



April 11 2010

Paul Tang, MD, Chairman  
Jodi Daniel, JD, Co-chairman  
HIT Policy Committee – Strategic Plan Workgroup  
c/o Office of the National Coordinator for HIT  
Hubert H. Humphrey Building  
200 Independence Ave., S.W., Suite 729D  
Washington, D.C. 20201

RE: Comments on Health IT Strategic Framework

Dear Dr. Tang and Ms. Daniel:

These comments are written on behalf of the more than 57,000 members of the American Health Information Management Association (AHIMA) to comment on the *Health IT Strategic Framework: Strategic Themes, Principles, Objectives, and Strategies*. As a group of professionals who has long labored with you and many of the workgroup and the Office of the National Coordinator for HIT (ONC) to achieve the goal of electronic health records (EHRs) and health information exchange (HIE) we welcome the opportunity to provide comments and questions on the April 1, 2010 (Version 3.1) draft.

### **AHIMA**

As you know, AHIMA is a not-for-profit association of health information management (HIM) professionals, who work throughout the healthcare industry and government in a variety of roles and functions. AHIMA and its members have promoted the development, adoption, implementation, and use of standard EHR and HIE and are active in all facets of this endeavor including the confidentiality, privacy, and security of health information and the utilization of “secondary” data to benefit both the individual and population health. AHIMA is also very active in seeking uniformity, standards, and data integrity is the collection, storage, flow, and use of healthcare information as well as insuring a properly trained workforce to implement, manage, use, and protect the EHR and the infrastructure for its use and the appropriate flow of health information.

Our comments and questions regarding the Framework have been arranged, where possible, to follow the April 1, Version 3.1.

### **General Comments**

In general, AHIMA is pleased you have approached this strategic plan as one that covers both government and the healthcare industry, including those not recognized in ARRA. There can be no separation, given government makes up a significant part of the healthcare industry as a provider, sponsor, and payer of healthcare. Likewise; state governments and quasi-state and federal programs and organizations impact the provision of healthcare and the flow of health information as do health plans. We hope in the writing of the detailed strategic plan ONC will also consider highlighting the public-private-consumer partnership which must exist if the goals of the plan are to be achieved.

The ARRA-HITECH legislation of 2009 provides the healthcare industry with its first industry council for the adoption and use of standards, in the form of the HIT Policy and Standards Committees and their workgroups. Working with ONC, these bodies provide not only the opportunity to develop an industry-wide strategic plan, but also in the assessment of that plan to inform Congress of situations where the Act falls short and additional resources or legislation are needed. We raise this point because while the ARRA-HITECH Act provides many resources, these resources are not aimed at all segments of the healthcare industry and even where there are resources, many entities are limited with regard to funding either within or shortly after the period between now and 2015.

In reviewing the Framework, AHIMA also reviewed the two previous plans. We believe the 2004 *Framework for Strategic Action* provided a clearer picture of what one would expect to see in the healthcare environment given the achievement of the strategic goals. With the vast array of partners in the industry and government, as well as consumers; we suggest the Workgroup and ONC consider writing the plan in the fashion of the 2004 document so there is a clear picture of what the outcomes will look like rather than the jargon we all tend to use. Making such a change, we believe, would allow for much better buy-in especially by consumers and individual professionals/providers.

### **Strategic Planning Scope and Approach**

We essentially agree with the scope identified for the strategic plan and agree it must cover all of the stakeholders. We are pleased the development of the strategic plan includes input from these stakeholders since gathering information from a variety of sources only enhances the initiative through a stronger foundation. We appreciate opportunities for input to the various HIT Committees and workgroups; however, we must note that such opportunities to comment generally occur after the body has had its discussion and made its decisions. While these decisions are only recommendations to the National Coordinator, it is not always clear how stakeholders can insure comments will be included in the decision making process. The capability to comment through various channels and the transparency of decisions will greatly enhance the support of the final plan and the cooperation of stakeholders. We urge this opportunity be offered often.

It is also important to include various environmental concerns into the strategic plan. While ARRA-HITECH is the source of this strategic initiative, the healthcare industry is also impacted with the federal mandates and associated requirements for upgrading the HIPAA transactions, the implementation of ICD-10-CM and ICD-10-PCS, and new requirements from the Patient Protection and Affordable Act (PACCA). These requirements overlap with Meaningful Use and must be taken into consideration, or it is possible that the data required to meet the nation's goals for EHR, HIE, healthcare reform and population health improvement will not be met.

