinicians who have explicit responsibility for their care
- Early studies and experience in staff model environments demonstrate improved quality and patient satisfaction while reducing utilization and costs
- Reimbursed by multiple national and local payers

KEY ISSUES

1. Reimbursement
2. Medical Liability and Licensure
3. Standards for Secure Patient-Clinician Messaging and Supporting Systems
4. Consumer and Clinician Access
5. Privacy and Security

What is the justification for reimbursement?

RECOMMENDATION 1.0:

HHS should develop and regularly update the evidence base for informed reimbursement policies with respect to secure messaging between clinicians and their patients. This should include monitoring and reporting the effect of secure messaging on cost, quality of care, patient and caregiver satisfaction, and medico-legal issues.

DISCUSSION:

- Barriers
- Methods of reimbursement

X	**Accept**		**Table**		**Reject**

What are the best methods of reimbursement?

RECOMMENDATION 1.1:

HHS should compile and assess the effect of various reimbursement methodologies for secure messaging on clinician workflow in various care models, and report on best practices.

X	**Accept**		**Table**		**Reject**

What can be done to expand reimbursement?

RECOMMENDATION 1.2:

By 09/30/2006, Public and private payers should implement secure messaging pilots or demonstration projects based on HITSP-approved standards that evaluate:

a) Possible forms of reimbursement for secure messaging;
b) Integration of secure messaging into physician workflow; and
c) Impact of secure messaging on patient involvement in their care

[X] **Accept** [ ] **Table** [ ] **Reject**

How can state-level barriers be removed?

RECOMMENDATION 2.0:

HHS should convene the appropriate State agencies and professional societies to develop and adopt new licensing alternatives which will address the ability to provide electronic care delivery across State boundaries while still ensuring compatibility with individual State requirements.

DISCUSSION:

- Who/what are the appropriate agencies?

X	**Accept**		**Table**		**Reject**

How can standards be identified?

RECOMMENDATION 3.0: (cross-cutting recommendation)

ONC should direct HITSP to define standards for secure patient-clinician messaging transactions so that they may be interoperable with electronic health records.

[X] **Accept** [ ] **Table** [ ] **Reject**

How can secure messaging be integrated in the EHR?

RECOMMENDATION 3.1:

ONC should direct CCHIT to establish certification criteria for system interoperability with patient-clinician secure messaging.

[X] **Accept** [ ] **Table** [ ] **Reject**

How can equal access to secure messaging be enabled?

RECOMMENDATION 4.0:

AHRQ should conduct a synthesis of current knowledge from existing studies of health information technology use by elderly, ill, and underserved populations including an analysis of barriers and drivers. The barrier and driver analysis should elucidate for which subpopulations barriers can be overcome and how.

[X] **Accept** [ ] **Table** [ ] **Reject**

How can equal access to secure messaging be enabled?

RECOMMENDATION 4.1:

HHS will work with appropriate organizations to report on secure messaging availability to providers across the country and report on a plan and timetable to make securing messaging available uniformly.

[X] **Accept** [ ] **Table** [ ] **Reject**

How can privacy protections be designed?

RECOMMENDATION 5.0: (cross-cutting recommendation)

The Community should create a consumer empowerment subgroup comprised of privacy, security, clinical, and technology experts from each Community Workgroup. The subgroup should frame the privacy and security policy issues relevant to all the Community charges and solicit broad public input and testimony to identify viable options or processes to address these issues that are agreeable to all key stakeholders.

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How can privacy protections be designed?

RECOMMENDATION 5.0: (continued from previous slide)

The recommendations developed should establish an initial policy framework and address issues including, but not limited to:

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- Methods for controlling access to personal health information
- Policies for breaches of personal health information confidentiality
- Guidelines & processes to determine appropriate secondary uses of data
- A scope of work for a long-term independent advisory body on privacy and security policies.

