

# HIT Policy Committee Meaningful Use Workgroup

**June 4, 2010**

9:00 a.m. – 3:30 p.m. (Eastern)  
Washington Marriott @ Metro Center  
Washington, DC

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## Instructions and Questions for Panelists

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### Background

Testimony from this hearing will help the Meaningful Workgroup formulate recommendations to the HIT Policy Committee and National Coordinator on the issue of improving disparities in healthcare processes and outcomes. If you have any questions, please contact Joshua Seidman at [Joshua.seidman@hhs.gov](mailto:Joshua.seidman@hhs.gov)

### Format of Presentation:

The Workgroup respectfully requests that panelists limit their prepared remarks to 5-7 minutes. This will allow the Workgroup to ask questions of the panelists and allow every presenter time to present his or her remarks. We have found that this creates a conversation for a full understanding of the issue. You may submit as much detailed written testimony as you would like, and the Workgroup members will have reviewed this material in detail before the hearing. PowerPoints will not be needed.

### Pre-Presentation Questions/Themes:

The questions below represent areas the Workgroup intends to explore at the hearing. Please feel free to use them in preparing your oral and written testimony; the Workgroup recognizes that certain questions may not apply to all presenters.

The Workgroup respectfully requests panelists to provide written testimony by **May 28, 2010**. Please submit the testimony to Josh Seidman and Judy Sparrow at [Joshua.seidman@hhs.gov](mailto:Joshua.seidman@hhs.gov) and [Judy.sparrow@hhs.gov](mailto:Judy.sparrow@hhs.gov).

### Presenter Biography

In addition, the Workgroup requests that all presenters provide a short bio for inclusion in the meeting materials. Please send your short bios to Judy Sparrow, [judy.sparrow@hhs.gov](mailto:judy.sparrow@hhs.gov)

## THEMES/QUESTIONS

### Hearing on: “Using HIT to Eliminate Disparities: A Focus on Solutions”

As providers across the country begin to meaningfully use health information technology to improve care to vulnerable populations, we acknowledge the need to pay special attention to ensuring that we are improving disparities in healthcare processes and outcomes, not exacerbating them. We ask that speakers address the following questions in their testimony:

1. What do you see as the greatest risks posed by the implementation of HIT in relationship to potentially increasing disparities in health processes and outcomes?
  - ***IHS Response:*** Populations suffering from health disparities are almost by definition served disproportionately by under-resourced and otherwise challenged providers such as small rural practices and FQHCs. These health care delivery entities are less likely to be able to afford HIT, let alone innovations, or to have the support necessary to successfully implement and maintain them. Moreover, access to services may be limited by literacy, geography, weather, and fiscal burdens. A broad push for adoption of health IT without targeted implementation and support plans that are adapted to respond to these factors may worsen inequities. The benefits of HIT will not be available to these populations. The widened gap between the quality of care available to patients whose providers are able to access advanced technologies and those whose providers are unable to take advantage of them will actually increase disparities in health care and outcomes.
  - ***Sample Risks:***
    - Current HIT focuses on traditional health factors, and does not address the non-traditional health factors influencing health status in populations – literacy, language and cultural barriers, violence and other domains. If Meaningful Use continues to be defined by traditional health measures, while other non-addressed factors are critical contributors to inequity, unanticipated negative outcomes may result.
    - Focusing on e-prescribing, which favors large networks such as SureScripts/RxHub, while much of pharmacy practice in underserved areas takes place in smaller pharmacies not yet connected to these networks.
    - Focusing on providers having access to electronically delivered laboratory results – implying capable, motivated and responsive reference laboratories – while actually many providers rely for lab tests on local community hospitals (and possibly their secondary reference labs) which are equally under-resourced and may not be able to supply these results or support needed interfaces; moreover, those practices that do use larger commercial reference

labs may not have the leverage to compel these labs to prioritize their interfaces or even to use the required code sets.

- Focusing on measures that are more suited to integrated care networks than to the typical patchwork ‘networks’ that characterize rural practice or care for the underserved. Primary care will occur in one location while laboratory tests, imaging, consultation, specialty treatment, hospitalizations, and after-care may each occur in different locations, even in different towns or cities. They will also vary for different patients depending on their conditions and coverage. Expectations that the primary provider will have consistent electronic access to the full picture for a significant proportion of patients, particularly in the form of structured data from which performance measures can be calculated, will be premature until the health information exchange networks are well established.

