

# MONITORING NATIONAL IMPLEMENTATION OF HITECH: STATUS AND KEY ACTIVITY QUARTERLY SUMMARY

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JULY TO SEPTEMBER 2014

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# MONITORING NATIONAL IMPLEMENTATION OF HITECH: STATUS AND KEY ACTIVITY QUARTERLY SUMMARY:

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Prepared by Mynti Hossain and Marsha Gold of Mathematica Policy Research under Contract with the ONC Evaluation Office for a Global Assessment of HITECH

This summary supports the global assessment by synthesizing in one place selected statistics and activity reports relating to implementation of HITECH. It is developed quarterly and reflects information made available between July 1, 2014 and September 30, 2014. The list is not meant to be exhaustive, but to reflect a subset of reports and activities that have been reported on elsewhere—on the ONC or CMS websites, or in a few other sources that have come to our attention. The report now relies less than in the past on the ONC and HHS News Briefings to identify activities because the scope of those briefings has been reduced in intensity. Quarterly reports are posted by ONC and are publicly available under the [Evaluations of HITECH Programs section on the Health IT Dashboard](#).

## MEANINGFUL USE INCENTIVE PAYMENTS—STAGE 1

- The [August 2014 CMS incentive program report](#) summarizes active registrations and provider payments under the Meaningful Use Program. Through August 2014, active registrations include 325,134 Medicare eligible professionals, 161,074 Medicaid eligible professionals, and 4,744 hospitals (of whom 4,325 are eligible for both Medicare and Medicaid incentives). This totals to 490,952 active registrations as of August 2014 program-to-date. Almost all had previously been registered, with 3,086 new registrations in August 2014 (2,084 Medicare eligible professionals, 999 Medicaid eligible professionals and 3 hospitals).
  - Eligible professionals
    - Total program-to-date payments were \$6.5 billion through the Medicare program and \$3.3 billion through the Medicaid program.
  - Hospitals
    - Total program-to-date payments were \$15 billion, with \$14.1 billion to hospitals that were jointly eligible for Medicare and Medicaid incentives. (The program requirements for eligible hospitals differ from those for eligible professionals in that eligible hospitals can receive incentives for both Medicare and Medicaid while eligible professionals must choose between the two programs if they qualify for both).
  - According to the CMS incentive program report, all 50 states and five territories are open for Medicaid registration. A [CMS matrix](#) (last updated in August 2013) also lists the District of Columbia as open for registration, and provides links to states' websites and additional detail on the dates states started different functions (e.g. disbursements and attestations).
  - So far almost all payments have been based on Stage 1 requirements. Through August 2014, Medicare spent \$16 billion to eligible providers (\$6.4 billion) and

hospitals (\$9.8 billion) meeting Stage 1 requirements. There were 1,277 Medicare eligible professionals and 25 Medicare eligible hospitals meeting Stage 2 requirements with a total payout to date of \$16.6 million.

- In August, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a [report that finds that the state of Louisiana made Medicaid EHR incentive payments that did not meet federal and state requirements](#), including overpayment to 13 hospitals and underpayment to six hospitals. The report outlines possible factors leading to the errors, such as state agency personnel clerical errors and errors in the formula used to calculate hospital discharge-related amounts. OIG made several recommendations to Louisiana to adjust payments for the providers and hospitals that received incorrect incentive payments and to ensure that similar errors do not happen again in the future. The report includes Louisiana's response to an earlier draft of the report, describing its agreement with the recommendations and corrective actions that the state initiated.
- "[When IT Matters: Improving Care Delivery and Patient Outcomes through Technology](#)" is a College of Healthcare Information Management Executives (CHIME) case study of a critical access hospital in rural Nebraska that moved from a paper based health record system to an EHR, and attested for Stage 1 Meaningful Use as well. The case study highlights major activities the hospital undertook to successfully transition to an EHR and to attest for Stage 1. Activities include the hospital conducting an in-depth study of workflow before selecting an EHR vendor, and assigning a "super-user" in each department to serve as a resource or EHR expert for individuals who needed assistance with the EHR.

