April 6, 2007

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

Dear Consumer Access to Clinical Information Use Case Team:

The American Health Information Management Association (AHIMA) welcomes the opportunity
to comment on the Office of the National Coordinator's Consumer Access to Clinical Information
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.

Our comments focus on those areas of particular interest to our members. We believe that 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
1. The stakeholders defined in the use case are appropriate; however, the HIM professionals
    responsible for managing, collecting, aggregating, and reporting 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 data flow chain. HIM professionals have in-depth knowledge of
    the challenges associated with data quality and information workflow. Improving the quality
    of the data in hospital and ambulatory EHR systems may result in better information
    exchanged with PHR systems.

Section 3 Issues and Obstacles
1.   The issues and obstacles section adequately describes the issues and concerns with the lack of harmonized standards and vocabularies for exchanging information. This key point must continue to be emphasized in appropriate future use cases since it is vital to PHR functionality and interoperability between PHR systems, as well as between PHR and EHR systems.

Section 3 Issues and Obstacles: Section Entitled, "Policies for Consumer Entered Information"
1.   The first sentence states: "Consumers may need the ability to modify or annotate the health information which they retrieve from external sources." The word "modify" should be changed to "request changes to." "Modify" is too strong a word and may give the impression that consumers can demand that health information in external sources be changed. For some administrative data (e.g., wrong payer listed, spelling of name) such changes are easy to make. However, clinical data which are part of an external source's **legal** health record can only be corrected through an amendment, not written over in the record. Section 6.1.5 correctly uses the phrase "request changes." Making the suggested changes will not only make the concept accurate in Section 3, but will maintain consistency with Section 6.1.5 and other areas in the use case.

Section 6.1.5 Annotates information or requests change
1.   There is a HIPAA mandated process already in place regarding a patient's right to amend his/her records. This prototype use case correctly states that requests for amendments should go through the originator of the medical record, not the Health Information Exchange. The HIPAA mandate should be referenced in the detail use case when it is developed.

Section 7.1.4 Retrieve access logs
1.   This section accurately conveys the concept and process of the consumer reviewing who has accessed his/her health information, and correctly points to the fact that an EHR system should then have the capability to export logs for PHR systems to import. However, the logs in the EHR system may not account for all the instances in which the consumer's health information was viewed. The accounting of disclosures, which resides in the Health Information Management department, may also need to be made available.

Section 7.2.1 Requests and views available clinical information
1.   This section correctly cautions the provider that some of the consumer's information is not viewable as a result of the consumer's access decisions. The provider should also be cautioned about the reliability and integrity of the data and take appropriate actions accordingly, such as confirming with providers from whom the data originated.

Section 8.1.3 Selects information to send to another PHR
1.   It is understood that these prototype use cases are high level and focused on the interoperability issues, rather than policy. Nonetheless, some addition of simple wording may address interoperability within the context of policies. In this section, the consumer has the ability to select information to transfer to another PHR. As written, the section is feasible for stand-alone PHR systems, or those from a service provider. However, if the PHR is "tethered" to a provider's EHR, consumers will need to be cognizant of the provider's policies for data access and use. Such policies, while advocating for the consumer's right to determine who can access the record, may still vary from provider to provider. Suggested wording change in italics: "At some point the consumer decides to move the information in PHR (A) and the consumer, *based on local policies for data access and use,* selects the information which should be transferred to another PHR (B)."

AHIMA thanks ONC for this opportunity to submit our findings on this issue. 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 me at (312) 233-1135 or donald.mon@ahima.org.

Sincerely,
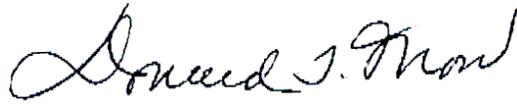
Donald T. Mon, PhD
Vice President, Practice Leadership

cc: Jill Burrington-Brown, RHIA