AHDI's Comments on Draft Recommendations for Stage 3 Definition of Meaningful Use of Electronic Health Records

Health Information Policy Committee
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Association for Healthcare Documentation Integrity
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About AHDI:

Founded in 1978, the Association for Healthcare Documentation Integrity (AHDI) is the world's largest not-for-profit association representing individuals and organizations in healthcare documentation. AHDI and our 13,000 members champion excellence in healthcare documentation and advance patient safety through the precise capture of the patient's health story. Visit our website, www.ahdionline.org.

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I. Meaningful Use Objectives and Measures

1) Improving Quality, Safety, and Reducing Health Disparities
2) Engaging Patients and Families
3) Improving Care Coordination
4) Improving population and public health
5) Information Exchange
6) Overarching MU questions

SGRP 106

Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate medication list.
Certification criteria only: Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval.

AHDI Comment:

- It is recommended that human review/confirmation of the medication reconciliation is needed to ensure integrity of the process. Human review of the medication reconciliation is especially critical upon discharge from inpatient hospitalizations. Although the provider writes discharge orders and reconciles the discharge medication list, for the highest levels of patient safety, ideally the pharmacy staff should perform a discharge medication reconciliation as well within specified established timeframe (create a process measure for this). Specific instructions should be included to delineate clarification. For example, if a medication is being held, must specify "hold until followup with Dr. XYZ," or "hold until INR is between 1.5 to 2.0 for 2 days, then resume."
- Continue to require CDA Content Exchange Data Standard.

SGRP 107

Certification criteria only: EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction.

AHDI Comment:

- Continue to require CDA Content Exchange Data Standard, SNOMED CT + US Ext, Rx Norm.
- Include text boxes for providers to capture specific details of allergic reactions and allow this data to be entered by either direct provider entry or partial dictations of the allergic reaction details. Menu-driven input would not be as robust or enable capture of the detailed information needed to accurately reflect the patient's allergic reactions.

SGRP 113

Objective: Use clinical decision support to improve performance on high priority health conditions.
Measure:

1. Implement 15 clinical decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty:

- Preventative care (including immunizations)
- Chronic disease management (e.g., diabetes, hypertension, coronary artery disease)
- Appropriateness of lab and radiology orders
- Advanced medication-related decision support* (e.g., renal drug dosing)

2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Certification criteria only:

1. Ability to track CDS triggers and how the provider responded **
2. Ability to flag preference-sensitive conditions and provide decision support materials for patients
3. Capability to check for a maximum dose in addition to a weight-based calculation
4. Use of structured SIG standards
5. Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists)

AHDI Comment:

- Clinical Decision Support triggers are presently being tracked, with the ability of EHRs to consume CDS intervention from central data repositories to analyze for appropriateness of lab and radiology orders, etc.
- It is critically important that the clinical data entered by the physician is correct. Data containing errors, which are auto filtered to data repositories, will result in potential immediate negative consequences at points of medical decision-making and Clinical Decision Support alerts by the EHR systems. It also impacts (on the back end) the ability to leverage the data to drive all of these processes/achieve desired outcomes. Only through human quality assurance, a "second set of eyes," will the accuracy of the EHR information be at the level needed to allow CDS to perform optimally.

SGRP 117

EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

Measure:

1. More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.
2. Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.

AHDI Comment:

- In response to #2 in SGRP 117: Human review/data reconciliation will help eliminate mismatches in medications. Tracking mismatches is an after-the-fact data collection process; reconciliation of the data by human review is needed before the medication at the dose ordered has been dispensed. Healthcare documentation specialists' (also known as medical transcriptionists) skill sets could be employed to generate this review process.

SGRP 119

CORE Objective: Record high priority family history data.
CORE Measure: Record high priority family history in 40% of patients seen during reporting period.
Certification criteria: Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).

AHDI Comment:

- It is critical to include a text box to enable providers to input free-text, rich, robust information. Providers should be able to either dictate partial dictation of this free-text information or directly input detail-rich information. Very often, family history information can be complex and require greater detail than structured data capture drop-down boxes enable or can anticipate. Family history created with space-limited templates in the absence of other acceptable medical record entries would not constitute sufficient documentation.