## **STAGE 2 MEANINGFUL USE INCENTIVE AND CERTIFICATION REQUIREMENTS**

- On August 29, 2014, [CMS issued a press release](#) announcing the final rule for the 2014 Meaningful Use reporting requirements, which was subsequently [published in the Federal Register](#), on September 4<sup>th</sup>. The final rule gives providers more flexibility in using certified EHR technology for 2014, extends Stage 2 from 2015 to 2016 for a number of providers, and introduces the timeline for Stage 3 (2017 start date for providers who first became "meaningful users" in 2011 or 2012). Previous to the publication of the final rule, several organizations responded, this quarter, to the [proposed rule](#) that was released in May 2014. Below are reactions from various organizations on the proposed rule as well as the final rule.
  - The Healthcare Information and Management Systems Society (HIMSS) Electronic Health Record Association (EHRA) sent a [letter](#) to ONC and CMS asking them to finalize the proposed rule as soon as possible. They also asked that any timeline changes, such as shortened reporting periods, be made immediately so that physicians and hospitals currently making strategic decisions based on the proposed rule are not negatively affected. [iHealthBeat](#) reports that EHRA's Mark Segal said "We appreciate that many of our customers will have more flexibility in achieving Meaningful Use for 2014 given the timing issues created by the Stage 2/2014 regulatory and certification schedule."

- The American Hospital Association (AHA) released a [statement](#) encouraging CMS and ONC to finalize the proposed rule. In their statement, they also cite a recent article published in *Health Affairs*: “[More Than Half of US Hospitals Have at Least a Basic EHR, but Stage 2 Criteria Remain Challenging for Most](#),” by Adler-Milstein et al. (The article finds that only 5.8% of hospitals meet all of the Stage 2 Meaningful Use criteria. The authors suggest that policymakers develop targeted strategies to help all hospitals with EHR adoption and effective use.) However, in response to the final rule, as reported by [iHealthBeat](#), AHA Director of Policy Chantal Worzala said that the “rule offers little relief because CMS did not grant a shorter reporting period for 2015...,”
- The American Medical Association’s (AMA) [letter](#) in response to the proposed rule expressed four main concerns: 1) the proposed rule continues to engage the pass/fail approach for physicians and hospitals in the Meaningful Use program; 2) it caters toward early EHR adopters and larger providers; 3) it does not address alignment of reporting for Meaningful Use and Physician Quality Reporting System (PQRS); and 4) the timeline for publication that is outlined in the proposed rule may not be early enough for physicians to benefit from it. [iHealthBeat](#) reports that, in response to the final rule, AMA President Robert Wah expressed disappointment: “...the Meaningful Use program continues to move full steam ahead without regard to the challenges faced by physicians and hospitals during the past few years...”
- In September, in response to the final rule, a group of 16 organizations—including HIMSS, AHA, and AMA—sent a [joint letter](#) to HHS Secretary Sylvia Mathews Burwell recommending that the 2015 EHR reporting period be shortened to 90 days to help providers meet Stage 2 requirements. The organizations urged HHS to take immediate action on this, as the reporting period will begin in October. Around the same time, Representatives Renee Ellmers (R-NC) and James Matheson (D-UT) introduced [HR 5481 “Flexibility in Health IT Reporting Act,”](#) which would shorten the reporting period to 90 days. [Clinical Innovation and Technology, September 16, 2014](#)
- Representatives Ellmers and Matheson also wrote a [letter](#) to CMS in regard to providers being unable to attest for Meaningful Use via the CMS Registration and Attestation website until mid-October. They are concerned that, if the website is not available till mid-October, providers who are in their first year of EHR attestation and are required to attest by October 1, 2014 will be penalized. The Medical Group Management Association (MGMA) wrote a [letter](#) expressing similar concern. [iHealthBeat](#) reports that a CMS representative stated that they cannot change the website until the final rule for the 2014 Meaningful Use reporting requirements is effective on October 1, 2014.
- In August, [iHealthBeat](#) reported on a *Modern Healthcare* analysis that finds that, out of the eligible professionals and hospitals that attested to Stage 1, only 1.1% of professionals and 3.1% of hospitals are meeting Stage 2 Meaningful Use requirements.
- In September, HIMSS Analytics released “[2014 US Ambulatory PM and EHR Study.](#)” The study is based on responses from 563 health IT professionals at free-standing and hospital-affiliated ambulatory facilities. [iHealthBeat](#) reports that the study finds declining

confidence in providers' ability to meet Stage 3 requirements, with 25.7% of free-standing facilities and 36.2% of hospital-affiliated facilities attesting for Stage 2.