### **Vision and Preamble**

Our reviewers found the concept of a learning health system intriguing, and we agree with it for the most part; however, we find it is too evasive of the parties within the system itself. As noted, it does not paint a picture of the environment in terms providing stakeholders to see themselves. The terms “patient-centered,” “safe,” “timely,” “effective,” “efficient,” and “equitable” are used but do we have a common meaning and understanding. How does the primary care provider get a comfort level with this plan? Who is the decision maker? Where are the decisions being made? Are they made in the context of provider and patient, or are they made in some other location? Consider bringing this vision down to earth; to a delivery system stakeholders can relate to even if it is not the delivery system we have today. We fear that if this is not done the resistance to change will be stronger than anticipated.

Within the discussion in the second paragraph of this section, the phrase “patients can exercise choices about sharing of their data” raises concern. AHIMA champions the patient's right to exercise choices, but this must be an informed choice, and the ability to become informed or understand the choices must be achieved with the patient or their care giver as well as the providers, professionals or organizations they are working and communicating with. Significant education must occur across the consumer sector and at all ages so choices can be made out of intelligence and not fear, and with an understanding of the value of sharing their health information under the watchful stewardship of professionals striving to keep information integrity while maintaining confidentiality. While this is addressed in some part under the Preamble, we believe it is important to note it within the Vision as well.

We are concerned the vision does not clearly articulate the necessity of EHRs to not only share information but have the semantic interoperability needed through standard terminologies and classifications to maintain understanding and data integrity. We envision that under the new US infrastructure there is a coordination body to oversee the development, use, and harmonization of terminologies and classifications<sup>1</sup> to meet this need. This is a subject that while of great importance to AHIMA and AMIA has not been of seeming importance until just recently.

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<sup>1</sup> See the AHIMA and American Medical Informatics White Paper *Healthcare Terminologies and Classifications: An Action Agenda for the United States* at <http://www.ahima.org/infocenter/whitepapers/>. A summary of the white paper *Healthcare Terminologies and Classifications: Essential Keys to Interoperability* is also available at this same site.

AHIMA takes issue with the sentence: “Health Information Technology (HIT) provides a critical infrastructure for an effective learning health system.” This sentence and this paragraph lose sight of the fact that it is much more than the technology that permits an effective learning health system. Besides the technology is a knowledgeable workforce to manage the body of knowledge and the technology to ensure it does what it is suppose to do and that data or information accurately reflect the care, the diagnosis, the treatment, and other knowledge from each encounter as the foundation of the system. In addition, it is the standards, security practices, policies and other actions and activities which provide structure to which the technology is applied. While the paragraphs that follow (on page 5) address some of this, and highlight the role of government, it very much leaves out the workforce, dedication, and consensus that must be achieved to meet the values and transformations suggested. Often in discussions the “cultural changes” needed are mentioned, but they seem to be lacking here. As a workforce that often shepherds transformation of technology and culture, HIM professionals believe this vision cannot be achieved if we do not talk of all the transformations that must take place – not just the technology. We recognize the healthcare industry is behind in its use of technology and we join with ONC and the HIT Committees in dedicating our efforts to achieve these goals, but we must also recognize these non-technical components of change or our technology will not be used effectively and individuals, providers, and the population will not experience the value of this investment by the government and the industry.

### **Strategic Themes: 1. Meaningful Use of Health Information Technology**

**Goal (a)** AHIMA suggests this goal be expanded. We have already noted that it is more than technology that is needed to achieve these goals. The term “adoption and meaningful use” has been used often in recent history to suggest the role of the healthcare provider (who receives incentive funding); however, it ignores the larger role of government, the industry, standards development organizations, and so forth. If this goal is to be achieved the right uniform standards, measures, terminologies, coordination, certification, etc. must all play a role in partnership with the professionals and organizations who must implement and use the technology, rules, guides, and so forth to achieve meaningful use and outcomes.

As noted, we believe the strategic plan will be more understandable and have a better opportunity for acceptance if the goals and principles can be “pictures” of the end results and not just statements that can be misconstrued by those outside of the HIT establishment.

**Principles (b)** AHIMA welcomes principle No. 3; however, we do not envision this can be achieved without a very active participation of HIM and informatics professionals as well as a cooperative team of vendors and health information technologists who can ensure the technology and infrastructure provide the information in an understandable and usable fashion.