IEWG 101

Certification criteria: The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. This query may consist of three transactions:
a) Patient query based on demographics and other available identifiers, as well as the requestor and purpose of request.
b) Query for a document list based on an identified patient.
c) Request a specific set of documents from the returned document list.

When receiving inbound patient query, the EHR must be able to:
a) Tell the querying system whether patient authorization is required to retrieve the patient's records and where to obtain the authorization language*. (E.g., if authorization is already on file at the record-holding institution it may not be required).
b) At the direction of the record-holding institution, respond with a list of the patient's releasable documents based on patient's authorization.
c) At the direction of the record-holding institution, release specific documents with patient's authorization.

The EHR initiating the query must be able to query an outside entity* for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient's records. Upon the patient signing the form, the EHR must be able to send, based on the preference of the record-holding institution, either:
1. A copy of the signed form to the entity requesting it.
2. An electronic notification attesting to the collection of the patient's signature.

*Note: The authorization text may come from the record-holding EHR system, or, at the direction of the patient or the record-holding EHR, could be located in a directory separate from the record-holding EHR system, and so a query for authorization language would need to be directable to the correct endpoint.

AHDI Comment:

- We continue to support requirement for CDA Content Exchange Standard to enable interoperability of health information exchange over the NwHIN and all goals identified above.

IEWG 103

Certification criteria: Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at § 170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s):
(i) *Encounter diagnoses.* The standard specified in § 170.207(i) or, at a minimum, the version of the standard at § 170.207(a)(3);
(ii) *Immunizations.* The standard specified in § 170.207(e)(2);
(iii) Cognitive status;
(iv) Functional status; and
(v) *Ambulatory setting only.* The reason for referral; and referring or transitioning provider's name and office contact information.
(vi) *Inpatient setting only.* Discharge instructions.

AHDI Comment:

- Continue to support requirement for CDA Content Exchange Standard, and for Vocabulary standard continue to support MU Common Data Set, SNOMED CT + US Ext, RxNorm. All data standards adopted and required in stage 2 final rules should continue to be supported to enable achievement of the goals within IEWG 103.

SGRP 204A

• EPs should make info available within 24 hours if generated during course of visit
• For labs or other types of info not generated within course of visit, it is made available to patients within four business days of info becoming available to EPs
• Potential to increase both thresholds (% offer and % use) based on experience in Stage 2

Note: Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g., specialists) for view/download/transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available information on the provider's portal.
MENU item: Automated Transmit*: (builds on "Automated Blue Button Project"): Provide 50% of patients the ability to designate to whom and when (i.e., pre-set automated & on-demand) a summary of care document is sent to patient-designated recipient** (for example, a one-time request to send information from specialist to primary care, or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures).

*Subject to the same conditions as view, download, transmit.

**Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.

AHDI Comment:

- Clarity is needed regarding **"**EPs should make info available within 24 hours <u>if generated during course of visit.</u>"
    - Does this mean only EHR-generated information (generated with voice recognition/template driven/menu driven), or does this also mean documentation created using the dictation/transcription process?

  - Does this include partial dictations/snippets dictated?
  - Does this include the clinical documentation of the care encounter?

- "(Pre-set automated & on-demand) a summary of care document is sent to patient-designated recipient"
  - Need ability to have flexibility in turnaround times for providers.
  - Need clarification and specifics regarding what exactly is included in these "pre-set automated & on-demand" templates.
  - Enough emphasis cannot be placed on the fact that the Summary of Care documentation needs robust, free-text clinical data capture capability, not strictly structured documentation capture, in order to reflect the patient experience with enough detail to be meaningful to the end-user.

SGRP 205

The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.

What specific information should be included in the after-visit summary to facilitate the goal of patients having concise and clear access to info about their most recent health and care, and understand what they can do next, as well as when to call the doctor if certain symptoms/events arise?

