The Certification Commission for Healthcare Information Technology (CCHIT) Update

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Chair, CCHIT

Presented before the National Committee on Vital and Health Statistics
June 30, 2005
Washington, DC
Topics to be Covered

- Origin, Mission and Concept
- Organizational Structure
- Scope, Deliverables, and Timeline
- Development Process
- Overview of Work Products and Public Comment Process
- HHS Health IT Strategy and the Future of CCHIT
- Q & A
Origin, Mission and Concept of CCHIT
# Origins of CCHIT

## Goals and Strategies of HHS’s Framework for Strategic Action

<table>
<thead>
<tr>
<th>Goals</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| **Goal 1:** Inform clinical practice with the use of electronic health records (EHR) | 1. Incentivize EHR adoption  
2. Reduce risk of EHR investment  
3. Promote EHR diffusion in rural and underserved areas |
| **Goal 2:** Interconnect clinicians so that they can exchange health information using advanced and secure electronic communication | 1. Foster regional collaboration  
2. Develop a national health information network  
3. Coordinate federal health information systems |
| **Goal 3:** Personalize care with consumer-based health records and better information for consumers | 1. Encourage use of personal health records  
2. Enhance informed consumer choice  
3. Promote use of telehealth systems |
| **Goal 4:** Improve public health through advanced biosurveillance methods and streamlined collection of data for quality measurement and research | 1. Unify public health surveillance architectures  
2. Streamline quality and health status monitoring  
3. Accelerate research and dissemination of evidence |

Source: HHS.  
* Phase I strategies are shown in bold type.
Founding of CCHIT

- Founded by three HIT associations:
  - American Health Information Management Assoc (AHIMA)
  - Healthcare Information and Management Systems Society (HIMSS)
  - The National Alliance for Health Information Technology (Alliance)
- Formed panel to nominate first Commissioners
- Provided seed funding and resources
- First official meeting Sept 14, 2004
Broadened Funding Support

- **Unrestricted grants, $110k total, from:**
  - American Academy of Family Physicians (AAFP)
  - American College of Physicians (ACP)
  - Hospital Corporation of America
  - McKesson
  - Sutter Health
  - United Health Foundation
  - WellPoint Health Networks, Inc.

- **Grants supporting testing development, $215K total**
  - California HealthCare Foundation
Mission of CCHIT

To accelerate the adoption of robust, interoperable HIT throughout the US healthcare system, by creating an efficient, credible, sustainable mechanism for the certification of HIT products.
Guiding Principles

- **Timeliness**
  - Need decisive private-sector action now

- **Value**
  - Deliver value for all key stakeholders and the larger healthcare community
  - Process must be efficient and not add net costs

- **Integrity**
  - Operate in credible, objective, transparent manner
  - Certification must be objective, laboratory verified to the greatest extent practical
Key Points to Clarify

- **Product Certification** is different from:
  - Organizational Accreditation
  - Professional Certification
- **Certification is binary, i.e. “pass/ fail”**
  - Not a subjective, comparative rating system
  - Competition and innovation can thrive “above the line”
- **Voluntary process**
  - Initial requirements must be market reality-based
  - A forward-looking requirements roadmap provides the best means to influence market direction
Standards and Certification Create “Tipping Points” for New Technologies

The IBM-standard PC launched the personal computing revolution

The Ethernet networking standard gave PC’s connectivity

The Wi-fi standard made it wireless
How Product Certification Can Accelerate HIT Adoption

- Increase the confidence of providers to invest in and adopt HIT
- Facilitate interoperability of HIT products within the emerging national health information network
- Enhance the availability of HIT adoption incentives from public and private purchasers/payers
The HIT Adoption Deadlock

**HIT Vendors**
Can’t bring down costs until provider adoption accelerates

**Providers**
Hesitant to buy HIT until costs and risks are lower and/or incentives higher

**Payers/Purchasers**
Can’t offer incentives unless benefits and interoperability of EHRs are assured
Breaking the Deadlock