In looking at national health outcomes and priorities, as well as objectives and strategies, we believe ONC must add to its objectives and strategies the requirements now challenging the healthcare community in this same health information environment and time period. Currently, the healthcare industry must by January 1, 2012, upgrade and use a new versions (X12 5010,

NCPDP D.0) of the HIPAA transactions. While HIPAA transactions are often not seen as clinical, the information in the transactions and the systems which must deliver this information are highly integrated in clinical data especially in larger providers and hospitals or health systems. This calls for healthcare vendors to be currently upgrading products and working with customers (HIPAA entities) to make these changes and test the transactions within the next 19 months. The industry is also faced with a compliance date of October 1, 2013, to convert to the conventional ICD-10-CM and ICD-10-CPS classifications. This is a date that cannot slip because this country and its healthcare entities can ill afford a system that has to use two versions of the classification. The ICD-10-related classifications do represent clinical data and the lagging conversion has limited the detail necessary to achieve improvements in health reform, quality measurement, population health, and so forth. As your various HIT-related committees and work groups have discussed, it will be the ICD-10-related classifications and terminologies which will provide the information necessary to achieve the goals for use of standard EHRs and HIE.

In addition to considering the terminologies and classifications, we believe the principles should also recognize the impending need for enterprise content and records management, which would include the need to ensure providers have and maintain a legal EHR. Government, private, and research programs all call for data from throughout the organization or system for various secondary programs as well as fraud prevention and similar concerns. Providers need to have a legal record for a variety of legal and business processes. While these practices do not necessarily reflect on meaningful use from an incentive perspective, we do a disservice to healthcare providers if we do not move toward a standard record that can meet these needs and support their effective and efficient provision of care. In addition to supporting these concepts and programs in the development and use of EHRs, we also believe these need to be added to the curriculum of those being trained under HITECH funding and by the regional extension centers (RECs) as well.

**Objectives (c)** In line with our comments above, ONC and the healthcare community should be working with providers to ensure that their adoption and implementation of EHRs are accomplished while also ensuring that these providers meet the requirements for HIPAA transaction upgrades and the implementation and use of the ICD-10-CM (all healthcare entities) and ICD-10-CPS (inpatient facilities) by their respective compliance dates. We urge consideration of how future upgrades of these standards ought to be accomplished more often (like most software) to be in sync with other standards adopted under HITECH and at less expense. We also urge the Workgroup and ONC to consider adding the legal EHR and the concepts under ECRM added to the meaningful use objectives to provide EHR users with a legal and fully functional model.

Finally, we are concerned the objectives are not explicit with regard to how the standards and requirements for the EHR should be in sync with standards for personal health records. We are aware such interface standards exist within Health Level Seven (HL7) standards and believe these should be incorporated so providers and patients can fully communicate with each other.

**Strategies (d)** AHIMA agrees with the strategies listed. With regard to the fourth strategy, we would note a recommendation from AHIMA and AMIA with regard to training the workforce and especially allied health<sup>2</sup> since the effective and efficient use of EHRs will only occur through training of the entire healthcare workforce.

In addition to the strategies listed, we urge that strategies be added to reflect our comments above as to HIPAA transactions, ICD-10 adoption, provider and patient education, and education of RECs.

### **Strategic Themes: 2. Policy and Technical Infrastructure**

**Goal (a)** AHIMA suggests the goal be expanded to also include appropriate standards (beyond just “technical specifications”) and regulation or legislation (where necessary). There are both state and federal policies, regulations, and legislation that will need to be address to afford a workable infrastructure. We also note there are multiple reimbursement and healthcare information or data requirements that do or could run counter to the concept of collect once (in the EHR) and report or use many for a variety of internal and external (secondary data) purposes. As we saw in the ONC’s Health Information Security and Privacy Collaborative (HISPC) project, such conflicts exist throughout the industry and government and we believe this exists beyond privacy and security.

**Principles (b)** AHIMA agrees with the principles listed; however, they need to be expanded. While we presume public health entities are included in the infrastructure, we believe it is crucial to explicitly identify the need to have it specifically identified and such involvement should occur as soon as possible. There was significant discussion in the American Health Information Community (AHIC) meetings regarding this need and what coordination was needed among state and federal entities and the healthcare provider community. Very little has been done since then and if the overall strategic goals are to be met there must be efforts now among all those impacted and this would include laboratories who are also affected by a number of the meaningful use requirements as well as the ICD-10 conversion.

Beyond public health we suggest quality measurement and patient safety be added to this set of principles since along with research they are major players in achieving both improved population health and also providing information into the Learning Health System.

In addition, AHIMA believes a balance must be achieved between the medical and legal requirements for an EHR and the policy and technical regulations cited in the goals. This would in turn also mean an educated consensus among the healthcare community, policymakers, and consumers as to how the infrastructure will permit the flow of information while providing the

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<sup>2</sup> See the AHIMA and AMIA White Paper *Health Information Management and Informatics Core Competencies for Individuals Working with Electronic Health Records* at <http://www.ahima.org/infocenter/whitepapers/>.

necessary confidentiality and security needed for health information among all elements of the infrastructure.