## DEVELOPMENT OF STAGE 3 MEANINGFUL USE REQUIREMENTS

- On July 10, 2014 89 House lawmakers sent a [joint letter](#) to CMS asking that a five-year hardship exemption be made for pathologists in Stage 3.

## REGIONAL EXTENSION CENTERS

- ONC announced, via a [September 17<sup>th</sup> Health IT Buzz Blog post](#) written by National Coordinator for Health IT Karen DeSalvo, that RECs now support more than 100,000 providers in meeting Stage 1.

## AVAILABILITY OF CERTIFIED PRODUCTS AND THE VENDOR MARKET

- “[The Office of the National Coordinator for Health Information Technology’s Oversight of the Testing and Certification of Electronic Health Records](#)” is an OIG August 2014 report that looks at ONC’s oversight of Authorized Testing and Certification Bodies (ATCBs), with a focus on the security and privacy of electronic patient data in EHRs. OIG finds that ONC’s oversight of ATCBs does not ensure that test procedures and standards lead to patient data security and protection. OIG recommends that ONC: 1) develop procedures to periodically evaluate whether or not certified EHRs meet federal standards; 2) develop a personnel training program to increase competency for testing and certifying EHRs; and 3) work with the National Institute of Standards and Technology (NIST) to strengthen EHR test procedures. ONC submitted written comments to OIG in response to the report, stating that ATCBs are no longer active in the ONC Certification Program. ONC also said that the 2014 Edition EHR Certification Criteria includes stronger test procedures for security and privacy. However, OIG said that they do not believe that the 2014 Edition addresses their security concerns (e.g. password length and complexity, logging emergency access, and user privilege changes).
- In September, HHS [announced](#) a [final rule](#) that revises the current 2014 Edition EHR certification criteria through the introduction of 2014 Edition Release 2. The optional and revised criteria in 2014 Edition Release 2 take from the 2015 voluntary criteria that was proposed earlier this year in February 2014. [iHealthBeat, September 10, 2014](#)

## PRIVACY AND SECURITY

- “[The Double-Edged Sword of Electronic Health Records: Implications for Patient Disclosure](#),” by Campos-Castillo and Anthony, is a study published in the *Journal of the American Medical Informatics Association*. The authors find that patients may withhold information from providers when they are using EHRs. The authors suggest that providers discuss privacy and security issues with patients during clinic visits to address patients’ concerns.

## HEALTH INFORMATION EXCHANGE

- In July, the Government Accountability Office (GAO) released “[Electronic Health Records: Fiscal Year 2013 Expenditure Plan Lacks Key Information Needed to Inform Future Funding Decisions.](#)” The report summarizes a GAO study on the Department of Veterans Affairs’ and the Department of Defense’s progress towards interoperability between their two EHR systems. GAO finds that, out of the six statutory conditions they were expected to meet, they only meet one.
- “[Health Information Exchange Among U.S. Hospitals: Who’s In, Who’s Out, and Why?](#),” by Adler-Milstein and Jha, is a study that was published in *Healthcare*. The authors find that most hospitals do not participate in health information exchange even though the HIE participation rate for hospitals has increased since the introduction of the HITECH Act. The authors suggest that stronger incentives may encourage hospitals to participate in HIE.
- This quarter several organizations submitted comments on the proposed [risk-based regulatory framework for health IT](#) that was released in April 2014 by the Food and Drug Administration, ONC, and Federal Communications Commission. (More information on the proposal can be found in the “[Monitoring National Implementation of HITECH: April to June 2014](#)” quarterly summary). Stakeholder comments on the proposed framework included the following:
  - The Bipartisan Policy Center expressed support of the proposed framework in a [statement](#) on their website. The Center believes that the draft framework aligns with their February 2013 “[An Oversight Framework for Assuring Patient Safety in Health Information Technology.](#)”
  - In its [July 7, 2014 letter](#), the Telecommunications Industry Association (TIA) expresses support for the draft framework, but also mentions a few areas of concern. For example, TIA says that classifying all health information and communications technology into three categories (administrative health IT functions, health management health IT functions, and medical device health IT functions) may be problematic because, in the currently dynamic health IT environment, these categories converge and, as a result, technology does not always fall easily into one of the three categories.
  - Also on July 7, 2014, CHIME and the Association of Medical Directors of Information Systems (AMDIS) submitted a [joint response](#) to the proposed framework. The organizations say that they support the overall approach of the framework but have several recommendations. Recommendations include that ONC model its certification program off of the software development cycle, meaning that the certification program should have focuses and standards on best-testing, post-certified performance, and live-setting.
- In an [August 6, 2014 Health IT Buzz Blog post](#), National Coordinator for Health IT Karen DeSalvo and Interoperability and Exchange Portfolio Manager Erica Galvez launched a [new online community](#) to which they invite the public to comment on the nationwide interoperability roadmap. The comment period ended on September 12th.