Beneficial effects and interoperability assured, unlocking incentives

Payers/Purchasers

IT Vendors
Growing market attracts investment, lowers costs

HIT Adoption

Providers
Reduced risk and availability of incentives accelerates adoption
Key Stakeholder Relationships

- **HIT Users -- Providers and Provider Organizations**
  - Information on market & needs
  - Increase confidence in investment

- **HIT Vendors**
  - Information on current and future state of products
  - Accelerate market; roadmap of future expectations

- **Payers with Incentives for IT Adoption or IT-Enabled Quality**
  - Commitment to incentives for certified products
  - Assurance that certified products, properly deployed, can deliver results

- **HIT Standards Organizations**
  - Standards against which compliance can be tested
  - Feedback on current standards; drive development of new standards

Additional Stakeholders: consumers, public health, research, quality org’s
Organization of CCHIT
CCHIT Organization

- Business Operations Committee
- Program Management Team

CCHIT Commissioners

- Work Group: Functionality
- Work Group: Interoperability
- Work Group: Security & Reliability
- Work Group: Certification Process

Work Group: Use Case and Test Plan

Advisory Councils and Liaisons:
- Vendor Associations
- Provider Organizations
- Payer/Purchaser Organizations
- Standards Development Organizations
- Others
Stakeholder Balance and Diversity on the Commission and Work Groups

**Commission**

- 2 - 4 from each key stakeholder group:
  - Providers
  - Vendors
  - Purchasers/payers/coalitions
- 2 - 4 total drawn from other stakeholders:
  - Government (ex-officio, nonvoting)
  - Standards development organizations (e.g. HL7)
  - Others, e.g. healthcare consumer advocates, etc.

**Work Groups**

- Open Call for Participation
  - 275 applicants
  - Commissioners ranked by qualifications then adjusted for stakeholder balance
- Co-Chairs
  - Two Co-Chairs
  - Must represent two different stakeholders
- Members
  - 8 – 10 members
  - Qualified experts
  - Diversity of backgrounds
Scope, Timeline, and Deliverables
Scope, Deliverables, and Timeline

• **Initial scope**
  • Certify EHR products for physician offices and other ambulatory care settings

• **Deliverables:**
  • Operational capability for certification
  • Roadmap forecasting future certification plans 1-2 years ahead

• **Timeline**
  • Pilot process ready in September 2005
## Certification Roadmap Concept

<table>
<thead>
<tr>
<th>EHR Product Attributes</th>
<th>Current Year</th>
<th>1 Year Ahead</th>
<th>2 Years Ahead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functionality</td>
<td>Final 2005 Requirements</td>
<td>Forecast 2006 Requirements</td>
<td>Forecast 2007 Requirements</td>
</tr>
<tr>
<td>Interoperability</td>
<td>Final 2005 Requirements</td>
<td>Forecast 2006 Requirements</td>
<td>Forecast 2007 Requirements</td>
</tr>
</tbody>
</table>
Timeline
(Subject to adjustment)

2005

April
- April 18 -- Publish Phase I interim work product for comment
- Phase I Public Comment Period April 18 – May 18
- “Town Calls” April 21-27

May
- July 11 – Publish Phase II interim work product for comment
- Phase II Public Comment Period July 11 – Aug 11
- “Town Calls” July 11 - 25

June

July
- Sept -- Publish 2005 pilot test requirements
- Pilot test of certification process

August

September
- Begin certifying products
- Publish final requirements

TODAY
Description of Project Phases

- Phase I - Data Gathering
- Phase I Public Comment period
- Phase II - Draft requirements
- Phase II Public Comment period
- Finalize requirements and begin pilot test
- Publish final requirements and roadmap
- Launch product certification
Process for Development of Certification Criteria
Work Group Process

Phase I: Gather Data

Available Standards Framework
- Element X

Phase II: Finalize Requirements

Certification Reqmts for 2005
- Requirement X

Certification Roadmap 2006-2007
- 2006
- 2007
- Future X
- Do not certify X

Element Decision Process (see next slide)

Priority as seen by stakeholders
Availability in the marketplace
Practicality of certification

Availability in the marketplace
Priority as seen by stakeholders
Practicality of certification

