April 5, 2007

Office of the National Coordinator for Health Information Technology
Attention: Quality Use Case Team
Mary Switzer Building
330 C Street, S.W. Suite 4090
Washington, DC 20201

Dear Quality Use Case Team:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Office of the National Coordinator's Quality Prototype Use Case.

AHIMA is a not-for-profit professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most.

AHIMA and its members participate in a variety of projects with other industry groups and Federal agencies related to the use of healthcare data for a variety of purposes including direct care, quality measurement, reimbursement, public health, patient safety, biosurveillance, and research.

We recognize the industry's need for timely and accurate data depicting the quality and safety of America's healthcare system, but extracting data electronically from interfaced systems remains a challenging process because there are few broadly agreed-upon standards for data content. This climate of variation and confusion may well have a negative impact on the abilities of providers to report and use accurate and timely data about their performance.

Our comments focus on those areas of particular interest to our members. We believe the use case is a good foundation; however, we have outlined some recommendations as ONC continues to expand the document.

Section 2.0 Use Case Stakeholders
- The stakeholders defined in the use case are appropriate; however, the HIM professionals responsible for managing, collecting, aggregating, and reporting quality measurement data should be added to the list of stakeholders. Serving as essential data stewards of a healthcare organization, they provide a critical link in the chain of health information management. HIM professionals have in-depth knowledge of the challenges associated with disparate data collection and reporting requirements and information workflow.

- Part of the foundation of the data flow rests with system vendors who are responsible for the development and implementation of systems or applications that capture, aggregate, and submit the data for quality information. The diagram flow does not reflect these key components of the overall system of data quality measurement and reporting. AHIMA recommends adding System Vendors to the stakeholder list and integrating them into the use case.

Table 1: Recommended Additions to Section 2.0 Use Case Stakeholders

Stakeholder	Working Definition
Data Management Professionals	Those coordinating the electronic and manual data collection, validation, integration and reporting of healthcare data to support quality measurement, including professionals in the field of health information management, information technology, informatics, etc.
System Vendors	Organizations which are responsible for the implementation of the software development lifecycle (SDLC) for such applications as laboratory, coding and reimbursement, radiology, pharmacy benefits management, computerized physician order entry, etc.

- The Information Sources & Recipients depicted in each of the flow diagrams is confusing for the reader. Harmonizing the terms used in Section 2.0 Use Case Stakeholders with the Information Sources & Recipients listed in the flow diagrams will assist the reader when interpreting the use case diagrams (for example, Lab/PBM in the flowchart should be Ancillary Entities, Providers should be Clinicians and Health Care Delivery Organizations, and so on).
- Please clarify or provide an example of "Processing Entities". Would the services of a Clearinghouse serve as an example of a Processing Entity?

Section 3.0 Issues and Obstacles
- Attribution is an issue that should be described in this section of the use case. There is a lack of consensus in the industry regarding which aspects of care should be attributed to individual physicians versus shared accountability by a health care organization. For example, in cases where patients require treatment from multiple providers, the ability to link the patient's quality of care to one specific provider over the course of his/her treatment is difficult to prescribe and therefore poses a challenge to attribute the quality care received to one provider.
- "Limited EHR penetration" – The initial cost of implementation is not the only obstacle contributing to the slow rate of EHR adoption. One must also consider the challenges associated with the total cost of ownership (TCO) which is more likely to become a higher expense on an annual basis for the healthcare delivery organization. TCO may include annual maintenance which can include updates to the hardware and database that hosts the system and its data; annual upgrades to the system which can include new software releases or upgrades to the measures; and training or interim training for users of the system. Thus, the initial implementation may actually be lower in regards to the TCO of the system.