2. What are you, or others with whom you work, doing (or planning to do) to reduce the risk of exacerbating disparities as HIT is implemented across the county?

- ***IHS Response:*** In the Indian Health Service, our focus is on a population with well documented health disparities, and our entire mission is devoted toward the improvement in health status for American Indian and Alaska Native people nationwide. Our approach has been to (1) leverage a taxpayer-funded public domain health information solution developed by the VA, (2) augment this solution at extremely low cost with innovative features addressing population health, public health, and clinical performance reporting, and (3) deploy and support this solution, again at low cost, throughout the Indian health care system. While the core of our information system has been in widespread use for many years, the full electronic health record that will be certified for meaningful use is still being deployed. The numerous small hospitals, health centers, and Alaska village clinics that remain will pose a substantial logistical challenge for implementation and support. We envision collaborating with one or more Regional Extension Centers to provide consultation on the adoption and use of HIT across Indian country, and with one or more Tribal Colleges to provide consultation on the development of new curricula for training the workforce to support the same.
- We have also developed software and standards for non-traditional data fields (domestic violence, etc) that allow us to aggregate and evaluate community health status, as well as track community normalization processes. The ability to aggregate and track population health over time, coupled with development of appropriate intervention tools, should also contribute to increased health equity. This work in IHS has been ongoing for over a decade, and has resulted in improved access to quality care. We have developed our focus by working with the communities that we serve, and ensuring that they have a voice in the software development requirements process. In addition, the IHS IT advisory committee and investment review board include tribal members, who help direct the prioritization process for software development and IT acquisitions.

3. What research is being done, or needs to be done, in this area to inform the HIT Policy Committee in trying to establish guidelines that will move providers to implement methods of using HIT to reduce disparities?
  - ***IHS Response:*** More research is needed on telehealth implementation in rural and underserved communities. The telecommunication and information technology infrastructure in rural and underserved urban communities is often not ready or enabled to support the full utilization of new technologies (e.g. telehealth). Also, innovations such as telehealth are disruptive, requiring redefined clinical and business processes. Training, technical support, and coordination must be readily available.
  - Another barrier to use of new tools and capabilities is the requirement for change in our clinical care model. There is no doubt that telehealth and other innovations can improve access, quality, and value. But these improvements cannot be realized without substantive change in delivery system models and requisite change in licensure, reimbursement, and related policies.
  - Similar issues need to be researched for the use of new media and social networking in communicating with and providing services to patients. Services without reimbursement, or those that the provider perceives as increasing his/her risk from a regulatory, compliance, or medicolegal standpoint are not likely to be adopted regardless of other incentives.
  - Identification and focused development of the non-traditional determinants of health.
  - Inclusion of community voices at the local, regional and national level.
  - Integration of non health data sets into the HIT systems, such as Head Start, WIC, and judicial data.
  
4. With patient and family engagement in care at the forefront of our thinking about improving our Nation's health, what particular strategies would you recommend to us as potential meaningful use requirements in 2013 and 2015 for the vulnerable populations we have asked you to address?
  - ***IHS Response:*** Specifically addressing the perspective of patient and family engagement, we believe that encouragement to use new media and social networking for appropriate aspects of patient communication and care should continue to evolve. We also believe that the concept of access to care includes access to information about the care giver, i.e. performance data. Meaningful Use should include transparency, and publication of performance measure results in a manner that enables patients to exercise choice in selecting providers. This is already done for hospitals, and can be extended to individual providers as well. As with all such efforts, however, it will be critical to find ways to avoid negative impacts such as refusal to care for high risk patients that could adversely affect performance outcomes.
  - In addition, measures that are specific to rural and other vulnerable populations need to be developed. We recommend that these be developed through the creation of a "measure forum group" that would be established and financed by the federal government. This group would be responsible for proposing candidate developmental measures to address community health care needs, such as

screening for domestic violence. These proposed measures would then undergo a screening process to evaluate them for inclusion as national electronically derived measures. This is a process that Indian Health Service has used, and it has been an effective tool for ensuring community engagement.

