Better, Smarter, Healthier

Michael J. McCoy, MD, FACOG
Chief Health Information Officer

June 24, 2015
1. Ensures that **key health information technology initiatives are coordinated** across HHS programs;

2. ensures that **health information technology policy and programs of HHS are coordinated** with those of relevant executive branch agencies (including federal commissions and advisory committees) with a goal of avoiding duplication of effort and of helping to ensure that each agency undertakes activities primarily within the areas of its greatest expertise and technical capability;

3. reviews federal health information technology investments to ensure federal health information technology programs are **meeting the objectives of the strategic plan**, required under Executive Order 13335, to create a **nationwide interoperable health information technology infrastructure**;

4. at the request of OMB, provides comments and advice regarding specific federal health information technology programs;

5. develops, maintains, and reports on measurable outcome goals for health information technology to assess progress within HHS and other executive branch agencies; and in the private sector, in developing and implementing a nationwide interoperable health infrastructure (HIE coordination);

6. provides oversight of the ONC federal health architecture; and

7. fulfills the administrative (i.e., executive secretariat), reporting, program management, legislative affairs, infrastructure, and budget support needs of the office.

Person-centered Care

Access

Contribute

Use/Share

Culture Change

Privacy/Security
<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td>Increase consumers electronic access to their health information</td>
</tr>
</tbody>
</table>
| • Increase consumer access to **useable formats**  
• **Increase consumer demand** for their health data.  
• Ensure that **policies, standards and funding mechanisms support patient access** to their health data and other health related information (cost, treatment info, etc.).  
• **Address disparities** that may exist regarding consumer access to health information  
• Advance individuals’ **ability to control the use and disclosure** of their health information.  
• **Increase consumers’ digital health literacy** |
| **CONTRIBUTE** | Enable consumers to collaborate with their care team by contributing to their electronic health records and co-managing their health |
| • Ensure **industry standards support capture and use of PGHD** in clinical and research settings  
• Identify and promote **best practices for incorporation of PGHD** in health care delivery  
• Support the adoption of person-centered care planning processes and tools that ensure all members of the care team have access to consumer’s health goals and information to effectively coordinate care |
| **SHARE/USE** | Increase consumers’ ability to easily use and share their own health information |
| • **Foster innovation** to develop tools to help consumers manage information beyond EHRs  
• Address **technical, policy and cultural barriers** to consumers being able to share their health information with trusted individuals and entities  
• Drive **community-led demonstrations of Blue Button** |
| **CHANGE CULTURE** | Encourage a culture change away from a focus on health care and providers to one that supports person-centered health. |
| • **Inform and influence the national conversation** supporting person-centered health and health care  
• **Generate greater consumer demand** and provider support for more collaborative care models. |
**Goal:** a health system that provides better care, spends dollars more wisely, and has healthier people

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay Providers</strong></td>
<td>- Promote value-based payment systems</td>
</tr>
<tr>
<td></td>
<td>- Test new alternative payment models</td>
</tr>
<tr>
<td></td>
<td>- Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
</tr>
<tr>
<td></td>
<td>- Bring proven payment models to scale</td>
</tr>
<tr>
<td></td>
<td>- <strong>Align quality measures</strong></td>
</tr>
<tr>
<td><strong>Deliver Care</strong></td>
<td>- Encourage the integration and coordination of clinical care services</td>
</tr>
<tr>
<td></td>
<td>- <strong>Improve individual and population health</strong></td>
</tr>
<tr>
<td></td>
<td>- Support innovation including for access</td>
</tr>
<tr>
<td><strong>Distribute Information</strong></td>
<td>- <strong>Bring electronic health information to the point of care for meaningful use</strong></td>
</tr>
<tr>
<td></td>
<td>- Create transparency on cost and quality information</td>
</tr>
<tr>
<td></td>
<td>- Support consumer and clinician decision making</td>
</tr>
</tbody>
</table>

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
Goal 1: 30% of Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

Goal 2: 85% of all Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment Learning and Action Network to align incentives
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical Performance</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>All Medicare FFS (Categories 1-4) 0%</td>
<td>Alternative payment models (Categories 3-4) 0%</td>
</tr>
<tr>
<td>2014</td>
<td>FFS linked to quality (Categories 2-4) &gt;80%</td>
<td>Alternative payment models (Categories 3-4) ~20%</td>
</tr>
<tr>
<td>2016</td>
<td>FFS linked to quality (Categories 2-4) 85%</td>
<td>Alternative payment models (Categories 3-4) 30%</td>
</tr>
<tr>
<td>2018</td>
<td>FFS linked to quality (Categories 2-4) 90%</td>
<td>Alternative payment models (Categories 3-4) 50%</td>
</tr>
</tbody>
</table>
## A Ten Year Vision for the Nation:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide ability to send, receive, find, use a common clinical data set</td>
<td>Expand interoperable data, users, sophistication, scale</td>
<td>Broad-scale learning health system</td>
</tr>
</tbody>
</table>