Recently, the concept of “NHIN Light” or “NHIN Direct” has been introduced potentially as a process that would circumvent the health information exchange organizations (HIEO) and their internal and external information exchange. We recognize HIE is relatively new, but firmly believe exchange, whether direct via the internet or through an HIEO or RHIO, must be governed by the same standards and principles. This needs to be an explicit principle in order to achieve the Nation’s healthcare goals.

Finally, we must suggest that a specific principle address the need for a coordinated and harmonized set of terminologies and classifications, including uniform principles in turn for their standard development. While we can build several channels or pipes to exchange data; however, if we do not ensure the information that flows through it can be understood on both ends and integrity maintained, we will have a polluted knowledge base on which to learn and make crucial decisions.

**Objectives (c)** In light of the discussion above, we suggest Objective 1 include and differentiate between standards for transactions and standards for terminologies and classifications. Further we would add an objective for the establishment of a governance and coordination process over the developers and maintainers of terminologies and classifications and the principle under which they operate.

AHIMA believes there should be an objective for uniform and consistent value sets for reporting of information such as quality measures. Such values sets should meet the criteria for “collect once – use many” so that the collection requirements can accurately rely on the standard EHR and not necessarily be built into the EHR (especially since value sets and reporting requirements will change. In addition, these value sets should be used uniformly by those “collecting” the data or receiving reports including public health, quality measure, patient safety, reimbursement, and other uses of secondary data. Furthermore, the guidelines for reporting data both in and out of the HIPAA transactions should be coordinated. (PPACA includes a requirement for a single guide for the use of the different HIPAA transaction sets.) Uniformity and standards also need to be a part of the HIE in order to achieve uniform exchange and data integrity.

It is not clear to us how the functions managed the Health Information Technology Standards Panel (HITSP) are being incorporated into the new process for standards. The harmonization process is difficult and HITSP is to be congratulated for its accomplishments and for its inclusion of significant industry and consumer participation. Harmonization calls for a variety of input and efforts and we do not currently see how this can be achieved within the limited constraints and size of the HIT Standards Committee and its work groups. We urge you to consider these functions and the success of HITSP in putting together the new processes for standards approval, harmonization, uniformity, semantic interoperability, and certification.

Finally, while data integrity has been considered by some a function of security, AHIMA believes it should be a goal or objective for health information communications, technology, and systems, as well as the management of health information. We urge that data integrity be added as a separate objective.

**Strategies (d)** To the strategies already listed, we suggest adding strategies related to terminologies and classification which appear to be overlooked in the current list, and the uniformity and consistency of value sets as discussed under objectives. We suggest ensuring a harmonization process is established or continued somewhat in its present form.

Certification is key to the meaningful use of standard EHRs and we urge ONC to not only continue to support the efforts of the Certification Commission for Health Information Technology (CCHIT), but also to work with CCHIT and similar groups to move this process along. With this interest we also recommend adding in the CCHIT criteria already established as part of meaningful use. These criteria have been fully vetted and certainly directed toward the goals expressed here..

Data integrity begins with good documentation and good documentation is a product of clinical training and practice as well as uses of technology, terminologies, transcription, and management processes to transform documentation into data or information. Data documentation is an issue of long concern and needs to be addressed both as to training and education to ensure proper and complete documentation, as well as an examination of the data trail to ensure integrity. This is an HIM role as well as an education practice and we look forward to working with you to achieve this end.

Public health also needs to be better identified in the strategies. Without closely engaged provider and public health (local, state, and federal) involvement in standards, data requirements, and communication standards the improvements in population health and a learning health system will not be met especially in situations where the communication and learning must often be done on a fast track to ensure appropriate response to a public health outbreak or pandemic.

### **Strategic Themes: 3. Privacy and Security**

**Goal (a)** While the stated goal is vague we do not disagree with it. Building trust and participation in the system goes beyond just the public and extends to a sizable number of professionals in the healthcare industry. Education is a significant factor in the “solutions” you raise.

**Principles (b)** AHIMA is patently in agreement with the principles listed under this theme. We suggest under the first principle, in the bullet *Collection, Use, and Disclosure Limitation* the last phrase should be modified to read “and never to either discriminate inappropriately through the use of health information or to misuse health information.” We would also add a bullet which is on the order of active prosecution and penalties on those who do discriminate or misuse

information. Together these two concepts should significantly improve our practices since no one has yet found a perfect system.