X	**Accept**		**Table**		**Reject**

American Health Information Community

Consumer Empowerment Workgroup

CONSUMER EMPOWERMENT WORKGROUP MEMBERSHIP

- **Co-chairs:**
  - Nancy Davenport-Ennis — National Patient Advocate Foundation
  - Linda Springer — Office of Personnel Management
- **Members:**
  - Helen Burstin — Agency for Healthcare Research and Quality
  - Jodi Daniel — Office of the National Coordinator
  - Lorraine Doo — Centers for Medicare and Medicaid Services
  - Kevin Hutchinson — Surescripts
  - Robert Kolodner — Veterans Health Administration
  - David Lansky — Markle Foundation
  - Ross Martin — Pfizer
  - Susan McAndrew — Department of Health and Human Services
  - JP Little — RxHub
  - Davette Murray — Tri-Service Infrastructure Management Program Office
  - Nancy Nielsen — American Medical Association
  - Lynne Rosenthal — National Institute of Standards and Technology
  - Charles Safran — American Medical Informatics Association
  - Scott Serota — Blue Cross Blue Shield Association
  - Steve Shihadeh — Microsoft
  - Robert Tennant — Medical Group Management Association
  - Myrl Weinberg — National Health Council
- **Office of the National Coordinator:**
  - Kelly Cronin

CONSUMER EMPOWERMENT WORKGROUP CHARGES

- **Broad Charge for the Workgroup:**
  - Make recommendations to the Community to gain widespread adoption of a personal health record (PHR) that is easy to use, portable, longitudinal, affordable, and consumer centered.

- **Specific Charge for the Workgroup:**
  - Make recommendations to the Community so that within one year, a pre-populated, consumer-directed, and secure electronic registration summary is available to targeted populations. Make additional recommendations to the Community so that within one year, a widely available pre-populated medication history linked to the registration summary is deployed.

BACKGROUND

- Consumer involvement in self-care and care management could be encouraged with the successful deployment of some form of easily accessible personal health information.
- Consumer commitment to PHRs could increase efficiency in the healthcare system, lower overall costs, and improve access to health care information.
- Making a medication history and registration summary widely available to targeted patient populations is an incremental step to realize progress in the short term.

KEY ISSUES

1. Privacy and security safeguards and consumer control of personal health information need to be established and enforced.
2. There is no widely accepted standard definition or functional specification for the features of a PHR.
3. There are no standards or functional specifications for populating PHRs.
4. Appropriate incentives for consumer and provider use of PHRs must be identified and supported.
5. Generally, consumers are unaware of the availability and value of medication histories and electronic registration summaries.

How can standards be identified?

RECOMMENDATION 1.0: (cross-cutting recommendation)

HITSP should identify the technical and data standards to enable the availability of a core registration dataset and medication history (with comprehensive review of recommendations for registration and medication history provided to HITSP by the Workgroup), including vocabularies, messaging, authentication, security standards, and appropriate documentation, by 9/30/06.

X	**Accept**		**Table**		**Reject**

How can access to and value of medication history and registration summary be demonstrated?

RECOMMENDATION 2.0:

HHS, through CMS, AHRQ, other interested Federal agencies, and private-sector partners, should pilot programs that measure and demonstrate the value of an electronic registration summary and medication history to patients with chronic disease and their clinicians. The sponsoring organizations should strive to implement pilot programs that meet all the objectives identified by the Workgroup no later than 12/31/06, and an evaluation of the initial results should be reported to the Community by 6/30/07.

X	**Accept**		**Table**		**Reject**

How can consumers be made aware of the breakthrough?

RECOMMENDATION 2.1:

In the next 6 months, Federal agencies sponsoring pilots for an electronic registration summary and medication history should work with appropriate private-sector health organizations, such as patient advocacy organizations and medical professional societies, to promote provider and consumer participation in a breakthrough project through a targeted outreach initiative.

X	**Accept**		**Table**		**Reject**

How can privacy protections be designed?

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The Community should create a consumer empowerment subgroup comprised of privacy, security, clinical, and technology experts from each Community Workgroup. The subgroup should frame the privacy and security policy issues relevant to all the Community charges and solicit broad public input and testimony to identify viable options or processes to address these issues that are agreeable to all key stakeholders.