AHDI Comment:

- Agree with the statement that the clinical summary needs to be pertinent and not just an abstract reported in template form. Specifically, the following need to be included in an after-visit summary: A chief complaint, current diagnosis(es), medication list (reconciled), allergies, review of systems ("A 10-point review of systems was performed and within normal limits except for …. note any abnormalities within a concise review of systems)," labs and diagnostic studies that were performed during the visit with results and which ones have been performed but are awaiting results, physical exam including abnormalities, treatment plan including when to follow up and with whom.
- A template is not necessarily the most efficient option because it creates voluminous documentation with much information repeated, causing the patient and other caregivers to perhaps miss important information or to not read the document fully due to its length.
- It is vital that an additional critically thinking human, in partnership with clinicians, at least on the back-end, review patient records to ensure quality and accuracy of clinical data and to eliminate errors before data is authenticated and auto-filtered/reported directly into large data repositories or warehouses. If critical errors are discovered, the patient would then be contacted with a corrected summary.

SGRP 302

EP / EH / CAH Objective: The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for:
- medications
- medication allergies
- problems

EP / EH / CAH Measure: The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more

than10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).

SC&C Recommendation: Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e., severity).

Feasibility to add additional fields for reconciliation e.g. social history?

AHDI Comment:

- All reconciliations, including medications, allergies, problem lists, as well as reconciliation of social, family, past medical and past surgical histories should be performed. It is critically important to involve patients directly in the reconciliation process, at the point of care. It is imperative to consider family history and social history when contemplating diagnoses and treatments.

SGRP 303 & SGRP 304

EP/ EH / CAH Objective: EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care.

Provide a summary of care record for each site transition or referral when transition or referral occurs with available information.

Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):
1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and/or referral).
2. Setting-specific goals.
3. Instructions for care during transition and for 48 hours afterwards.
4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF).

Measure: The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically).

Certification Criteria: EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral.

Certification Criteria: Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013:

1) Consultation Request (Referral to a consultant or the ED)
2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency

Specific ONC Question's seeking input on:
How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers?
Think through these priority use cases:
1. Patient going home from an acute care hospital admission
2. Patient in nursing home going to ED for emergency assessment and returning to nursing home
3. Patient seeing multiple ambulatory specialists needing care coordination with primary care
4. Patient going home from either hospital and / or nursing some and receiving home health services

What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions, including advance orders, and care team members. What data strategy and terminology are required such that the data populated by venue specific EHRs can be exchanged. How might existing terminologies be reconciled?

What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed?

AHDI Comment:

- Agree with ONC that free-text is a critically important way to communicate the unique information specific to each unique individual. Physicians' documentation is more complete and accurate when the dictation/transcription or human editing process is used.
- Emphasize use of technology such as Natural Language Processing, Natural Language Understanding, and data analytics tools to auto encode free text into discrete data and pull data from free text.
- The human interface of a patient advocate can advance the concept of collaboration tools for patients.
- Standardized data elements and data dictionaries are critical in order to achieve interoperability. If the Common MU Data Set does not yet include a standardized basic data dictionary and data elements, a standardized data dictionary should be established, with the requirement to incorporate it into individual EP/EH/CAH's more extensive data dictionaries.
- Support physician efficiency by being able to dictate free-text, use the technology of NLP, NLU, etc, data dictionaries, data mapping.

SGRP401A

EP/ EH Objective: Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice.
Measure: Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period.
Exclusion: EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories.

Certification criteria: EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.

AHDI Comment:

- Allow patients to self-report immunizations when technology is not available to auto report this info.

SGRP 402B

EP Objective: Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice.
Measure: Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice.
Certification criteria: The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. Could similar standards be used as those for clinical trials (SGRP 209)?

AHDI Comment:

- Total agreement with Objective above, and reinforce that Consolidated CDA standard is a necessary requirement. As indicated above, "standardized (Consolidated CDA) case reports are submitted to state/local jurisdictions." As we are able to exchange more robust public health monitoring/syndromic surveillance information, it is appropriate to require Consolidated CDA content exchange standard for these purposes in addition to all other data standards currently required for these purposes.

PSTT 01

How can the HITPC's recommendation be reconciled with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification which strongly encourages the re-use of third party credentials?

AHDI Comment:

- The credentialed medical transcriptionist/healthcare documentation specialist has expertise in HIPAA law and regulations. Credentialed medical transcription/healthcare documentation professionals have objectively demonstrated this knowledge.
- While we agree this would bring requirements into better alignment with the types of requirements of the Fair Trade Commission's policies and procedures, we have great concern of how this could negatively impact medical transcription/healthcare documentation service owners with regard to potential financial burden and practical use of industry systems. We recommend including large and small healthcare documentation/medical transcription service owners as stakeholders in further strategies regarding PSTT 01.