An additional principle should be added to address the need to educate the public and to some extent the industry on the role of EHRs and HIE for individual and population care and safety including prevention. Associated with this education must be how confidentiality and security are and should be applied to safeguard individual identified information, and the role all stakeholders have in these policies and security practices.

**Objectives (c)** AHIMA suggests you add in objective 1 “data/information management” – all aspects of data/information management, HIT, and health information exchanges. If we are going to have data integrity then we must address more than the technology and communication aspects of the EHR and HIE.

In objective 5, we would add understanding of health information. Just access or engagement is not enough. The problems surrounding healthcare literacy must also be addressed. Furthermore, but potentially beyond the scope of this strategic plan, is the ability (and time) to discuss information with an individual’s healthcare provider. Our experience is that due to the demands for healthcare and the limits on healthcare reimbursement, practitioners have limited time to talk with patients. We believe the appropriate approach with process change and the use to technology may resolve some of this, but it must be hand in hand with the ability of the provider to have the time and reimbursement to include healthcare discussions as part of the treatment and care of individuals whether in a personal visit or via electronic communication.

Finally, and perhaps most importantly, a 6<sup>th</sup> objective is needed or goal 3 needs to be revised; namely that the federal government (ONC and /or the Office of Civil Rights) lead a national effort to develop and put into practice a set of nation-wide privacy and security laws (and perhaps also laws affecting EHRs or HIE). There have been previous efforts by ONC via the HISPC project and the National Governor’s Association, but we still are faced as practitioners with a myriad of laws and the situation grows. Healthcare does not stop at political lines, consolidation within the industry continues (again across state lines) and the sooner we can come up with uniform and consistent laws and regulations the better the compliance and the understanding by covered entities and consumers.

**Strategies (d)** As noted under objectives, strategies should be developed to included the industry, consumers, state government, and federal government in policies, procedures, regulations, guidance and legislation to arrive at consistent understanding, compliance and enforcement. This is an optimistic recommendation, but short of full preemption of stronger federal laws and regulations, we must achieve uniformity to be effective.

#### **Strategic Themes: 4. Learning Health System**

**Goal (a)** AHIMA suggests the goal should read: “Transform the current health care delivery system into a high performance learning system by leveraging health information communications and technology.”

**Principles (b)** The principles ignore the role of healthcare professionals that are the transformers in this system – researchers, educators, analysts, and a cadre of others use and manage the technology and study the information to create the body of knowledge. Their ability to use and manage health information correctly also impacts the application of evidence-based care. We believe it is important to note this role because it is central to the use of information.

**Objectives (c)** Again, objective 1 ignores the role of health information management and informatics to achieve creation of knowledge while protecting the data.

Knowledge is greater than just national data collection. It is through the use of terminologies and classifications, as well as transaction standards that data is exchanged and knowledge is shared internationally. There are too many examples of international pandemics to ignore this point, or the fact that terminology, classification, and transaction standards are already international in scope and the US participation in these standard bodies is absolutely necessary if the body of knowledge and learning health system are to be complete. Adding such an objective better supports your strategies.

In objective 3, we suggest adding the term “informed,” as in “individual’s informed decisions.”

**Strategies (d)** We have no specific comments but note there are a number of professional groups, including AHIMA, already pursuing many of these objectives and strategies and we hope ONC will partner with us in this endeavor. We appreciate the approach of engagement and communication, but we seek to achieve these goals in partnership with ONC not as consultants.

#### **Conclusion**

The hard work of the ONC and the Workgroup shows in the Framework you have presented. As a group of professionals who have pursued many of these same goals, we have taken the time to review your work and hope these comments will be helpful as you move to refine the framework and develop the Strategic Plan. We look forward to future opportunities to provide comments and recommendations toward the final draft of the plan and we look forward to involvement with the HIT Committees and Workgroups and ONC in seeing these goals achieved. We urge you to take advantage of our experience and knowledge and we look forward to sharing these with you.

If you have any questions or concerns regarding these recommendations and comments, please do not hesitate to contact me either at the address or phone noted or via e-mail at

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[dan.rode@ahima.org](mailto:dan.rode@ahima.org). In my absence please feel free to contact Allison Viola, MBA, RHIA, AHIMA's director for federal relations at these same contact points or via e-mail at [allison.viola@ahima.org](mailto:allison.viola@ahima.org).

Our thanks for your time and consideration.

Sincerely,

*Dan Rode*

Dan Rode, MBA, CHPS, FHFMA  
Vice President, Policy and Government Relations