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- A scope of work for a long-term independent advisory body on privacy and security policies.

X	**Accept**		**Table**		**Reject**

DISCUSSION – PHRs

- The Workgroup recognizes that consumers are among the last stakeholders to become engaged in these important discussions on PHRs and there are many key policy issues/barriers to be addressed to assure the general public that a personal health record can be developed that will provide for the privacy and security of consumer information.
- The Workgroup recognizes that its recommendations will be subject to periodic review and possible revision as we continue to work on both the broad charge and the specific charge from the AHIC. Some questions to be addressed are:
  - Should the market be left alone for innovation or could vendors compete around a minimum criteria set for PHRs?
  - Would a minimum set of PHR elements ensure that consumers have the features and options most important to them when choosing a PHR to manage their medication history or registration summary?
  - Who should identify the most important elements of a PHR?

DISCUSSION – Certification

- Some think certification of PHRs would be a positive voluntary market-based mechanism to ensure privacy and security of personal health information and interoperability.
- Some think we don't know enough about what consumers want to develop requirements for PHR certification.
- Would certification of PHRs advance the specific and broad charge?
- Is the timing important and is there a sense of urgency given the diversity, complexity, and mobility of today's population and the demand for availability of PHRs at the point of care?
- Should the Workgroup's recommendations in this area include a definition, process and measurement system that would support the best treatment at the best place and at the best time?

American Health Information Community

Biosurveillance Workgroup

BIOSURVEILLANCE WORKGROUP MEMBERSHIP

- **Co-chairs:**
  - Julie Gerberding — Centers for Disease Control and Prevention
  - Charles Kahn — Federation of American Hospitals
  - Mitch Roob — Indiana Family and Social Services Administration
- **Members:**
  - Michael Barr — American College of Physicians
  - Scott Becker — Association of Public Health Laboratories
  - Larry Biggio — State of Wyoming
  - Mary Brady — National Institute of Standards and Technology
  - Leah Devlin — North Carolina Department of Health and Human Services
  - Lawrence Deyton — Veterans Health Administration
  - Thomas Frieden — NYC Department of Health and Mental Hygiene
  - Rick Friedman — Centers for Medicare and Medicaid Services
  - Brian Keaton — American College of Emergency Physicians
  - John Loonsk — Office of the National Coordinator
  - Adele Morris — Department of the Treasury
  - David Parramore — Department of Defense
  - Mark Rothstein — University of Louisville School of Medicine
  - Edward Sondik — Centers for Disease Control and Prevention
- **Office of the National Coordinator:**
  - Kelly Cronin

BIOSURVEILLANCE WORKGROUP CHARGES

- **Broad Charge for the Workgroup:**
  - Make recommendations to the Community to implement the informational tools and business operation to support real-time nationwide public health event monitoring and rapid-response management across public health and care delivery communities and other authorized government agencies.
- **Specific Charge for the Workgroup:**
  - Make recommendations to the Community so that within one year, essential ambulatory care and emergency department visit, utilization, and lab result data from electronically enabled health care delivery and public health systems can be transmitted in standardized and anonymized format to authorized public health agencies within 24 hours.

Scenarios

- Environmental Signals
- Suspect Illnesses
- Intelligence Warning
- Monitor an Ongoing Event
- Ascertain Size and Rate of Spread

BACKGROUND

Biosurveillance functions to be supported with advanced, enhanced, or real-time transmission of electronic health data:

- Initial Event Detection
- Situational Awareness
- Outbreak Management
- Response Management

SURVEY RESULTS APRIL 2006 - ASTHO

Important Findings:

- *Summary* – Majority of State public health agencies have the capacity and the need to participate in biosurveillance efforts. Emphasizes the need for public health to be actively engaged.
- *Status* – 82% are receiving, or plan to receive within 6 months, electronic data from clinical care settings for one or more biosurveillance capabilities.
- *Capacity* – 89% have an active relationship with some clinical partners to develop capacity for electronic exchange and use of data for notifiable disease reporting or biosurveillance efforts.
- *Primary Obstacles for Participation*:
  - 82% Lack of funding
  - 70% Lack of trained personnel