The comments provided will be incorporated into a draft roadmap that will be reviewed by the Federal Advisory Committees in October. They anticipate that, in early 2015, a final version of the roadmap, that includes the Committees' recommendations, will be available for public comment. Galvez presented about this online forum at both the [August 6<sup>th</sup> Health IT Policy Committee meeting](#) as well as the [August 20<sup>th</sup> Health IT Standards Committee meeting](#).

- In August, several organizations sent letters to Senators Ron Wyden (D-OR) and Chuck Grassley (R-IA) in response to the [senators' June 12, 2014 letter](#) in which they ask stakeholders four main questions in response to the growth of electronic health data: 1) What data sources should be made more broadly available (to move toward more health care data transparency and to improve the health care system)? 2) How, in what form, and for what purposes should this data be conveyed? 3) What reforms would help reduce the unnecessary fragmentation of health care data? What reforms would improve the accessibility and usability of health care data for consumers, payers, and providers? and 4) What barriers stand in the way of stakeholders using existing data sources more effectively and what reforms should be made to overcome these barriers?. Responses include:
  - The [Bipartisan Policy Center's letter](#) addresses all four of the senators' questions. Their answers include the recommendation that CMS prioritize electronic information sharing within certain federal programs as well as the recommendation that ONC advance requirements that promote interoperability. They also say that greater education and training for providers is necessary to address privacy and security concerns.
  - The [West Health Institute's letter](#) also speaks of the importance of interoperability. The Institute recommends that federal incentives for providers be used to promote greater data exchange.
  - [The National Committee for Quality Assurance \(NCQA\) letter](#) includes the call for "both full interoperability and public reporting of errors and potential harm...[to] be required for all federally certified health IT systems."
- In August 2014, ONC released two reports on HIE prepared by NORC at the University of Chicago:
  - "[State Approaches to Enabling HIE: Typology Brief](#)" is a typology that characterizes the State Health Information Exchange Cooperative Agreement Program (State HIE Program) grantees' approaches to enable health information exchange into three domains: 1) HIE program leadership and organizational structure; 2) legal and policy approach; and 3) technical approach. NORC plans to further develop this study in the future by looking at the impacts of these different approaches on HIE outcomes.
  - "[Key Challenges to Enabling Health Information Exchange and How States Can Help](#)" looks at five states' experiences with health information exchange under the State HIE Program. (The states are Florida, Indiana, Maryland, Oregon, and Montana). Some common enablers and challenges emerged from



the data. Common enablers are: 1) effective use of legislation; 2) effective use of policy levers (grants, incentives, and executive orders); and 3) strategic leveraging of existing investments in HIE. Common challenges are: 1) limited demand for HIE; 2) sustainability; and 3) HIE integration into provider workflow.