PSTT 02

How would ONC test the HITPC's recommendation in certification criteria?

AHDI Comment:

- Written policy should outline the two factor (or higher) authentication process. ONC could require a copy of the policy as well as the authentication logs for a given period of time.

PSTT 03

Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider?"

AHDI Comment:

- Both should be included, the standalone EHR and an EHR with third party authentication service provider.
- Request clarification be provided on cost and impact of these recommendations, specifically the recommendations of "This included recommending that organizations/entities, as part of their HIPAA security risk analysis, should identify any other access environments that may require multiple factors to authenticate an asserted identity, and that organizations/entities should continue to identity proof provider users in compliance with Health Insurance Portability and Accountability Act (HIPAA)."
- Will all business associates be required to implement multiple-factor authentication? How this requirement is implemented could negatively impact the healthcare documentation service industry.

PSTT 04

What, if any, security risk issues (or Health Insurance Portability and Accountability Act (HIPAA) Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3? For example, the requirement to make staff/workforce aware of the HIPAA Security Rule and to train them on Security Rule provisions is one of the top 5 areas of Security Rule noncompliance identified by the HHS Office for Civil Rights over the past 5 years. In addition, entities covered by the Security Rule must also send periodic security reminders to staff. The HITPC is considering requiring EPs/EHs/CAHs to attest to implementing HIPAA Security Rule provisions regarding workforce/staff outreach & training and sending periodic security reminders; we seek feedback on this proposal.

AHDI Comment:

- Absolutely, EPs/EHs/CAHs should attest to implementing all portions of the rule.
- We recommend including a requirement for encryption; currently, encryption is not being done on a consistent basis until a breach has occurred.
- Yes, require encryption for certification and be sure it cannot be bypassed or turned off in the system.

PSTT 05

Feedback on standards for accounting for disclosures would also be appreciated. Accounting for disclosures, surveillance for unauthorized access or disclosure and incident investigation associated with alleged unauthorized access is a responsibility of organizations that operate EHRs and other clinical systems. Currently, the 2014 Edition for Certified EHR Technology specifies the use of ASTM E-2147-01. This specification describes the contents of audit file reports but does not specify a standard format to

support multiple-system analytics with respect to access. The HITPC requests comment on the following related questions:

"Is it feasible to certify the compliance of EHRs based on the prescribed standard?"

AHDI Comment:

- Yes. This is feasible and this standard is appropriate for this purpose.
- As well, access rights clarification is needed.
- Access to past patient data is extremely useful to healthcare documentation professionals in order to accurately document current clinical data.

ONC 01

Subject area: Query

For the item identified as IEWG101 – **Certification criteria:** The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example.

Could a **MENU** objective be added to recognize providers who are proactively querying (e.g., For patients transitioned without a care summary, an individual in the practice should query an outside entity). Should the measure be for a number of patients or a percentage of patients?

AHDI Comment:

- Yes, this should be a menu item.
- The measurement should be a percentage of patients.

ONC 02

Subject area: Identity matching. What could facilitate identity matching – query, e.g., maintain external patient ID, standards for matching attributes?

AHDI Comment:

- It is time to ensure a unique national patient identifier is utilized. Final specifications need to be outlined (Personal Unique Identifier HITSP.83139.v2). The unique identifier is to be used for each patient at every location of care, no matter where the patient seeks healthcare services.
- Unique national patient identifiers ensure the integrity of the information and presumably could reduce the potential for inappropriate placement of documentation into the EHR for any one patient. Unique identifiers must also be practical as far as use within all areas of the workflow process including correctly identifying dictation audio to correct patient demographics. Unique identifiers have the capacity to create better efficiencies in documentation workflow processes and reduce errors.
- Health Networks that include many facilities use an Enterprise Patient Identifier; a National Patient Identifier is just one step further in making it possible for medical information to be truly captured nationwide for each unique patient.

ONC03

Subject area: Transitions of Care

For the objective identified as SGRP303 - The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically).
Could the electronic threshold be raised to 50% for this measure?