Responses from: 29 states, 3 territories and the District of Columbia

SURVEY RESULTS APRIL 2006 - NACCHO

Important Findings:

- *Summary* – Majority of local public health agencies have the capacity and the need to participate in biosurveillance efforts. Emphasizes the need for public health to be actively engaged.
- *Status* – 68% are receiving, or plan to receive within 6 months, electronic data from clinical care settings for one or more biosurveillance capabilities.
- *Capacity* – 98% have an active relationship with clinical partners for local preparedness planning.
- *Primary Obstacles for Participation*:
  - 68% Lack of funding
  - 51% Lack of technology infrastructure

Responses from: 93 large (>200,000 population) local public health agencies

KEY ISSUES

1. Data and technical specifications needed to support key public health functions
2. Share data in a way that supports all levels of public health
3. Protect patient confidentiality
4. Define clear goals, metrics and rigorous program evaluation

How can data needed for biosurveillance be defined?

RECOMMENDATION 1.0:

By 6/30/06, HHS, in collaboration with Federal, State, and local governmental public health agencies and clinical care partners, should establish, convene, and oversee a Data Steering Committee to carry out the activities described in the recommendations below.

What data should be captured?

RECOMMENDATION 1.1: (cross-cutting recommendation)

The Data Steering Committee will identify the data elements and the appropriate filtering of data from ambulatory care settings, emergency departments and laboratories; as well as hospital utilization data needed to enable the key public health functions as outlined above. HITSP should identify the technical specifications for these initial data requirements by 9/30/06. CDC and others should provide HITSP with the public health expertise and funds needed to perform this task.

What data could enable broader geographic coverage?

RECOMMENDATION 1.2:

By 8/15/06, the Data Steering Committee should identify the data sources and requirements necessary to allow for collection of a more limited set of data across a broader geographic area.

X	**Accept**		**Table**		**Reject**

How are the traditional roles of local, State and Federal public health agencies protected?

RECOMMENDATION 2.0:

For the purposes of the Biosurveillance Breakthrough Initiative, the CDC should establish memoranda of understanding to enable simultaneous data flow from data providers to local, State, and Federal public health entities while preserving traditional investigation roles at local and State public health levels, whereby local and State jurisdictions continue to have lead roles in public health investigations. State and local public health agencies should ensure such memoranda of understanding are put into place and supported.

X	**Accept**		**Table**		**Reject**

How can patient confidentiality be protected?

RECOMMENDATION 3.0:

By 8/30/06, HHS should develop sample data use agreements to facilitate the sharing of data from health care providers to local, State and Federal public health agencies. HHS should also offer practical implementation guidance to data providers and State and local public health agencies to address HIPAA concerns about transmitting data (with obvious identifiers removed) for public health purposes.

How can patient confidentiality be protected?

RECOMMENDATION 3.1:

HHS, in collaboration with privacy experts, State and local governmental public health agencies and clinical care partners, should develop public communication materials to educate the general public about the information that is used for biosurveillance including the benefits to the public's health, improved national security, and the protection of patient confidentiality by 9/30/06.

X	**Accept**		**Table**		**Reject**

How can the breakthrough be evaluated?

RECOMMENDATION 4.0:

The CDC, State and local governmental public health agencies, and clinical care partners with firsthand experience in managing ongoing biosurveillance programs should design and conduct evaluations of the biosurveillance breakthrough. These parties should establish goals, develop outcome measures and establish metrics for evaluation of the breakthrough by 9/30/06.

How can lessons learned steer future direction?

RECOMMENDATION 4.1:

The Data Steering Committee will monitor the progress continuously, interpret the results of program evaluations, and assess the value of the data. The Committee will use the results of program evaluations; taking into account the minimum data necessary for public health purposes, to inform recommendations for modifications to the program. The Committee should consider large-scale implementations and suggest modifications to data collection when sufficient evidence exists that demonstrates the value of the information derived or lack thereof. The Committee should monitor adherence to the protection of patient confidentiality.