- HIMSS and the National Association of County and City Health Officials (NACCHO) released a [toolkit](#) to help public health departments understand health information exchange, how to use and support exchange services, and how to measure the value of using such services.
- Health insurers Anthem Blue Cross and Blue Shield of California announced that they will work together to create the [largest health information exchange in California](#)—the California Integrated Data Exchange (Cal INDEX). The two insurers have nine million customers total, and they are inviting other health insurers to move their customers' electronic medical records to the network as well. Anthem and Blue Shield anticipate moving their electronic medical records to Cal INDEX by the end of 2014.
- In August, the Robert Wood Johnson Foundation published "[Health Information Technology in the United States: Progress and Challenges Ahead, 2014](#)" by DesRoches et al. The Foundation released a [blog post](#) on their website sharing several highlights from the report. Findings include that the number of physician practices with at least a basic EHR has doubled since 2009 (almost half of all physician practices in the country have at least a basic EHR). The Foundation also, on August 7<sup>th</sup>, held a briefing on this report as well as on the report "[A Robust Health Data Infrastructure](#)" (also mentioned directly below). [Health Data Consortium, August 8, 2014](#) The report is written by the MITRE Corporation's JASON advisory group, and was funded by the Agency for Healthcare Research and Quality (AHRQ). Overall, the report recommends the development of a central health IT software architecture that would unify health IT across the nation. [Healthcare IT News, September 3, 2014](#)
- [iHealthBeat](#) reports that, at the [September 3, 2014 Health IT Policy Committee meeting](#), JASON Task Force co-chairs David McCallie and Micky Tripathi said that the report "[A Robust Health Data Infrastructure](#)" is outdated and inaccurate because the initial study "was conducted in early 2013, but much has changed in the industry in the last 18 months, such as market deployment of Direct-enabled functions and beginning of [Meaningful Use Stage 2] attestations." (The draft summary of the Committee meeting was not posted as of press time but is expected to be available in October.) McCallie and Tripathi suggest that ONC "take into account the current state of interoperability as well as current trends before incorporating JASON findings in any decisions on HIE plans, policies, and programs."
- In a [September 23, 2014 press release](#), Surescripts announced that more than 2,000 provider organizations and 23 HIEs and health information service providers make up their health information exchange network. Organizations that have recently joined the network include Geisinger Health System and Mount Sinai Health System. On the same day, Surescripts released another [press release](#) announcing that they are expanding their Immunization Registry Reporting service by working with EHR vendors (Amazing

Charts, Aprima, and digiChart) and pharmacies (CVS/pharmacy, Rite Aid, Safeway, and Walgreens). Through the registry, EHR vendors and pharmacies may access immunization data for 88% of the population.

## **WORKFORCE PROGRAMS**

- On July 31, 2014, CHIME issued a [press release](#) introducing the Association for Executives in Healthcare Information Security (AEHIS). This association will offer educational resources and professional development services to senior executives working in health information security.
- The “[2014 HIMSS Workforce Survey](#)” summarizes a total of 200 responses from providers, vendors, and consultants in health care. Survey findings show that there is a strong market for health IT professionals for three reasons: 1) there is a high demand for health IT professionals in vendor organizations (more so than provider organizations), 2) 82% of survey respondents said that they plan to hire at least one full-time health IT professional in the next year, and 3) the health IT industry remains stable despite a small increase in health IT lay-offs.

## **PROVIDER EHR ADOPTION, OTHER SOURCES OF SUPPORT, AND ISSUES**

- ONC continues to administer challenges and contests to promote health IT use among both providers and patients seeking to improve health outcomes. The [EHR Innovations for Improving Hypertension Challenge](#) is a new challenge in which health care providers as well as caregivers are encouraged to share health IT tools they use to reduce high blood pressure. The Department of Health and Human Services (HHS) [announced](#) the challenge in July. Winners will be announced in October.
- In July, *Health Affairs* published a number of articles that assess health IT adoption and use among various health care provider groups:
  - “[Progress and Challenges: Implementation and Use of Health Information Technology among Critical-Access Hospitals](#),” by Hufstader Gabriel et al., summarizes findings from an examination of a 2012-2013 HIMSS survey of critical-access hospitals. The authors find that, while health IT adoption and use is financially challenging for many critical-access hospitals (especially those that operate independent from hospital systems), 89% of the surveyed hospitals had at least partial EHRs. A high percentage of hospitals also used some type of telehealth functionality.
  - “[Adoption and Use of Electronic Health Records among Federally Qualified Health Centers Grew Substantially during 2010-12](#),” by Jones and Furukawa, summarizes findings from an analysis of 2010-2012 administrative data from HRSA’s Uniform Data System. The authors find disparities in EHR adoption for federally qualified health centers (FQHCs) when it came to region, health center size, and health center clientele. Overall, the authors find a significant increase of EHR adoption and use among FQHCs during the 2010-2012 time period, particularly in regard to those functionalities required to receive payments through the Meaningful Use incentive program.