- If there are customizations and upgrades to the system this will also possibly alter the data that is aggregated to satisfy the new or modified quality measure. This will require a change in data collection processes and methods. AHIMA recommends that this be reflected in the Issues and Obstacles section.
- "Health information security concern" – The items listed in this section as *data/coding standardization, data integrity/harmonization, system interoperability* should not be categorized as a *security* concern. These items would best be served in the section for Data Interoperability and Standards.
- The use of updated classification systems – The collection and use of accurate and complete data is critical to healthcare delivery both for clinical care (primary) and secondary uses such as quality monitoring and patient safety, research, analysis, and reimbursement. The integrity of coded data and the ability to turn it into functional information require that all users consistently apply the same official coding rules, conventions, guidelines, and definitions (the basis of vocabulary- terminology or classification standards). Use of uniform data and coding standards enhances the integrity and quality of data and facilitates interoperability, which in turn enhances quality, reduces administrative costs, improves knowledge and decision-making, and provides data interoperability – all leading to quality healthcare delivery and information. Achieving interoperability and quality healthcare information therefore requires terminology and classification systems and data measurements that reflect current medical practice and are complementary, such as in the use of ICD-10. AHIMA recommends that this be reflected in the Issues and Obstacles section.

Section 4.0 Use Case Perspectives
- Health Information Exchanges are listed in the table of "Use Case Stakeholders" however these organizations are not discussed anywhere else in the document nor are they depicted in the diagrams within the document. AHIMA strongly encourages ONC to clarify the role of Health Information Exchanges in the quality measurement and reporting process. Page 10 states "Health Information Service Providers are another possible example of such an entity, particularly if they play a central collection and processing role." Please clarify the differences or similarities between Health Information Service Providers and Health Information Exchanges.
- The term "Health Information Service Providers" (HISP) are identified on Page 10 under Multi-hospital and Multi-entity Measurement and Reporting. These entities are not discussed anywhere else within the document other than a mention on Page 11 as an example. Although there is a description in the glossary of this term, AHIMA recommends that there be some clarification or further description in the role of the HISP.
- The acronym "HIS" (Health Information Services) is used within the diagram flows and corresponding detailed text, but these services are not discussed elsewhere within the document. Although there is a description of the acronym in the glossary, AHIMA recommends that there be clarification and further description in the role of the HIS, perhaps as a considered stakeholder for example.

Section 6.0 Hospital-based Care Quality Information Collection and Feedback Flow

- Section 6.1.2 states "The clinician documents care into the EHR, which collects data attributed to the quality measures in a standardized fashion." Defined measure and abstraction guidelines (section 6.1.3) should be provided prior to step 6.1.2 to facilitate effective data capture and documentation for quality measurement.
- Section 6.1.3 states "The hospital's internal quality improvement program/department receives the listing of defined quality measures and their associated abstraction guidelines and works with its EHR vendor to update internal systems such as the EHR accordingly." AHIMA strongly recommends ONC to discourage further customization of EHR products at the provider level whenever possible. We highly recommend that the Information Collection and Feedback Flow incorporate steps to provide defined measures and abstraction guidelines directly to EHR vendors. This process will reduce the costs associated with EHR customization and provide a consistent mechanism for integrating standard quality measurement metrics into EHR systems.
- Section 6.2.1 indicates that Multi-entity Measurement and Reporting and Hospital-level Measurement and Feedback entities will voluntarily collaborate in an effort to standardize quality measure specifications. AHIMA recommends national oversight and guidance by a public-private entity that would have primary responsibility of setting uniform operating rules and standards for the sharing and aggregation of quality and efficiency data used in both the public and private sectors for the purposes of performance measurement and reporting.
- It is not clear how the Information Sources & Recipients section of the workflow diagrams fit into the overall process, specifically those entities such as Consumers, Health Researchers, and Public Health Monitoring System. These entities are not included in the process for scenario flow #1. Wouldn't the Health Researchers and the Public Health Monitoring Systems be integral through the feedback process? Please clarify further.

