

January 14, 2013

Farzad Mostashari, MD
National Coordinator
Office of the National Coordinator for HIT
US Department of Health and Human Services
Hubert H. Humphrey Building, Suite 729-D
200 Independence Avenue, SW
Washington, DC 20201

RE: HIT Policy Committee: Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)

Dear Dr. Mostashari:

The American Health Information Management Association (AHIMA) appreciates the opportunity to respond to your request for information regarding potential requirements to be issued under Stage 3 of the ARRA-HITECH Meaningful Use incentive program.

AHIMA is a non-profit professional association consisting of more than 65,000 health information management (HIM) professionals who have been educated, trained, and certified to maintain the availability, integrity, and confidentiality of health information for not only clinical care but also secondary uses across the healthcare industry. Now in our 85th year, AHIMA members are encouraged by the progress in the adoption and use of a standardized electronic health record brought on by the ARRA-HITECH Meaningful Use program and the work of your office as well as the Centers for Medicare and Medicaid Services (CMS) and the HIT Policy and Standards Committees.

Specific Comments on RFI

Our response to the RFI is maintained in a Microsoft Excel Spreadsheet similar to that provided in the RFI; see the attached. Each tab in the spread sheet represents our comments on the four areas provided.

General Comments on RFI

In addition to responses regarding specific recommendations and questions, we have a few general comments when looking at the RFI in its full context:

- **Vocabulary**

- **Terminologies and Classifications:** It remains clear throughout the entire RFI that the department of Health and Human Services (HHS) must address the vocabulary used in standardizing EHRs and health information exchange requirements. For some time, AHIMA and the American Medical Informatics Association (AMIA) have recommended that a public/private governance process be established with HHS (potentially under the NIH National Library of Medicine) to oversee the development, selection, maintenance, and harmonization of terminologies and classifications used in the US health systems. With Stage 2 and now Stage 3, it is clear that there is a need to coordinate the use of SNOMED-CT®, ICD-10-CM and PCS classifications, LOINC terminology, and other terminologies and classifications. Terminologies and classifications provide the ability to have data and information interoperability and integrity.

January 14, 2013

While vocabulary has been addressed by the HIT Standards Committee, it is up to HHS to address the need for clinical and administrative vocabularies across the various standards used (or required).

- **Meta Data:** Requirements and certification requirements coming out of the Meaningful Use Stages, as well as the rapid transitions in the healthcare industry, are calling for the necessary use of metadata. This recognition is not new. However, it is clear from work to date that the HIT Committees, ONC, and other HHS agencies have not addressed the need for a coordinated and uniform approach to development of standards for metadata vocabulary. For example, as patient generated information becomes a part of the health information system and this information is integrated with clinical data from clinicians, there is a need to differentiate the information. If a standard vocabulary is not established, the inability to exchange records could create a number of difficulties and potential harm to the patient.

- **Continuity of Care**

- **Non-MU Providers:** There is an inherent assumption that information transmitted from the EHR to others for the purpose of continuity of care and public health will somehow be received and understood. Unfortunately, many of these healthcare components, including consumer/patients and their caregivers, were not included in ARRA-HITECH. Therefore they do not necessarily have the technology or the shared understanding of the information MU covered entities are expected to transmit. While we understand that ONC and CMS do not have the authority to include these entities under the Meaningful Use program, it behooves this program to pay attention and ascertain the needs and capabilities of those involved in post-acute, primary medicine, behavioral health and public health so that the appropriate requirements and criteria can be adopted and implemented.

AHIMA also urges ONC and the HIT Committees to explore the requirements necessary for communication of health information to and from those healthcare providers not currently under the MU program. There is potential for programs like the Direct Project to be used to answer some of these groups until something is done to address their needs more formally in the Meaningful Use program. This would include a mutual consensus on the standards that are being used and their content, vocabulary, metadata, and so forth. Further, AHIMA encourages HHS to continue to work with Congress and associations such as ours to include all healthcare providers (at a minimum providers under either Medicare and Medicaid or the federal health care program) to be included under an expanded Meaningful Use program.

- **Consumers Communication – Mobile Devices:** Included in the continuity of care discussion is the consumer/patient or their care givers. As more and more consumers become attached to mobile devices, these devices must be considered as we look at the ability to query or be queried by the EHR. While HL7 has developed a standard for PHRs to connect with EHRs, it is not clear that there will be consistent applications available to allow EHRs to connect to all of the mobile applications available. Again, we have the situation where the mobile devices are not covered under ARRA-HITECH (unless they are a PHR) but it would benefit consumers if something was done to develop criteria that mobile device vendors could use to ensure compatibility.
- **Consumer Notification:** We have noted criteria that allow consumers to submit information to a provider, via a portal process. However, there is nothing in the criteria that calls for the system to notify someone on the provider side that a communication has occurred. For example, if the individual sends a request to the provider for an amendment to their EHR information, how will

January 14, 2013

the provider, who may have hundreds if not thousands of patients, know a request has been received? And in this example, will the individual initiating the request receive a notification that the request has been received? We suggest this type of notification and receipt be added to these types of exchanges as well as for exchanges that go from one provider to another.