- [“No Evidence Found that Hospitals are Using New Electronic Health Records to Increase Medicare Reimbursements”](#) by Adler-Milstein and Jha, uses national data to see whether there is a relationship between EHR adoption in hospitals and “upcoding” or overbilling for Medicare. The authors find no evidence for such a relationship.
- [“E-Prescribing Trends in the United States,”](#) by Hufstader Gabriel and Swain at ONC, examines Surescripts data to find that the number of physicians and community pharmacies e-prescribing via EHRs rose significantly between 2008 and 2014. The number of physicians e-prescribing rose from 7% to 70% while the number of community pharmacies using e-prescribing rose from 76% to 96%.
- At the [July 8, 2014 Health IT Policy Committee meeting](#), the committee unanimously approved the recommendation for ONC to lead the creation of a Health IT Safety Center. At the meeting, Safety Task Force Chairperson David Bates outlined various functions the Center could offer, such as serving as a clearinghouse for safety-related rules. [iHealthBeat](#) reports that the recommendation for the Health IT Safety Center will next be presented to ONC leadership.
- This quarter, several activities occurred related to telehealth promotion and adoption, including:
  - In July, Senator Thad Cochran (R-MS) and Senator Roger Wicker (R-MS) introduced [S 2662 “Telehealth Enhancement Act of 2014.”](#) This bill, if passed into law, would expand telehealth services to patient-centered medical homes, among other things. The American Telemedicine Association (ATA) [expressed support](#) of the bill.
  - [iHealthBeat](#) reports that the bill [HR 3230 “Veterans Access, Choice, and Accountability Act of 2014”](#) has been signed into law. This law will expand telehealth services to mobile Veterans Affairs centers, among other things.
  - An August 13, 2014 HIMSS [press release](#) introduced the [“2014 Telemedicine Study.”](#) This study is intended to serve as a baseline for assessing use of telehealth products and services by health care organizations and for looking at drivers of telehealth adoption. [iHealthBeat](#) reports that the study finds that 46% of hospitals and physician practices use up to four telehealth products or services.
  - In September, the ATA [released](#) “50 State Telemedicine Gaps Analysis: Coverage and Reimbursement” and “50 State Telemedicine Gaps Analysis: Physician Practice Standards and Licensure.” These reports grade all 50 states in terms of telehealth coverage, reimbursement, physician practice standards, and licensure. [iHealthBeat](#) reports that, in the report assessing coverage and reimbursement, seven states earned A grades. In the second report on physician practice standards and licensure, 23 states earned A grades, while North Dakota was the only state to earn a failing grade.

- “[Actionable Recommendations in the Bright Futures Child Health Supervision Guidelines](#),” by Finnell et al., is a study published in *Applied Clinical Informatics* that looked at the action items in the Bright Futures pediatric preventive guideline and made recommendations for them to be formatted to facilitate computer implementation.
- An [August 15, 2014 Health IT Buzz Blog post](#) shares some [analyzed data](#) from the Health Resources and Services Administration (HRSA). The data show that 96% of federally funded health centers have an EHR. Nearly 85% of these federally funded health centers have providers who are receiving Meaningful Use incentive payments.
- In September, HIMSS made three [formal requests to Congress](#): 1) minimize disruption from federally mandated health IT program changes in the nation’s health system; 2) fund the National Coordinator for Health IT for interoperability, clinical quality improvement, and patient privacy and safety; and 3) expand telehealth services.