AHDI Comment:

- Recommend keeping the requirement at 30% for those transmitted electronically. EPs/EHs/CAHs are still struggling to implement certified EHR technology by deadlines and are likely nowhere near capable of achieving 50%.
- This requirement necessitates not only the sender to have already implemented and be using certified EHR technology, but it necessitates at least 50% of the receivers of this information to also have implemented and be using certified EHR technology in order to achieve the 50% requirement. In essence, it requires "an equal partner for the dance" at least 50% of the time in order to achieve a 50% rate of electronic transmission of Summary of Care documents. Again, recommend upholding the current 30% requirement.

ONC04

Subject area: Patient Generated Data

For the objective identified as SGRP204B - Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care…

What information would providers consider most valuable to receive electronically from patients? What information do patients think is most important to share electronically with providers? What data would be most valuable as an initial minimum set for patients to send to providers electronically outside the clinical visit? What other data could be added in the future?

AHDI Comment:

Information that would be valuable for physicians to receive and important for patients to share would be:

- For diabetics, their daily logs for testing their blood sugars.
- For hypertensive patients, their logs for checking their blood pressures.
- For all patients: Allergies. List of medications and dosages. Significant histories (i.e., surgical, family, social, etc.). Contact information for pharmacy and other healthcare providers. Immunizations and their dates. Health insurance information.
- All information above should be included in a minimum data set.
- In the future, additional data could include symptoms the patient is experiencing (reported before an office visit – this information could lead to either the patient being seen sooner or the ability to avert an office visit) as well as any recent travels, especially out of the country (this information could alert the physician to the possibility of preventive care the patient may need depending on CDC alerts).

ONC 05

Subject area: Clinical documentation
What is the best balance between ease of clinical documentation and the ease of practice management efficiency?

AHDI Comment:

- For many physicians, the use of dictation provides an easy-to-use method of documentation in sections of a report that cannot otherwise be efficiently captured with templates or point-and-click technologies. Recently released CMS requirements specify **"progress notes created with limited space templates in the absence of other acceptable medical record entries do not constitute sufficient documentation of a face-to-face visit and medical examination."** It is a critical need for second-set of human eyes to review, preferably prior to authentication by the provider, but at the very least on the back-end for quality and accuracy of clinical data to eliminate errors before data is authenticated and auto-filtered/reported directly into large data repositories or warehouses.

ONC06

Subject area: Test tracking
Could an additional objective be added for test tracking (e.g., 10% of test results are acknowledged within 3 days)?

AHDI Comment:

- Yes. There should be a log maintained for this purpose. Ultimately all test results should be acknowledged within 3 days or sooner, not just 10%.

ONC 07

Subject area: Safety risk assessment. To ensure the safety of EHRs, should there be a MU requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance?

AHDI Comment:

- Health IT safety risk assessment should be a requirement but it needs to be clearly defined as to what the safety risk assessment includes. One element that must be included in this assessment would be a quality review of the documentation. Some critical components of the required safety risk assessment should be identified as core requirements. EPs/EHs/CAHs should retain the freedom to identify and assess various safety risks unique to their situation but other core issues should be mandatory inclusions of all safety risk assessments.
- As direct provider-input data capture methods are increasingly employed through adoption of EHR technology, coupled with the ability of the author or technology to auto-sign medicolegal documentation with or without the author reading completely through the documentation encounter, perhaps bypassing QA review by trained professionals from the healthcare documentation industry, our concern is that documentation errors are being made and then perpetuated. Documentation errors are often undiscovered even after authentication by the provider/author until an unintended event occurs and patient safety is compromised. Periodic quality assessment of all documentation at regular intervals for the purposes of accuracy and completeness as it relates to clinical care, regardless of how it is entered into the system, should be included in the safety risk assessment.