The Certification Commission for Healthcare Information Technology
# Element Decision Process

<table>
<thead>
<tr>
<th>Priority</th>
<th>Availability</th>
<th>Priority</th>
<th>Availability</th>
<th>Priority</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>Optional</td>
<td>Widely Available: Do not certify</td>
<td>Available in 2006 or 2007: Do not certify</td>
<td>Availability Uncertain: Do not certify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overview of Work Products and Public Comment Process
Phase I Work Products on Website
(Note: Comment period is now closed)

Instructions for reviewing the Phase I interim work products and submitting public comment

The CCHIT Phase I interim work products are available here for your review. Click on any of the links below to view a document online, or right-click and select “Save Target As…” to download the file (in Adobe PDF format) to your computer for offline review.

- Functionality Work Group: Overview and Spreadsheet
- Interoperability Work Group: Overview and Spreadsheet
- Security & Reliability Work Group: Overview and Spreadsheet
- Certification Process Work Group: Overview

After reviewing the documents, click here to submit your comments. More instructions will be found in the online comment submission instructions and in your interest!
## Functionality Work Group Spreadsheet - Left Portion

<table>
<thead>
<tr>
<th>Line #</th>
<th>Criterion Name</th>
<th>WG</th>
<th>Criterion Description</th>
<th>Source (map to Standard source)</th>
<th>Priorities (L.M.H)</th>
<th>Providers</th>
<th>Vendors</th>
<th>Payer/Purchasers</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify &amp; maintain a patient record</td>
<td>Funct</td>
<td>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.</td>
<td>DC.1.1.1</td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Manage patient demographics</td>
<td>Funct</td>
<td>Contact information including addresses &amp; phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored &amp; maintained for reporting purposes and for the provision of care.</td>
<td>DC.1.1.2</td>
<td></td>
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<tr>
<td>12</td>
<td>Manage summary lists</td>
<td>Funct</td>
<td>Patient summary lists can be created from patient specific data and displayed and maintained in a summary format. The functions below are important</td>
<td>DC.1.1.3</td>
<td></td>
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</tr>
</tbody>
</table>

**Evidence on Priorities**

**Functions from HL7 EHR TC DSTU (Subset)**
### Functionality Work Group

**Spreadsheet - Right Portion**

<table>
<thead>
<tr>
<th>Availability</th>
<th>Test Method</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>1. The system SHALL create a single patient record for each patient.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>2. The system SHALL associate (store/link) key identifier information with each patient record.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>3. The system SHALL store multiple identifiers for each patient record.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>4. Using the key identifying information, the system SHALL identify (look up) the unique patient record.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>5. The system SHALL maintain and make available dynamic data elements for each patient record.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>6. The data in the patient record and the integrity or the record itself SHALL be maintained until specifically deleted based on local policies, procedures and/or applicable laws and regulations.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>1. The system SHALL capture and maintain demographic information as part of the patient record.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>2. The system SHALL provide ability to report demographic information.</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3. The system SHALL keep track of demographic information over time.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>4. The system SHALL allow a user to modify demographic information about the patient.</td>
<td></td>
</tr>
</tbody>
</table>

**Conformance Criteria and Test Specifications**

**Evidence on Availability**

**To be developed (Phase II):**

- 2005 Criteria and 2006-07 Roadmap
## Interoperability Work Group Spreadsheet

<table>
<thead>
<tr>
<th>Line Num</th>
<th>Use Case Component</th>
<th>Description</th>
<th>Priorities</th>
<th>Discussion / Barriers to Market Availability</th>
<th>Source Standard or Vocabulary</th>
<th>Implementation Guide</th>
<th>Source Available Today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Laboratory and Imaging</td>
<td>Results using common vocabulary with inbound interface optionality removed</td>
<td>H M</td>
<td>(1) Interface optionality; (2) lack of standard result and result values vocabularies; (3) non-standard handling of microbiology; (4) Coding standards (once defined) must be kept current. Process must be efficient and fast to keep up with the addition of new tests; (5) Need to provide discrete data and laboratory specific reports. This is especially true for anatomical pathology and esoteric reporting; (6) Myriad of communication architectures increases costs to support send and receipt of results; (7) What is business model to support real-time result feeds? Who will pay? (8) Potential for innovation (technological and clinical) to be throttled by standards bodies.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>L.1 Receive results</td>
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<td>3</td>
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<td>HL7 v2.4</td>
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<td>HL7 v3</td>
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<td>LOINC result naming</td>
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<td>6</td>
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<td></td>
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<td>Result values naming</td>
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<td>X</td>
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<tr>
<td>7</td>
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<td></td>
<td></td>
<td></td>
<td>SCCP Implementation Guide - Batch</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Interoperability Use Cases – Priority cases highlighted