Section 7.0 Hospital-based Care Quality Information Reporting Flow

- In Section 7.1.4, AHIMA has strong concerns about making changes to the HIS at the local level. Making customizations at the local level will further increase the gap of standard vendor applications and the application that has been implemented within an organization. We understand that with every health IT implementation there are certain levels of customization to accommodate workflow processes, but the further that occurs the harder it will be for the organization to implement the vendor's application without extreme costs associated with retrofitting the application and its upgrades with the severely customized application at the local level. AHIMA recommends that there be some standardization of data elements, data definitions, and data transformation rules within the EHR system to reduce the amount of resources that will be required to implement upgrades/updates to the vendor systems. This process would lend itself similar to the Certification Commission for Health Information Technology where vendors go through a rigorous certification process and receive approval for those products that have passed the testing.
- Section 7.2.1 (Collect Information/Data) is misleading. This section indicates that the Multi-hospital Measurement and Reporting entity receives patient-level data from the Hospital-level Measurement and Feedback level, but the Hospital-level Measurement and Feedback level is not depicted on this page of the flow diagram. We recommend changing the label of section 7.2.1 to "Receives Quality Measurement Data" for clarity.

Section 8.0 Clinician Quality Information Collection and Feedback Flow

- Section 8.1.2 states "The clinician documents care into the EHR, which collects data attributed to the quality measures in a standardized fashion." Defined measure and extraction guidelines (section 8.1.3) should be provided prior to step 8.1.2 to facilitate effective data capture and documentation for quality measurement.
- Section 8.1.3 states "The clinician or clinician practice's internal quality improvement program receives the listing of defined quality measures and their associated abstraction guidelines and works with its EHR vendor to update internal systems such as the EHR accordingly." Once again, AHIMA strongly recommends ONC to discourage further customization of EHR products at the provider level whenever possible. We highly recommend that the Information Collection and Feedback Flow incorporate steps to provide defined measures and abstraction guidelines directly to EHR vendors. This process will reduce the costs associated with EHR customization and provide a consistent mechanism for integrating standard quality measurement metrics into EHR systems.
- Section 8.2.1 indicates that Individual Multi-entity Measurement and Reporting entities will voluntarily collaborate in an effort to standardize quality measure specifications. AHIMA recommends national oversight and guidance by a public-private entity that would have primary responsibility of setting uniform operating rules and standards for the sharing and aggregation of quality and efficiency data used in both the public and private sectors for the purposes of performance measurement and reporting.

Section 9.0 Clinician Quality Information Reporting Flow

- In Section 9.1.3, AHIMA has strong concerns about making changes to the HIS at the local level. Making customizations at the local level will further increase the gap of standard vendor applications and the application that has been implemented within an organization. We understand that with every health IT implementation there are certain levels of customization to accommodate workflow processes, but the further that occurs the harder it will be for the organization to implement the vendor's application without extreme costs associated with retrofitting the application and its upgrades with the severely customized application at the local level. AHIMA recommends that there be some standardization of data elements, data definitions, and data transformation rules within the EHR system to reduce the amount of resources that will be required to implement upgrades/updates to the vendor systems. This process would lend itself similar to the Certification Commission for Health Information Technology where vendors go through a rigorous certification process and receive approval for those products that have passed the testing.

AHIMA agrees that capture and integration of data in electronic health records (EHRs) is necessary to support quality measurement and reporting. AHIMA is an active developer and promoter of EHR standards and AHIMA look forward to a day when secondary data, whether it is being produced for quality measurement, public health reporting, or reimbursement, accurately portrays the diagnoses, severity, and services or procedures provided. AHIMA welcomes the opportunity to work with ONC and the healthcare industries to see that all these goals are met.

ONC provided a very aggressive timeline in order to respond to the Quality Prototype Use Case. AHIMA took every opportunity to conduct a review and analysis of the use case; however, we feel that allowing more time for feedback within our organization would have provided ONC with a more comprehensive analysis of the documentation provided. We thank you for this opportunity to submit our findings on this very critical phase of quality measure development.

If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Crystal Kallem, RHIT, AHIMA's director of practice leadership at (312) 233-1537 or crystal.kallem@ahima.org, or me at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

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

cc: Crystal Kallem, RHIT
    Allison Viola, MBA, RHIA