



NCVHS Holds First Meeting of 2009

Washington, DC (March 3, 2009) - [The National Committee on Vital and Health Statistics \(NCVHS\)](#) held its first committee meetings of 2009 last week. The Subcommittee on Standards Meeting was held on February 24, 2009, the Full Committee Meeting was held February 25-26, 2009, and the Subcommittee on Population Health Meeting was held February 27, 2009. The topic of all four days of hearing was “Setting the Context for the Evolution of Health IT Standards”.

Prepared by: Stephanie Tsoucalas

Tuesday February 24, 2009

Panel 1: ONC Update and Strategies:

Robert Kolodner, M.D., *National Coordinator for Health IT*

Charles Friedman, Ph.D., *Deputy National Coordinator for Health IT*

Last June marked the first full cycle of standard harmonization and certification processes being accepted by HHS. The adoption of those standards must be incorporated into products.

The absence of incentives to adopt standards was the biggest barrier. Users weren't asking vendors for interoperability.

Integrating standards into federal purchasing had variable success. Barriers included the ability to exchange and lack of networking (or ease of use).

The Nationwide Health Information Network (NHIN) serves as a neutral platform to foster innovation and creativity.

The trial implementations last year were very successful.

This year, limited production pilots are being run for monitoring networks and for ongoing vulnerability detection.

Involved entities included 6 federal agencies, 2 integrated delivery networks, and community RHIOs from across the nation.

In August 2008, all of these entities were brought together to collaborate and test interoperability. A summary record of the meeting was published in [September 2008](#).

The passage of the American Recovery and Reinvestment Act of 2009 (ARRA) included significant funding into HIT.

There was a question of whether or not the activity of the last 4 years would carry over or not. The language of the bill and the actions of the new administration shows that the work HAS crossed over.

Highlights of The ARRA:

It contains the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which establishes ONC in statute. ONC will report to the Secretary of HHS.

It references the Federal HIT Strategic plan ONC released in June 2008

ONC is required to update this plan through collaboration with public and private entities

The American Health Information Community (AHIC) was a Federal Advisory Committee (FACA). The AHIC was transitioned to a public-private, [the National eHealth Collaborative \(NeHC\)](#).

Legislation created two FACAs, the HIT Policy Committee and The HIT Standards Committee.

The Congress is asking these two committees to deliver on the question: “How do we learn from the past and effectively accelerate the adoption and use of standards in a much more systematic approach?”

Observations on the FACAs:

It is a longer process when you have 2 FACAs that have to pass versus 1. We have to make sure that we have interested parties who will use and test the standards that come out of the harmonization process, and in addition they must give feed back so that the standards can be refined.

One goal outlined in HITEC is to get simplified standards (that have many different uses) in an effort to foster widespread adoption by 2014.

The use of incentives for sharing information will remove an adoption barrier for companies who are capable information sharing, but had no business incentive to do so.

Incentives will eventually lead to the voluntary adoption of standards because the improved quality and efficiency of care will be incentive enough.

Advancements should be made incrementally. One step is revising standards for nationwide use.

Other activities outlined in the HITEC Act have to do with the functions of HIT.

Conclusion:

We have to figure out how we can get \$10 of impact for every \$1 we spend. To do this we need real competition among products, and consumer awareness of the products.

We have to make sure that systems are upgradable.

Through standards, we must have the ability to prevent vendor-lock. In other words, customers should be able to switch vendors without substantial costs.

Panel 2: IT Thought Leaders:

Don Detmer, M.D., *The National Healthcare Information Technology Environment*

We must promote the international adoption of standard terminology.

National, as well as international work, is being done.

The standards process has shifted to top-down model approach.

We should be focusing on value-driven care and standards.

We must adopt an outcome model that will help the nation as a whole. This model must reflect important reports on quality, privacy and security, safety, rural health, etc,

Is there a need for a new working group, like the NHII working group, to take on the new robust HICT standards model?

Should we adopt more global marketing strategies? Yes

Patient-centered care is based on communication. Doctors aren't interested in the actual health records, they are interested in the communication aspect of EHRs.

John Tooker, M.D., M.B.A., *Chairman of the NeHC*

NeHC, which was formally established in July 2008, is working closely with ONC.

The NeHC Board was developed in November 2008.

The mission of the NeHC is to answer the fundamental issue of how you communicate among the necessary parties to deliver effective healthcare. All of the stakeholders had to be involved in this private-public partnership.

Federal liaisons to the Board include ONC and VA.

NeHC has a close relationship with HITSP and CCHIT. This relationship was made public through a roadmap that outlined what their working relationship should be.

There needs to be help implementing EHR systems at the state level.

What value will be derived from use-cases?

There is a problem with the underinsured withholding healthcare.

25% of the Medicare population has 5 or more chronic conditions, each of which require a different doctor. There is a great complexity of health information exchange to take care of these patients.

In patient safety, medication reconciliation is one of the most important challenges right now.

We need to decrease the cost of system integration.

E-prescribing has been identified as a “best-practice.” We must mandate the adoption of e-prescribing.

The typical value case prioritization process includes a value case steering committee and a public call for value cases.

We are envisioning a membership-dues model for the organization.

Carol Diamond, M.D., M.P.H., *Markle Foundation*

The ARRA marks the largest federal investment in HIT in history. We must see measureable improvements.

Adoption needs to be incremental. The first step should be making it easier to share data in its current form (while protecting privacy and security). Once we improve the ability to share data, there will be greater motivation to improve data quality.

Dr. Diamond stressed the need to address sharing itself before addressing the quality of data being shared.

NIST and NCVHS both have advisory roles.

We should take an open-market-based approach to data exchange.

Wednesday, February 25, 2009

Department Update, Including Transition Update, and CMS Update:

James Scanlon, *ASPE*:

Two dozen employees are in leadership positions in HHS. There shouldn't be any operational interruptions at HHS while we wait for a new Secretary to be nominated.

Last night the President gave an overview of his 2010 initiatives, which will start in October.

The ARRA designated \$137 billion to HHS. Some of this money will be one-time spending, while some of it will be spent over a couple of years.

There is pressure to get the money out to the states quickly.

\$20 billion is going toward health IT. \$2 billion of this \$20 billion is going to ONC. \$17.6 billion will go toward Medicare and Medicaid incentives, which will begin in 2011. For hospitals, incentives begin in fy2011, while for professionals it begins in cy 2011.

There will be a formula that defines meaningful use of EHR systems. The formula has not yet been finalized.

Hospitals can receive Medicare and Medicaid incentives, while professionals have to choose one or the other.

\$500 million will go to HRSA for community health providers.

Creates process for which HHS recognizes standards, creates health IT policy committee (FACA), a standards committee (FACA), half a dozen grants programs to assist states and others in the adoption of health IT.

There will be funding for education and training in health IT.

\$300 million will go toward the national health information exchange.

\$20 million will go to NIST for testing capabilities.

There is no specific reference to health statistics in the bill, but it is implied.

Karen Trudel, CMS:

Pilots are being run to test e-prescribing standards.

The final rules on ICD-10 and 5010 transactions came out in January 2009. They received lots of industry comments. A large number of these comments reference the NCVHS recommendations.

The final rule significantly changed the implementation timetable to move 5010 implementation dates from April 2010 to January 2012, and ICD-10 implementation dates from October 2011 to October 2013.

There is the question of why we wouldn't just wait until ICD-11. By the time ICD-11 underwent American clinical modification and implementation regulation, it would be 2020.

We need to decide what meaningful-use means, learn how to compute, distribute, and audit incentives, decide how to measure success, etc.

The definition of meaningful-use will change over time as we raise the bar for standards and quality.