Evidence on standards, vocabularies, barriers, and availability

To be developed (Phase II): 2005 criteria and 2006-07 roadmap
### Security & Reliability Work Group Spreadsheet

<table>
<thead>
<tr>
<th>Line Numbers</th>
<th>Security Criteria with references and rationale for inclusion/exclusion</th>
<th>Priorities and market availability</th>
<th>Preliminary recommendations (to be refined in Phase II)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Reference</th>
<th>Criteria</th>
<th>Preliminary Recommendation</th>
<th>Market Availability</th>
<th>Note</th>
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<tbody>
<tr>
<td>10</td>
<td>Health</td>
<td>Policy</td>
<td>Level 1</td>
<td>High</td>
<td>M</td>
<td>N</td>
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<tr>
<td>20</td>
<td>Health</td>
<td>Rule</td>
<td>Level 2</td>
<td>High</td>
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<tr>
<td>30</td>
<td>Health</td>
<td>Standard</td>
<td>Level 3</td>
<td>Medium</td>
<td>M</td>
<td>N</td>
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<tr>
<td>40</td>
<td>Health</td>
<td>Guideline</td>
<td>Level 4</td>
<td>Low</td>
<td>L</td>
<td>N</td>
</tr>
<tr>
<td>50</td>
<td>Technology</td>
<td>Specification</td>
<td>Level 5</td>
<td>Very Low</td>
<td>X</td>
<td>N</td>
</tr>
</tbody>
</table>

The spreadsheet contains security criteria with references and rationale for inclusion/exclusion, priorities and market availability, and preliminary recommendations (to be refined in Phase II).
I. Introduction

The Certification Process Work Group (CPWG) is pleased to present its Phase I report on its progress towards identifying the essential elements of a certification process for ambulatory electronic health records. The CPWG is actively seeking feedback on this Phase I deliverable in order to develop a consensus-based model that will serve the needs of the various stakeholders within the process. The goal of Phase I was to develop an assessment of current and potential testing methodologies and then provide a summary for public comment.

Phase I included the following deliverables:

- Research and examine a variety of current certification testing processes that had similar objectives to those of the CCHIT.
- Develop a summary of possible testing approaches
- Research capabilities of current software testing laboratories
- Construct a framework for an idealized certification process for electronic health records.

Phase II will commence once the initial public comment period has been completed. Phase II deliverables include the following:

- Details regarding the specific testing processes for certifying the individual criteria developed by the other Work Groups
- Specific cost estimates will be developed once the fundamental decisions regarding the methods, location and sponsoring organization(s) are reached.

There are two levels to defining a certification process for electronic health records:

- The first level is outlining the macro level process. This includes everything from the application process to the
Phase I
Public Comment Period:
Preliminary Results
Phase I Public Comment: Response Volume and Timing

- Total submissions: ~100
- Total comments: ~1000

Daily Total Responses

Day of Comment Period
Phase I Public Comment: Responses by Source

Responses by Source

Individual: 38%
Organization: 62%
Phase I Public Comment: Responses by Category

- HIT Vendor: 29%
- Health System: 10%
- Consultant: 12%
- Consumer: 1%
- Government: 4%
- Other Association: 23%
- Academic Health: 4%
- Physician Professional Association: 10%
- Physician: 7%
Phase I Public Comment: General Responses for Commission (does not include comments for WGs)