- Once an error is in the system, the errors are perpetuated with the possibility of exponential replication via health information exchange. Even if corrections are made after provider authentication the corrections lag behind the original documentation and cannot be guaranteed to reach recipients of the original information.
- Examples of areas of errors in healthcare documentation that go uncorrected include front-end speech recognition technology mistakes, inappropriate use of abbreviations, content discrepancies, demographic discrepancies, use of copy/paste from prior documentation, medication discrepancies or omissions, information omission, incorrect verbiage, incorrect point/click selection, incomplete or incorrect drop-down menu options, author/provider fatigue when documenting, breakdown of flagging process, blanks that go unfilled. Attached is an error abstract that identifies critical information errors that are corrected by medical transcriptionist/speech editors/quality assurance editors/healthcare documentation specialists.[1] This is a one-day study from 2009 and shows errors caught prior to authentication/signature by the provider. Since more EHR systems have been adopted since 2009 and multiple forms of documentation/data capture are being employed, AHDI and the American Health Information Management Association (AHIMA) are working collaboratively to establish a research study to explore information errors that occur regardless of data capture methods.
- It is also critical to identify inconsistencies within clinical records because clinical data fraught with inconsistencies lends to lack of trust in the quality and integrity of the clinical data.
- Every process MU intends to make a possibility (process improvement, quality improvement, increases in efficiency, decreases to disparities in care, increases to patient safety, etc.) all hinge upon having "quality data" as free from error as possible in order to leverage and utilize that data to drive these processes. Data containing errors auto filtered to data repositories will result in potential immediate negative consequences at point of medical decision-making and Clinical Decision Support alerts by the EHR systems (which this piece addresses tracking CDS interventions) but also, again, impacts (on the back end) the ability to leverage the data to drive all of these processes/achieve desired outcomes.
- EHRs that enable front-end data capture without the use of back-end QA, or some type of QA review prior to authentication, to ensure accuracy of clinical data poses significant risk to patient safety. This component should be included in any safety risk analysis requirement adopted.
- See ASTM standard E2117-060 “Standard Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription.” There are likely components of this standard that relate and may be incorporated into a referenced model/standard.
- AHDI, in collaboration with AHIMA and the former Clinical Documentation Industry Association (CDIA), developed a best practice manual for quality assurance of dictation/transcription, which is still an efficient method of patient information capture. A stakeholder group could be formed to address QA concerns in the EHR based on this model.[2]

ONC08

Subject area: Consent management

- Some federal and state health information privacy and confidentiality laws, including but not limited to 42 CFR Part 2 (for substance abuse), establish detailed requirements for obtaining

[1] *Improving the Accuracy of Narrative Patient Notes: The Role of Documentation Specialists in Supporting Physician Use of EMRs.* Abstract. Robin Daigh, et al. June 2009. [see attachment] <http://www.ahdionline.org/Portals/0/downloads/Dictation%20Error%20Report%20Abstract.pdf>

[2] *Healthcare Documentation Quality Assessment and Management Best Practices.* AHDI, MTIA, AHIMA. Updated March 2011. [see attachment] <http://www.ahdionline.org/LinkClick.aspx?fileticket=f3sQg96ixiQ%3d&tabid=601>

patient consent for sharing certain sensitive health information, including restricting the recipient's further disclosure of such information.

- How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange?
- How can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on a consent form, manage consent expiration and consent revocation, and communicate the limitations on use and restrictions on re-disclosure to receiving providers?
- Are there existing standards, such as those identified by the Data Segmentation for Privacy Initiative Implementation Guide, that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?

AHDI Comment:

- Regarding consent management and its impact on the portability of health information, healthcare enterprises, medical transcription service organizations, independent contractors, billing companies, coding companies, and many organizations can be located in multiple states. The practical ability to work across state lines needs to be taken into consideration as consent management decisions are made.
- It is time for HIPAA to be the one standard to follow for all healthcare purposes. The patchwork of state laws throughout the country that currently exists will always be burdensome and difficult to navigate when trying to exchange healthcare information. HIPAA should supersede all others when it comes to health care.

ONC09

Subject area: Application programming interface

There are many cases where EHR systems supply clinical information to other systems, e.g., registries, accountable care organizations. Is it possible to create an application programming interface (API) to represent the information defined in a CCDA so that systems can communicate with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information?

AHDI Comment:

- No. Simply requiring all EHs/EPs/CAHs and all third parties, such as registries, to implement certified EHR technology and interoperability will be possible. The purpose of identifying and requiring specific data standards for all certified EHR technology is to ensure interoperability. A single API cannot achieve interoperability between multiple disparate systems. This is the purpose of the mandated data standards and certified EHR technology.

