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AHIMA
American Health Information Management Association®

Thank you for the opportunity to comment on the National Quality Forum's (NQF) draft report, *Identification and Prioritization of Health IT Patient Safety Measures*.

Although the report covers a number of topics, we have focused our comments below on seven specific measurement areas that are critical to improving the safety of health information technology (HIT) and patient safety.

Clinical Decision Support

Poorly designed or improperly configured clinical decision support (CDS) can be disruptive to care and potentially threaten patient safety. Our members have expressed concerns not only about "alert fatigue" but have cited instances of inappropriate alert overrides that in turn can jeopardize patient safety. Periodic training, education, and measurement of user competency can play an important role in ensuring that clinicians are using CDS as it is intended to realize the full potential of HIT to improve the safety and effectiveness of patient care.

System Interoperability

System interoperability is crucial to ensuring that the right information is provided to the right person at the right time in the proper context. However, as NQF's HIT Safety committee notes in this report, many electronic health records (EHRs) today are not interoperable within and across health systems—leading to delays in treatment or wrong patient/wrong procedure problems. We believe that any measurement in this area that assesses whether systems are exchanging information should ensure that there is a consistent understanding among stakeholders in what data is in fact being exchanged and that the data be actionable. In other words, to properly measure system interoperability, there needs to be some degree of standardization of terminologies to ensure that the data exchanged is meaningful, consistently interpreted and vital to patient care.

Patient Identification

Accurate and reliable patient identification continues to be a major concern related to HIT safety. A number of our members have noted that patient matching errors often begin at registration and can generate a cascade of errors that continue until a patient is discharged. A recent survey of AHIMA members revealed that over half of HIM professionals routinely work on mitigating possible patient record duplicates at their facility. Of those, 72 percent work to mitigate duplicate records on a weekly basis.[1]

[1] Dooling, J., et al. "Survey: Patient Matching Problems Routine in Healthcare." *Journal of AHIMA*, Jan. 6, 2016. http://journal.ahima.org/2016/01/06/survey-patient-matching-problems-routine-in-healthcare/.

We agree with HIT Safety committee members that accountability for patient identification should be shared across stakeholders. HIM professionals could play an important role in ensuring that staff is properly trained in identifying the correct patient and that patients are educated about the importance of patient identification at the point of registration.

We also support the inclusion of the AHIMA measures mentioned in this report. These simple, best-practice, standardized formula(s) could serve as a sound basis for determining duplication rates at the facility level and/or enterprise level. That said, we acknowledge that different methods and algorithms are currently used to measure duplication rates, resulting in various EHR vendor systems yielding different patient matching errors. Therefore, we recommend that to properly measure patient identification, there should be consistency in the measurement tools used in evaluating the number of duplicate patients as well as consistency in the ability to measure the frequency of such duplicates.

User-Centered Design and Use of Testing, Evaluation, and Simulation to Promote Safety across the HIT Lifecycle

User-centered design is critical for safe and effective HIT. A number of our members have expressed concerns that EHR systems, particularly in the context of medication reconciliation, do not accurately reflect workflows, resulting in workarounds that heighten the risk to patient safety.

EHR vendor testing to assess the usability of a system should be considered as a critical measure concept in this area. That said, any testing performed should also include the testing of any upgrades or "fixes" to the system to ensure that potential challenges or problems that may arise are identified before the upgrade is implemented.

We also support end user involvement throughout the lifecycle of HIT as a potential measure concept in this area. Our members have expressed concerns that often times there is no "cradle to grave" testing throughout the lifecycle of the system. Participation by the end user in the design and development through implementation, use, and evaluation could help identify potential HIT-related safety risks or problems at the outset.

Finally, we agree with HIT Safety committee members that user-centered and organization/system-centered simulation should be considered as a measure concept in this area. End user competency is vital to improving patient safety. Measuring user-centered and organization/system-centered simulation could help ensure that users are adequately trained on how to use the system, particularly as HIT is rapidly evolving. That said, any development of simulation and training programs should ensure that the simulation program is updated to match the "live" system to ensure that the end user is sufficiently trained.

Feedback and Information Sharing

We agree with the HIT Safety committee members' concerns that vendor contracts often contain broad non-disclosure and confidentiality provisions as well as intellectual property protections that prevent certain EHR software information from being publically shared. Prohibiting timely information exchange not only hinders the safe and effective use of HIT but prevents institutions and clinicians from mitigating errors that have occurred in similar settings.

An appropriate measurement in this area should include requirements of information sharing in software license and hardware purchase agreements and contracts. Another potential measure concept could include whether such agreements and contracts specify that system issues will be fixed or resolved in a timely manner and not delayed until the next system release. Delaying such updates or "fixes" can often result in manual workarounds that can paralyze a health system and jeopardize patient safety.

Use of HIT to Facilitate Timely and High-Quality Documentation

Timely capture and transmission of high-quality clinical information is critical to ensuring patient safety. The use of structured or designated fields can play a vital role in sharing information across systems as patients transition across various care settings by enhancing the information that is exchanged and interpreted across systems. That said, while we believe the use of structured data should be encouraged whenever possible, there is still a need to maintain free text and not replace all free text fields with structured data. Patients and their situations are not always the same—should the data become too structured, clinicians may lose the value of prose in a patient's story—leading to inaccurate information in the patient's record and potentially endangering patient safety. In addition, we recommend that should the use of structured fields versus free text for documentation of active problems be addressed in the short term, it is critical to clearly define the structured data fields to ensure that any selections made by clinicians in the respective fields are accurate and consistently interpreted by whoever uses it.

Patient Engagement

Patient engagement is emerging as an important area for HIT safety. However, it is important to note that in addition to some of the concerns cited by HIT Safety committee members in the draft report, certain limitations and the variable functionality of patient portals by different EHR vendors presents a challenge. In other words, whether certain document(s) can be accessed through a patient portal often varies depending on the EHR vendor. Consequently, while some flexibility is needed in this area, further standardization of functionalities may be required in order to engage in effective comparative data analysis of patient engagement.

We thank you for the opportunity to submit comments on the draft report *Identification and Prioritization of Health IT Patient Safety Measures*. We look forward to working with NQF to further enhance HIT safety. Should you or your staff have any additional questions or

comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org, 312-233-1407, or Pamela Lane, Vice President, Policy & Government Relations, at pamela.lane@ahima.org, 312-233-1511.

Sincerely,

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Chief Executive Officer