TOTAL: 28

- General Support, 18%
- Constructive suggestions, 28%
- Request for Inclusion, 18%
- Broad Concerns, 18%
- Format Issues, 18%
Phase II
Work Products:
Preview of Changes
Phase II Work Products Will Be Available on Website July 11

www.cchit.org

The Certification Commission for Healthcare Information Technology
### New Common Format

Criteria from Functionality, Interoperability, Security & Reliability Work Groups now “harmonized” in a common format

<table>
<thead>
<tr>
<th>Line #</th>
<th>WG</th>
<th>Category and Description</th>
<th>Specific Criteria</th>
<th>Source or Reference</th>
<th>Priorities (L,M,H)</th>
<th>Availability</th>
<th>Recommend</th>
<th>Discussion / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
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</tr>
</tbody>
</table>
## Crosswalk: Functionality

<table>
<thead>
<tr>
<th>Line #</th>
<th>WG</th>
<th>Category and Description</th>
<th>Specific Criteria</th>
<th>Source or Reference</th>
<th>Discussion / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>Identify &amp; maintain a patient record</td>
<td>1. The system shall create a single patient record for each patient</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Identify information is stored and linked to the patient record</td>
<td>2. The system shall associate (store/link) key identifying information with each patient record</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>Both static and dynamic data elements will be maintained</td>
<td>3. The system shall store multiple identifiers for each patient record</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>A look up function uses this information to uniquely identify the patient</td>
<td>4. Using the key identifying information, the system shall identify (look up the unique patient record)</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>The system shall maintain and use available dynamic data elements for each patient record</td>
<td>5. The system shall maintain and use available dynamic data elements for each patient record</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>The data in the patient record and the identity of the record itself shall be maintained</td>
<td>6. The data in the patient record and the identity of the record itself shall be maintained</td>
<td>DC.1.1.1</td>
<td>H</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Manage patient demographics</td>
<td>1. The system shall capture and maintain demographic information as part of the patient record</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>Addresses &amp; phone numbers</td>
<td>2. The system shall provide ability to report demographic information</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>Birth dates, gender, and other demographic information</td>
<td>3. The system shall keep track of demographic information over time</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>The system shall allow a user to modify demographic information about the patient</td>
<td>4. The system shall allow a user to modify demographic information about the patient</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>Demographic information shall be stored in the patient medical in separate data fields, such that data extraction tools can subsequently be used to retrieve this data</td>
<td>5. Demographic information shall be stored in the patient medical in separate data fields</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>Manage summary lists</td>
<td>1. The system shall create and maintain a summary list for each patient</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>Patient summary lists can be created from patient</td>
<td>2. The system shall be capable of including</td>
<td>DC.1.1.3</td>
<td>H</td>
</tr>
</tbody>
</table>

### CCHIT Functionality Work Group Phase I

| Line # | Criterion Name | WG | Criterion Description | Source (Map to Standard source) | Priority (L/M/H) | Availability | Test Method | Test Specification | Recommendation | Discussion / Rationale |
|-------|----------------|----|-----------------------|---------------------------------|------------------|--------------|-------------|-------------|-------------------|----------------|-----------------------|
| 1     | Identify & maintain a patient record | F   | 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. | DC.1.1.1 | H | 1. The system SHALL create a single patient record for each patient |
| 2     |                 | F   |                      |                                 |                  | H | 2. The system SHALL associate (store/link) key identifying information with each patient record |
| 3     |                 | F   |                      |                                 |                  | H | 3. The system SHALL store multiple identifiers for each patient |
| 4     |                 | F   |                      |                                 |                  | H | 4. Using the key identifying information, the system SHALL |
| 5     |                 | F   |                      |                                 |                  | H | 5. The system SHALL maintain and use available dynamic data elements |
## Crosswalk: Interoperability

### 1. Laboratory and Imaging

**Receive results:** Using common vocabulary with inbound interface optionally removed
- **Specific Criteria:** HL7 v2.x available now; HL7 v3 in dev; LOINC for results naming (to be discussed)
- **Source of Reference:** H, M

**Discussion / Comments:** Discuss obstacles and solutions here.

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### 2. Laboratory and Imaging