ONC10

Subject area: Prescription drug monitoring

For the objective identified as SGRP113 - Use clinical decision support to improve performance on high priority health conditions…

Could certification criteria be added for EHR access to prescription drug monitoring programs (PDMP)?

Certification criteria: EHR technology supports streamlined access to the PDMP data

For example:

- Via a hyperlink or single sign-on for accessing the PDMP data
- Via automated integration into the patient's medication history

AHDI Comment:

- Yes, the certified EHR should be able to access the PDPM data. In the future, this could be elevated from access to monitoring the activity (i.e., prescriptions refilled, not refilled, etc.) as well as for suspicious overuse or lack of use of the medication.

II. Quality Measures

A. Patient Centeredness: Broaden Stakeholder Input

The HITPC intends to capture insights broadly from providers, patients, lay caregivers and other stakeholder groups across the healthcare landscape that have been previously less engaged in HIT policymaking but actively engaged as providers, purchases and recipients of care.

QMWGO1

Subject area:

How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?

AHDI Comment:

- ONC and NeHC could reach out to more providers and organizations through webinars and online questionnaires to capture more input. Recommend reaching out to groups such as the American Medical Association, American Osteopathic Association, Medical Group Management Association, National Association for Healthcare Quality, National Patient Safety Foundation, American Health Information Management Association, American College of Physicians, National Partnership for Women and Family, etc.

QMWGO2

What additional channels for input should we consider?

AHDI Comment:

- Support Blue Button technology requirement of all Eligible Providers, Eligible Hospitals and Critical Access Hospitals, as well as third-party payers. This increases patient access to information and enables patient feedback.
- Provide a way for patients to comment, possibly by including notices on Medicare/insurance statements.
- Utilize Facebook and social media to gather stakeholder input.
- Reinforce the human interaction necessary to end up with quality data in the PHR and EHR. Healthcare documentation specialists have the skill sets required to work with patients on this.
- New systems need to be created as the feedback loops are created.
    - For example, ONC is devoting vast resources to engage patients to read their medical records and become active participants in ensuring the accuracy of their clinical data, then to become active participants in their own health and health care. An expectation may be that patient feedback regarding any inaccuracies within the clinical data of their medical records will contribute to elimination of inaccuracies within EHR-derived data. An ONC website is also promoting patient awareness of their rights to accurate medical records, with posted instructions on how to request an amendment of inaccuracies within their medical records, including a link to the Office of Civil Rights, which enforces this

right. Providers have 60 days to investigate patient-initiated disputes of inaccuracies within their EHR-derived data (90 days under mitigating circumstances) and to either revise the inaccuracies or to provide the patient with an explanation of why the clinical information will not be amended. Should the ONC succeed in engaging patients as active participants in this regard, the volumes of patient-initiated disputes of perceived or veritable inaccuracies within their medical records could potentially rival the volumes of consumer credit disputes processed by consumer credit bureaus. The chair of AHDI Advocacy Alliance has created a report summarizing this topic, potential challenges to providers/health systems, and possible solutions. The report was drafted in the form of an SBAR report (Situation, Background, Assessment, Recommendations), commonly utilized within healthcare systems to identify urgent situations and provide rapid feedback and resolution. AHDI is currently seeking widespread input from all relevant stakeholders. Please see the attached SBAR report for more information.[3]

- Several sources of stakeholder input already exist with vast quantities of salient recommendations covering problem issues that need to be addressed and discussed further amongst stakeholder panels, with representation from multiple corners of the healthcare landscape. This could be done via workgroups hosted by NeHC.
    - For example,
        - Ensure revised workflow processes surrounding efficient clinical data capture in certified EHR systems do contemplate all potential downstream effects based upon those changes to data capture methods which emphasize efficiency efforts, yet do not tackle the "quality" data issue. We can achieve this by hosting several live nationwide meetings through NeHC on this topic with top thought leaders from: Physician associations (AMA, AOA, MGMA), AHDI (MT editors/QA specialists/healthcare documentation specialists/CMTs/RMTs/documentation managers and supervisors), AHIMA, quality (NAHQ), patient safety (NPSF), health informatics (AMIA), risk management associations/legal counsel, patient advocacy associations, patients/healthcare consumers, etc.
        - For the healthcare documentation sector, workgroups to include multiple stakeholders need formed to discuss and outline how we will achieve accuracy within clinical documentation to enable abstraction/reporting of reliable (quality) clinical quality data (CQMs) that can be effectively leveraged to achieve MU targeted outcomes, and support maintaining patient safety at the highest level possible, while still achieving efficiency goals and MU3 turnaround time criteria.