- **Quality Measurement:**

- **Data v Measurements:** AHIMA feels that quality measurements should be built into the EHR so that software is capable of pulling the data from the record as needed. This software can then be modified as needed to accommodate changes in quality measurement requirements. Likewise, data elements missing from an EHR can be added in a technology upgrade as needed.
- **Measurement Uniformity:** ONC and CMS must continue their work with the National Quality Forum and other industry groups, especially health plans, to develop and use quality measures that share the same vocabulary and work with the data that must be in the EHR for measurement mentioned above. In this time of rapid change, providers and their vendors cannot continue to maintain their EHR and appended software to respond to a variety of measures coming from different health plans. Given that CMS has engaged to share data, AHIMA asks that the health plans and CMS work with providers and the NQF to develop a common set of uniform quality measures. We would also like to suggest that quality measures are added and removed as needed but that these changes are consistent across the industry. This will allow for more administrative and technology savings and should also increase the integrity of the data in the measure.
- **Secondary Data:** Providers are required to report more than just quality measurement data. While the Meaningful Use program does not address many of these requests, we believe that it is important to consider the most common, such as public health information. We are aware that recent legislation is calling for the Secretary to approve an Attachment Standard under HIPAA for use by 2016. There is a good chance that these attachments will be similar or the same as some of the standards used under Meaningful Use and we encourage ONC to work with the National Committee on Vital and Health Statistics to ensure compatibility in these potentially shared requirements.

- **Privacy and Security**

- **HITECH-HIPAA Omnibus Changes:** A number of questions refer directly or indirectly to HITECH-HIPAA changes that are expected as part of an anticipated for Office of Civil Rights'(OCR) omnibus final rule that has been pending in the Office of Management and Budget (OMB) for some time. The anticipated rule is expected to include several requirements that will impact both the security requirements under HIPAA as well as software changes or improvements that will affect the electronic health record (EHR). While AHIMA understands and supports the desire to issue final Stage 3 requirements as soon as possible, we are concerned with developing Stage 3 requirements without the healthcare industry's understanding of the detail expected in the HITECH-HIPAA omnibus rule. We urge the HIT Committees and ONC, as well as OCR, to encourage the OMB to release these rules and then initiate a second RFI related to these rules for public Comment.
- **Other HITECH-HIPAA Changes:** In addition to the omnibus rule, there are other requirements coming from HITECH that will potentially impact Stage 3 such as the accounting for disclosures. These rules also should be moved along the final rule process so that Stage 3 requirements can be provided in concern to these final privacy and security requirements.

January 14, 2013

- **Privacy and Security Compliance:** The proposal related to certification that a provider is compliant with the HIPAA privacy and security requirements is appropriate; however, ONC/CMS should not be issuing any additional requirements with regard to privacy and security. Such requirements coming from yet another HHS agency(s) makes compliance more difficult and confusing. Any requirements for additional regulations, audit requirements, or reports (such as audit logs) should come from OCR as additions to the HIPAA rules. These rules should include requirements and standardization for reporting to provide continuity and standardization; otherwise, it will be difficult for vendors to program for compliance and the federal government to determine compliance issues across providers.
- **State Requirements:** Privacy and security requirements also come from the states and AHIMA urges the ONC Privacy Officer, OCR, and the HIT Committees' Privacy and Security Tiger Team to work with states to ensure consistency in reporting requirements affecting the EHR.
- **Fraud and Abuse:**
AHIMA was disappointed to see that the RFI did not include any questions or suggestions/recommendations related to the fraud and abuse issues that have been the focus of recent investigations by Congress and the HHS Office of the Inspector General (OIG). AHIMA believes that standards, certification criteria, and operating rules following health information management best practices can be harmonized to provide clear mechanisms to ensure the integrity of the EHR and its data. AHIMA has a number of projects underway that we believe can address the issues of integrity and fraud as well as assure that all primary and secondary data is complete and accurate.

AHIMA wishes to thank the ONC and its HIT Committees for their dedication and hard work to bring the US healthcare system into the 21st Century through their work with EHRs and HIE. We realize that development of requirements and certification criteria for the states of Meaningful Use take time, and that there will be additional requests for information, hearings, and other discussions to develop Stage 3. AHIMA is ready to address and respond to these processes in any way in which we are capable. AHIMA has worked closely with a number of the standards bodies to ensure that health information management best practices and principles are captured in the standards and in the harmonization and use of the various transaction and vocabulary standards that are needed to achieve the ultimate goals you have set forth.

Thank you and the HIT Committees for your time and consideration of these general and specific comments and recommendations. If you should have further questions or need for input from AHIMA, please contact Dan Rode, AHIMA's Vice President for Advocacy & Policy at dan.rode@ahima.org or (202) 659-9440.

Sincerely,



Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA
Chief Executive Officer

cc: Kathleen A. Frawley, JD, MS, RHIA, FAHIMA
President/Chair

Dan Rode, MBA, CHPS, FHFMA
Vice President, Advocacy and Policy