## PATIENT ENGAGEMENT

- In August, *Health Affairs* published “[Despite Substantial Progress in EHR Adoption, Health Information Exchange and Patient Engagement Remain Low in Office Settings](#),” by Furukawa et al. Analyzing data from the 2009-2013 Electronic Health Records Survey, the authors find that EHR adoption among office-based physicians has grown steadily since 2009 but that only 14% of physicians share data with providers outside their organization. They also find that online patient engagement is low, with only 24% of physicians giving their patients the option and ability to electronically view, download, or transmit personal health records. The authors conclude by saying that the HITECH Act focused on building infrastructure, but that policymakers should now focus on EHR use for care coordination and patient engagement.
- An [August 26, 2014 Health IT Buzz Blog post](#) highlighted a pilot project currently being conducted by ONC, the Centers for Disease Control and Prevention (CDC), and five states (Alaska, Arizona, Louisiana, Washington, and West Virginia). Via patient portals, providers in each state give parents and caregivers online access to their children’s immunization records to use as they manage their children’s immunization appointments and overall health care. ONC, CDC, and the American Academy of Pediatrics (AAP) held a webinar on August 27<sup>th</sup> sharing information on this pilot project. The pilot is scheduled to end in April 2016.
- “[Numeracy and Literacy Independently Predict Patients’ Ability to Identify Out-of-Range Test Results](#),” by Zikmund-Fisher et al., was published in the *Journal of Medical Internet Research*. The study finds that patients with lower literacy skills struggle with understanding their electronic lab test results. The authors recommend designing ways to present test results that are more intuitive for patients.
- *Telemedicine and e-Health* published two studies on telehealth:
  - “[Perceptions of Video-Based Appointments from the Patient’s Home: A Patient Survey](#),” by Gardner et al., finds that most patients in the sample were open to video appointments but preferred in-person appointments. The authors

conclude that, if challenges in conducting reliable video appointments for patients in their homes can be addressed, video appointments can be offered and used more frequently by those patients who are open to the idea of it.

- [“The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management,”](#) by Bashshur et al., studies the impact of telehealth on three chronic diseases (congestive heart failure, stroke, and chronic obstructive pulmonary disease). Through a systematic literature review, the authors find that the majority of relevant studies report lower hospital admissions and readmissions, length of stay, and emergency department visits when telehealth services are used.
- [“Individuals’ Access and Use of their Online Medical Record Nationwide”](#) is an ONC data brief by Patel et al. that finds that almost one third of individuals in the sample were offered access to their online medical record and that 46% of these individuals viewed their online record at least once. Individuals who accessed their records used it primarily to monitor their health (e.g. check test results) and the majority of these individuals felt that accessing their records was useful. For those individuals who chose not to access their records, 74% said it was because they did not need to, 28% said they were concerned about privacy and security issues, 23% said they did not have Internet access, and 16% said the website was difficult to navigate. Two of the brief’s authors, Vaishali Patel and Erin Siminerio, wrote a [September 15<sup>th</sup> Health IT Buzz Blog post](#) highlighting the data brief.
- [“Engaging Primary Care Patients to Use a Patient-Centered Personal Health Record,”](#) published in *Annals of Family Medicine*, is a study in which Krist et al. evaluate eight small to medium-sized primary care practices and their ability to engage patients to use patient portals. The authors find that if providers build in promotion of patient portals into routine care, compared to when providers simply mail patients invitations to use portals, patients are more likely to enroll and use the portals. Contrary to the idea that individuals aged 60 to 69 may be averse to technology, this age group had the highest use rate of patient portals in the study.
- The [4<sup>th</sup> Annual Consumer Health IT Summit](#) was held on September 15, 2014, an event held each year as part of [National Health IT Week](#). At the summit, National Coordinator for Health IT Karen DeSalvo announced that there will be a new Blue Button Campaign. A [new Blue Button toolkit](#) was also introduced on September 15<sup>th</sup> via a [Health IT Buzz Blog post](#). This toolkit is for organizations that are interested in adopting Blue Button. [Fierce Health IT, September 15, 2014](#)

## HEALTH IT AND HEALTH DELIVERY REFORM

- The Electronic Healthcare Network Accreditation Commission (EHNAC) [announced](#) the creation of the Accountable Care Organization Accreditation Program (ACOAP). The program will assess accountable care organizations (ACOs) and related IT service organizations on various functionalities, including health data exchange, and will recognize and highlight those organizations that demonstrate excellence.