B. Patient Centeredness: Patient-reported and Patient-Directed Data

The HITPC recognizes that both patients and providers generate and consume clinical quality data. The committee anticipates that consumer generated and directed data is most useful if the data spans settings and is oriented to outcomes. We appreciate that performance data is important for both quality improvement and for shared decision making. Contributors have challenged the workgroup to develop CQMs that accommodate personal care goals in addition to guideline-directed care goals. This is a commendable aspiration; still significant barriers to integration of patient-generated data with EHR clinical data remain.

[3] *Assessing the Need for a New Nationwide Infrastructure for Processing of Patient Disputes of Errors Within Their Electronic Medical Records.* Theresa Wilkes. November 2012. [see attachment] <http://www.ahdionline.org/portals/0/downloads/SBAR_Report_Requesting_Feedback_PDF__010813.pdf>

QMWGO4

Please provide examples of how patient-directed data is informing shared decision making. How does the public view the integration of EHR derived data with patient generated data for quality measurement? How important is it to keep this data separate? Should it be separate?

AHDI Comment:

- Recommend maintaining "EHR-derived data" (the objective clinical data) separately from patient-provided data. However, recommend patient-provided information be readily available within the EHR to the provider at the point of care.
- Of note, it is of critical significance to realize that not only patients and providers "generate and consume clinical quality data." For example, multiple parties are involved in generating and consuming clinical quality data (healthcare documentation specialists/QA editors/third-party payers).
- The accuracy and completeness, regardless of the method of data capture, needs to be ensured at the genesis of the information and then reconciled in order for EHR-derived data to be reliable.

C. CQM Pipeline: Process and Outcome Measures

The HITPC Quality Measure Workgroup has previously described, in the October 2010 "Tiger Team Summary Report" and the December 2010 Request for Comment, our intention to support the development of HIT-sensitive, parsimonious, longitudinal outcomes-focused CQMs for the EHR Incentive Program. The HITPC also recognizes that there remains value in developing near real-time, point-of-care, process measures for clinical use that can contribute nuance to performance demonstrated by value-oriented, outcomes measures.

QMWGO5

Please provide comment on how the HITPC should proceed with our focus on clinical outcomes. Should the HITPC focus its efforts on building point-of-care process measures or value-centered outcome measures?

AHDI Comment:

- At the point of care, the accuracy and completeness of clinical documentation is an issue. The accuracy/integrity of the information must be reconciled at the genesis of the documentation; if inaccurate information is allowed to move forward, outcomes would not be improved and could possibly result in treatments with undesired outcomes and possible deadly results.
- Currently, clinical data capture MU criteria emphasize the outcome measure of turnaround times, yet do not address a requirement for accuracy of all clinical data at the genesis so that EHR-derived data is reliably accurate thus usable and able to be leveraged to achieve targeted MU objectives.
- CQMs need to reflect data accuracy requirements for process measures of clinical data capture.

I. Quality Improvement Support: CQM Population Management Platform

The HITPC intends to encourage the development and expansion of HIT tools that leverage use of eCQMs for population management. The work group is especially interested in development of CQM population mapping and task-management platforms such as, clinical quality measure dashboard or business process management software and workflow engines that allow users to respond to actionable data on clinical care gaps and assign tasks both to individual patients and for user-determined cohorts.

The workgroup understands that this technology is desired by providers and requests comments on the potential role of the HITPC and HHS in this space.

QMWG26

What are the technical challenges to widespread release and adoption of CQM Population Management Platforms?

AHDI Comment:

- Traditionally, population management and public health surveillance reporting has involved only brief, discrete data. However, as more detail-rich, robust data are exchanged regarding population health, the CDA data standard becomes relevant for this purpose as well.
- Recommend adoption of consolidated CDA data standard in addition to all other data standards currently required for the purposes of Population Management and Syndromic Surveillance.