**Send orders to lab systems:** Complete order must be defined (minimum dataset). There is no good definition for a minimum data set for an order message. Laboratory costs are higher if electronic orders are incomplete
- **Specific Criteria:** HL7 v2.x available now; HL7 v3 in dev; LOINC for results naming (to be discussed)
- **Source of Reference:** H

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### 3. Receive PACS images, photos, and EKG images

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### Table:

<table>
<thead>
<tr>
<th>Line</th>
<th>WG</th>
<th>Category and Description</th>
<th>Specific Criteria</th>
<th>Source of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>L1</td>
<td>Laboratory and Imaging</td>
<td>Receive results using common vocabulary with inbound interface optionally removed</td>
<td>HL7 v2.x available now; HL7 v3 in dev; LOINC for results naming (to be discussed)</td>
</tr>
<tr>
<td>2</td>
<td>L2</td>
<td>Laboratory and Imaging</td>
<td>Send orders to lab systems. Complete order must be defined (minimum dataset). There is no good definition for a minimum data set for an order message. Laboratory costs are higher if electronic orders are incomplete</td>
<td>HL7 v2.x available now; HL7 v3 in dev; LOINC for results naming (to be discussed)</td>
</tr>
</tbody>
</table>

### Discussion / Barriers to Market Availability:

1. Interface functionality: (a) lacks of standard result and result values vocabularies; (b) non-standard handling of microbiology; (c) coding standards (once defined) must be kept current; Process must be efficient and fast to keep up with the addition of new tests; (d) Need to provide discrete data and laboratory specific reports. This is especially true for anatomical pathology and esoteric reporting.
2. Mutual or communication architectures increases costs to support send and receipt of results. What is business model to support real-time results feeds? Who will pay? Is potential for innovation (technological and clinical) to be throttled by standards bodies?
## Crosswalk: Security and Reliability

<table>
<thead>
<tr>
<th>Line #</th>
<th>WG</th>
<th>Category and Description</th>
<th>Specific Criteria</th>
<th>Source or References</th>
<th>Priorities (L,M,H)</th>
<th>Availability</th>
<th>Recommend</th>
<th>Discussion / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>SR</td>
<td>Security: Access Control</td>
<td>The system shall enforce the most restrictive set of rights/privileges or accesses needed by users (or processes acting on behalf of users) for the performance of specified tasks.</td>
<td>ISO 17799: 9.1.1.2.b, HIPAA: 164-312(a)(1)</td>
<td>H</td>
<td>M</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>The system shall provide the ability for an authorized administrator to define restrictions on the function access level. The system must be able to associate permissions with a user using one or more of 1 role-based, 2) entity-based or 3) context-based access controls.</td>
<td>Canadian: Alberta; CC SPR: FMT_MSA: SP 800-53: AC-6 LEAST PRIVILEGE; HIPAA: 164 312(a)(1)</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>10</td>
<td>SR</td>
<td>Security: Audit</td>
<td>The system shall continue normal operation even when security audit facility is non-functional.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First Draft of “Use Cases”

• Use cases: realistic clinical scenarios for test purposes
• Use cases should demonstrate product fulfillment of functionality, interoperability, and security criteria
• Common use cases will help unify and coordinate efforts in the new HHS health IT strategy
HHS Health IT Strategy and the Future of CCHIT
New HHS Health IT Initiatives Announced June 6-7, 2005

• American Health Information Community
  • Chaired by HHS Secretary Mike Leavitt
  • Five specific tasks requiring recommendations

• Four RFP’s released June 7
  • Standards harmonization process
  • Compliance certification and inspection process*
  • Prototypes for a National Health Information Network
  • Privacy and security solutions for interoperable health information exchange

*CCHIT is responding to this RFP
Collaborative Relationships

American Health Information Community

NIST
National Coordinator and Project Officer(s)

Standards Harmonization Contractor
Compliance Certification Contractor
NHIN Prototype Contractors
Privacy/Security Solutions Contractor

Multiple Public and Private Sector Stakeholders
Thank You!

Q and A

For more information, please visit the website:

www.cchit.org