## Critical Near-Term Components and Actions in the Roadmap

### Core technical standards and functions
- Publish available standards and implementation guidance and mandate use
- Refine standards for common clinical data set, CCDA, provenance, APIs

### Certification to support adoption and optimization of health IT products and services
- Improve rigor of ONC’s certification program, including surveillance for market transparency and accountability
- Work with industry on suite of ongoing testing tools that enhance usability

### Privacy and security protections for health information
- Educate industry on current laws
- Work with states to align laws that provide additional protections, without undermining privacy

### Supportive business, clinical, cultural, and regulatory environments
- Evolve and align policy and funding levers to incentivize adoption of certified health IT and electronic information sharing according to national standards

### Rules of engagement and governance
- ONC to establish governance framework with principles, rules of the roadmap, and process for recognizing organizations that align (certification mark)
- Call to action for industry to create coordinated process
2015 Edition Proposed Rule
Modifications to the
ONC Health IT Certification Program and
2015 Edition Health IT Certification Criteria

Michael J. McCoy, MD, FACOG
Chief Health Information Officer
Health IT Goals

- Interoperability
- Access
- User/Market Reliability
- Supporting the Care Continuum
The Common Clinical Data Set includes key health data that should be exchanged using specified vocabulary standards and code sets as applicable.

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Lab values/results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Vital signs</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Procedures</td>
</tr>
<tr>
<td>Race</td>
<td>Care team members</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Immunizations</td>
</tr>
<tr>
<td>Preferred language</td>
<td>Unique device identifiers for implantable devices</td>
</tr>
<tr>
<td>Problems</td>
<td>Assessment and plan of treatment</td>
</tr>
<tr>
<td>Medications</td>
<td>Goals</td>
</tr>
<tr>
<td>Medication allergies</td>
<td>Health concerns</td>
</tr>
<tr>
<td>Lab tests</td>
<td></td>
</tr>
</tbody>
</table>
• The 2015 Edition also proposes that Common Clinical Data Set be available for additional use cases, including data portability, VDT and API.

Data Portability

View, download, and transmit

Respond to application programming interface (API) requests for data
• Privacy and Security

• Patient Safety

• Surveillance and Certification Maintenance

• Transparency
• **Current:** Prior editions were adopted with a specific focus on the EHR Incentive Programs

• **Proposed:** A more accessible ONC Health IT Certification Program supportive of:
  - Diverse health IT systems, including but not limited to EHR technology ("Health IT Module" instead of "EHR Module")
  - Health IT across the care continuum, including long-term and post acute care settings
A number of programs currently use or propose to use the ONC Health IT Certification Program. Here are a few:

• Physician Self-Referral Law exception and Anti-kickback Statute safe harbor for certain EHR donations
• CMS chronic care management services
• Department of Defense Healthcare Management System Modernization Program
• The Joint Commission for participation as ORYX vendor – eCQMs for hospitals
Findings

• In 2014, 3 out of 4 (76%) hospitals had adopted at least a Basic EHR system.

• Nearly all reported hospitals (97%) possessed a certified EHR technology in 2014.

Hospital Adoption of Basic EHR Systems Increased in 2014
State Adoption Rates Increased From 2008 to 2014

- 0-19%
- 20-39%
- 40-59%
- 60-79%
- 80-100%
Use of Advanced Functionality Increased

[Chart showing the increase in the use of hospital management software from 2008 to 2014. The chart displays the percentage of hospitals using comprehensive, basic with clinician notes, and basic without clinician notes over the years.]

- 2008: 13.4% Comprehensive, 7.8% Basic with Clinician Notes, 4.0% Basic without Clinician Notes
- 2009: 16.1% Comprehensive, 9.4% Basic with Clinician Notes, 3.9% Basic without Clinician Notes
- 2010: 19.1% Comprehensive, 12.0% Basic with Clinician Notes, 3.6% Basic without Clinician Notes
- 2011: 34.8% Comprehensive, 18.8% Basic with Clinician Notes, 7.2% Basic without Clinician Notes
- 2012: 55.9% Comprehensive, 27.6% Basic with Clinician Notes, 11.5% Basic without Clinician Notes
- 2013: 60.3% Comprehensive, 33.7% Basic with Clinician Notes, 10.9% Basic without Clinician Notes
- 2014: 83.2% Comprehensive, 41.1% Basic with Clinician Notes, 7.7% Basic without Clinician Notes

Percent of Hospitals
Hospital Electronic Exchange of Health Information with Outside Providers Increased by 85% from 2008 to 2014.
Hospital to Hospital Electronic Health Information Exchange Increased by 55%

![Graph showing the increase in percent of hospitals engaged in electronic health information exchange.](chart.png)
Hospital Exchange of Clinical Data Increased

- **Laboratory Results**
- **Radiology Reports**
- **Clinical Care Summaries**
- **Medication History**

Percent of Hospitals

- 37% in 2008
- 35% in 2009
- 25% in 2010
- 21% in 2011
- 25% in 2012
- 27% in 2013
- 37% in 2014

Clinical Care Summary Exchange Among Hospitals and Outside Providers Increased in **49 States** and DC.