- In August, eHealth Initiative released [preliminary findings](#) from a 2014 survey of ACOs that focused on health IT infrastructure and workforce capability, use of data and health information exchange, and associated opportunities and challenges. All 62 of the ACOs who responded to the survey (to date) say that access to data from external organizations is a significant challenge. [iHealthBeat, August 14, 2014](#)
- “[Physician-Reported Safety and Quality Impacts of Electronic Health Record Use](#),” by Heisey-Grove et al., is an ONC data brief that looks at physician-reported impacts of EHR use on health care quality and patient safety related outcomes. Among the findings is that physicians with EHRs who are involved in delivery reform are more likely than the comparison groups to report improvements (related to EHRs) in health care quality and patient safety. Overall, the authors find that physicians’ EHR use is associated with more positive impacts than negative.
- In September, Premier and eHealth Initiative released findings from a national survey of 62 ACOs. An [eHealth Initiative press release](#) shares highlights from the study, including that 100% of the respondents reported that accessing and sharing health information with external providers and organizations was a barrier in using health IT.
- Representatives Diane Black (R-TN) and Peter Welch (D-VT) introduced [HR 5558 “ACO Improvement Act of 2014”](#) which would expand telehealth use by ACOs to improve care coordination.

## EFFECTIVENESS OF HEALTH IT

- “[Hospital Experiences Using Electronic Health Records to Support Medication Reconciliation](#),” by Grossman et al., is a research brief published by the National Institute for Health Care Reform. Via interviews with executives and clinical EHR users in hospitals, the authors find that more than one third of the hospitals in the sample used a partially paper-based process for medication reconciliation. Grossman and co-authors note that the transition to electronic medication reconciliation is still evolving, alongside vendors’ EHR product development.
- In August, HIMSS released “[EMR Effectiveness: The Positive Benefit Electronic Medical Record Adoption has on Mortality Rates](#).” The study find that hospitals with advanced EHR use had lower than predicted mortality rates for certain conditions. [Clinical Innovation and Technology, August 13, 2014](#)
- “[The Long-Term Financial Impact of Electronic Health Record Implementation](#),” published in the *Journal of the American Medical Informatics Association*, is a study that examined 30 ambulatory practices’ number of patient visits and reimbursement for two years after EHR implementation. When Howley et al. compared the number of patient visits and reimbursement after EHR implementation to their baseline (pre-EHR implementation), they find that the number of patient visits decreased and reimbursements increased. They conclude that the increase in reimbursement supports the idea for more EHR investment and that the decrease in patient visits may be because of greater efficiency within the practice via EHRs.

- [“Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy”](#) is a research report produced by RAND Corporation and the AMA that looks at professional satisfaction among physicians in the context of health care delivery changes currently taking place. The majority of physicians who were interviewed said that they believe EHR adoption has the potential to lead to benefits and improved patient care but, for many physicians, professional satisfaction is currently decreasing because of the lack of health information exchange between EHR products and other EHR technology issues. Building on this study, the AMA published a [framework](#) with eight priorities for improving EHRs: 1) enhance physicians’ ability to provide high quality patient care; 2) support team-based care; 3) promote care coordination; 4) offer product modularity and configurability; 5) reduce cognitive workload; 6) promote data liquidity; 7) facilitate digital and mobile patient engagement; and 8) expedite user input into product design and post-implementation feedback. [iHealthBeat](#) reports that the Deputy National Coordinator for Health IT Jacob Reider made a statement in response to the AMA’s framework: “We applaud the AMA for speaking out on this. It will take a few years before we will see an iPhone-like [EHR]. We’ll get there, but it’s primarily in the hands of developers.”
- In September, *JAMA Internal Medicine* published [“Use of Internist’s Free Time by Ambulatory Care Electronic Medical Record Systems”](#) by McDonald et al. The authors find that 59.4% of respondents (physicians and residents/fellows) said that they lost time after EHR implementation. The average time lost for physicians was 48 minutes and 18 minutes per clinic day for physicians and residents/fellows, respectively.

## RELATED FEDERAL POLICY INITIATIVES

- No new information to report.

## OTHER (CONTEXTUAL ETC)

- An [August 4, 2014 Health IT Buzz Blog post](#) lays out the new Health IT Policy Committee and Health IT Standards Committee Workgroups and chairs. It also introduces two new groups: 1) JASON Task Force and 2) Interoperability and Health Information Exchange—Governance Subgroup.
- In September, the White House [announced](#) that Megan Smith will be the next US Chief Technology Officer, replacing Todd Park.