5. How can the meaningful use of HIT specifically reduce a health disparity?
  - **IHS Response:** Telehealth is one of the most obvious examples of the use of HIT to reduce disparities in availability of and access to health care services. Geographic maldistribution of health care professionals is most pronounced in medical specialty areas and especially behavioral health. A very high proportion of health care visits are for behavioral health issues, and the availability of tele-psychiatry can substantially impact the disparity in access to these critical services.
  - In addition, the availability of capable, low cost, open source or public utility electronic health record and decision support systems can “even the playing field” for providers serving at-risk populations and improve both quality and safety of care for these patients.
  - Identification of specific measures and the integration of them into the HIT system are critical. Invasive pneumococcal disease was once ubiquitous in certain American Indian and Alaska Native communities. However, an increased focus on pneumococcal vaccination in our system (including reminders, measurements, feedback and tracking along with business process change) have resulted in increased immunization rates in these communities and in decreased mortality.
  
6. What specific HIT applications have been used to address health literacy (panel 1), culture (panel 2), or **access (panel 3)**?
  - Telehealth such as through the Alaska Federal Health Care Access Network (AFHCAN) which provides telehealth solutions throughout the Alaskan bush; the technologies are being used in the lower 48 states as well.
  - Expanded deployment of the RPMS EHR over the last five years.
  - Deployment of the EHR to Community Health Aide/Practitioner Clinics in rural Alaska.
  
7. Please share any relevant evidence on your topic.
  - “Alaska Federal Health Care Access Network Wins TETHIE Award for Most Innovative New Technology Device for Diagnosis”, <http://archive.afhcan.org/successes/awards.aspx>
  - “Telehealth Gets Connected”, *CMIO*, May 2010, <http://www.cmio.net>
  - Toedt, M; “Improvements in Screening Rates, Immunization Rate, and Clinical Outcomes using an Electronic Health Record at Cherokee Indian Hospital”, 2008 HIMSS Davies Public Health Award Recipient, [http://www.himss.org/davies/pastRecipients\\_ph.asp](http://www.himss.org/davies/pastRecipients_ph.asp)

- Chouinard, S. and Shaffer, J.; “Improving Patient Health Outcomes at Primary Care Systems in Clay, WV Using an Electronic Health Management System”, Community Health Network of West Virginia, Feb 2008, <http://www.chnvw.org>

### **Additional Questions for the Access Panel:**

What tools can be used to improve access for those who face access barriers to healthcare or technology?

- **IHS Response:** Telehealth tools improve access to timely diagnosis, consultation, and treatment. They facilitate new methods and models of service delivery. The successful use of telehealth tools relies on system change; integration of telehealth into clinical processes is as much a clinical and systems issue as a technology one. Importantly, telehealth tools require an emphasis on relationships, between care teams and patients, and primary care teams and specialists. Such an emphasis advances true patient-centered care and enhances the medical home.
- Handheld technologies including cellular and smart phones are penetrating rural and underserved populations faster than traditional internet access, and finding new ways to reach patients with information and services through mobile and social networks will be critical.
- For providers, low cost, public utility, remotely hosted EHR and clinical decision support solutions will ensure that the “have-not” provider community can focus its resources and skills on patient care and not IT.
- Ensuring that community and population health data is available and shared with the appropriate community in a way that is understandable and actionable.
- Identification of appropriate multiple services at the health care POC, including passive referrals to appropriate eligible resources (WIC, Medicaid, Earned Income Tax Credit) based on information obtained in the patient registration file.

What are the most innovative solutions you have seen to overcome these challenges?

- **IHS Response:** IHS and Tribal facilities use a diverse array of telehealth tools for real-time care, store-and-forward consultation, and remote patient monitoring/”connected care”. The Alaska Federal Health Care Access Network (AFHCAN) telehealth solution is an example of leading-edge store-and-forward capability that allows for unscheduled access and use after hours and across time zones.
- Just recently, the Community Health Network of West Virginia created a secure iPhone application interface to the IHS RPMS Electronic Health Record that has the potential to facilitate service delivery in any number of traditional and nontraditional settings without dependence on a wired network infrastructure.
- mHealth (or mobile health) is increasingly recognized as an important mechanism by which services will be delivered to the communities we serve.