X	**Accept**		**Table**		**Reject**

Certification Commission
for Healthcare
Information Technology

CCHIT Progress Report to the American Health Information Community (AHIC)

May 16, 2006

Mark Leavitt, MD, PhD -- Chair, CCHIT
Alisa Ray -- Executive Director, CCHIT

Report Outline

- Brief Introduction
- Recent Events
- Consensus-Driven Process
- Overview: Standards Compliance Criteria for Ambulatory Electronic Health Records
- Next Steps
- Q & A

Brief Introduction

- **Voluntary, consensus-based initiative**
  - Founded Sept 2004 by AHIMA, HIMSS, Alliance
  - Funding base broadened June 2005
  - HHS Compliance Certification contract Sept 2005
- **Accelerate adoption of robust, interoperable health IT**
  - Reduce risk of health IT investment
  - Facilitate interoperability with emerging networks
  - Enhance availability of incentives / regulatory relief
  - Protect the privacy of personal health information

Recent Events

- **May 1:**
  Published final 2006 Certification Criteria for Ambulatory EHR

- **May 3 – May 12:**
  Launched certification program
  Over two dozen applications received

- **May 12 - July 10:**
  Compliance inspections in progress
  First announcement of certified products ~ July 10

Consensus-Driven Process

- Broad participation by diverse stakeholders
- Policies and processes to ensure fairness, transparency, and credibility
- Three cycles of public comment, multiple channels of communication and feedback
- Criteria validated through Pilot Testing

Overview of Criteria

- Domain of 2006 certification: Ambulatory EHRs (physician office or clinic)
- Scope of compliance criteria:
  - Functionality
  - Interoperability
  - Security and Reliability
- Roadmap indicates starting year for inspection of each criterion

Sample Document: **Functionality Criteria**

Final Criteria: FUNCTIONALITY
For 2006 Certification of Ambulatory EHRs
Effective May 1, 2006

Note:
Items highlighted in yellow are Provisional for 2006 (see cover letter)

Original line # Phase I	WG	Category and Description	Specific Criteria	Source or References	Priorities (L,M,H)					Availability			Compliance			
					Providers	Vendors	Payers or Purchasers	Public Health	Patient	2006	2007	2008	Certify in May 2006	Roadmap for May 2007	Roadmap for May 2008 and beyond	
1	F	**Identify and maintain a patient record:** Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	1. The system shall create a single patient record for each patient.	DC.1.1.1	H	H	H	H	H	H			X			
2			2. The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	DC.1.1.1	H	H	H	H	H	H			X			Key identifier information must be unique to the patient record but may take any system defined internal or external form.
3			3. The system shall store more than one identifier for each patient record.	DC.1.1.1	H	H	M	H	M	H			X			For interoperability, practices need to be able to store additional patient identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national patient identifiers if/when such become available.
4			4. The system shall use key identifying information to identify (look up) the unique patient record.	DC.1.1.1	H	H	H	H	H	H			X			
5			5. The system shall provide more than one means of identifying (looking up) a patient.	DC.1.1.1	H	H	H	H	H	H			X			Examples of identifiers for looking up a patient include date of birth, phone number.
6			6. The system shall provide a field which will identify patients as being exempt from reporting functions.	DC.1.1.1									X			Examples include patients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a patient who will be included in reports. De-identifying patients for reporting is addressed in the "Health record output" functionality.
7			7. The system shall provide the ability to merge patient information in a controlled method when appropriate.	DC.1.1.1								X			X	If a duplicate chart is created, information could be merged into one chart.

Roadmap columns indicate what year each item is required

Standards reference and evidence base

Provisional criterion (undergoing validation)

Next Steps

- Certification program:
  - Announce first results: July 2006
  - Repeat application/inspection cycles quarterly
- Update ambulatory EHR criteria
  - Incorporate AHIC breakthrough use cases
  - Prepare criteria for 2007 certification year
- Develop inpatient EHR criteria
  - Certification to begin May 2007
- Develop network criteria
  - Certification to begin May 2008

Thank You!
Q & A

For more information:
www.cchit.org