HIMSS Electronic Health Record Association

	Inpatient	Ambulatory	Interoperability
Priority 1: Improve quality, safety, efficiency, and reduce health disparities	**The HIMSS EHR Association (EHRA) supports the use of comprehensive EHRs to attain meaningful use (MU) starting in 2011. Initial MU criteria should promote achievable objectives to promote as much adoption as possible.** • 2011 objectives should be based on software and standards that are currently deployed and implemented. Advancement towards 2013 and 2015 objectives will evolve naturally once adoption occurs. • We support MU criteria based on CCHIT inpatient 2007 functionality including CPOE, clinical decision support and closed-loop medication administration. This approach meets the majority of the 2011 objectives including adoption of CPOE (measured as a percent of all physicians) and electronic medication administration (EMAR) with bar-coding in later years.	**Challenges to physician practices in achieving this priority include capturing codified clinical data, reporting quality measures and using data to track clinical conditions and chronic diseases. The EHRA recommends reconsideration of requiring competence in all three areas for 2011.** In studying EHR adoption, many have reported low EHR usage among small practices (less than 25%, according to an April 2009 article in *The Wall Street Journal*, with use of comprehensive ambulatory EHRs is reported between 4% and 13% as cited in a 2008 *New England Journal of Medicine* article). We believe that the most successful approach to achieving MU, especially for the majority of physicians who practice in small groups, is through deployment of a comprehensive EHR certified to meet all aspects of MU. • Consideration must be given to specialists vs. family or general practitioners in developing MU criteria relative to this priority.	**Two 2011 objectives require clarification in order to avoid ambiguity in terms of interoperability:** • *"Send reminders to patients per patient preference for preventive /follow up care [OP, IP]"*. Patient preference should not be open-ended regarding technological methods used, but within the technologies available to providers (e.g., phone, mail). If reminders are to be generated from an EHR and if security is required, HITSP-recommended specifications should be used • *"Incorporate lab test results into EHR [OP, IP]"*. Is this about results (1) from a lab system in response to orders, or (2) about accessing shared historical lab tests (either in a separate report, or included in a CCD summary)? We suggest the use of option (1) and encourage access of lab results in a CCD for consistency with the sharing of results with patients.

	Functional objectives beyond this scope should not be considered for implementation in 2011. In order for the appropriate measures to be supported, there must be correlation between objectives, measures and underlying technology to make this possible. • CPOE use will be aided by EMAR and evidence-based order sets. Selecting a few evidence-based order sets for chronic diseases (e.g., diabetes and cardiovascular disease) for CPOE implementation will support desired outcomes for overall improvement in healthcare delivery. • Measures as described may require extensive manual data collection from electronic and paper sources to determine percentages. Reporting quality measures must initially be simple, neutral and based on accepted and readily usable standards. Quality reporting will expand with the addition of clinical documentation, incorporation of data sets or	**Another strategy that addresses implementation challenges for practices of all sizes, yet achieves improved healthcare outcomes and system performance through HIT adoption, is to limit the type of reporting required in 2011.** • There is precedent in the existing CMS PQRI program, as well as in the NCQA Medical Home recognition program, to allow practices to select three measures that are "important" to their patient population. • Based on comments to NeHC by the ACP (June 2, 2009), we support the concept that HIT adoption and MU will be more easily achieved if practices focus initially on the goals of data collection and use of data to care for patients and families rather than broader population health management. • We further recommend that criteria for reporting be scoped to demonstrated ability to report rather than reaching any particular measurement threshold. Moreover, as part of the foundation-building for quality reporting based on	**For 2011 and 2013, on the interoperability associated with NQF quality measures we suggest alignment on the single set of standards harmonized by HITSP**

	applicable standards. Reporting should allow submission of either patient-level data or population-level computed measures so long as the process for such computation is sufficiently specified and validated, and the underlying data comes from EHRs. • Consideration should be given to the volume of information that will be reported once mandatory programs exist and organizations are able to receive this information. Quality reporting should be tied to MU objectives and outcomes while remaining independent of healthcare reform mandates for pay-for-performance programs. • In addition to quality reporting, starting in 2011, there should be objective measures to evaluate the use of quality measures for patient care management. • We support the inclusion in 2011 criteria of the forthcoming HITSP C/106 guidance on the ability for EHRs to consume quality measures in electronic	clinical data, we recommend that data from EHRs be used for this reporting rather than billing and claims data.	

	format. This is an important keystone to the required decision support and quality reporting infrastructure. • The HITSP-recommended Quality Reporting standards support for 2011 is extremely aggressive for the EHR community. The RHQDAPU program is well-established for hospital baseline comparative data with extensive measure definition from reputable clinical groups. Any quality reporting components should be considered relative to established baselines for hospitals and clinical outcome benefits for patients with consideration for ability to electronically gather the data.		
Priority 2: Engage patients and families	**Careful consideration of the differences between patient engagement in ambulatory and inpatient settings is important. Patient preferences for access to personal health information via portals or other electronic means, as well as personal health record**	**Patient-centered care delivery requires engagement not only of patients and families, but also of designated caregivers. This can be facilitated through access to patients' healthcare data as well as educational tools to help manage health status.** • Many ambulatory EHRs today	**Two 2011 objectives require clarification in order to avoid ambiguity in term of interoperability:** • *"Provide patients with electronic copy of/or electronic access to clinical information (including lab results, problem list, medication*

	(PHR) preferences, may not be generally available in inpatient systems to meet 2011 objectives. Educational resources such as drug information monographs and clinical summaries are available and could be a significant starting point to engage patients.	provide patient education materials at the point of care. The "stretch goal" of providing remote electronic access to such resources adds another layer of complexity to physicians' practices that may not have access to adequate IT resources. • Our experience with customers is that implementation of patient-centered connectivity is just beginning to be adopted among small and solo practices because of the amount of setup and maintenance required. This should be later in the MU timeline.	*lists, allergies) per patient preference (e.g., through PHR) [OP, IP]".* The information *"transport"* method or medium requires clarification. Likewise the need to provide "access to clinical information" may be interpreted as a tethered PHR or as a network interfacing to a PHR. Furthermore the statement *"per patient preference"* implies that every provider would have to support all of the above. It is strongly recommended that sharing with PHRs uses the same transport, standards and terminologies as sharing among disparate EHRs. • *"Provide clinical summaries for patients for each encounter [OP, IP]".* Additional clarity is needed. Is this on paper, in electronic form? Clarity is also needed re content. Is it providing discharge instructions such as for IP, or a visit summary for OP?
Priority 3: Improve care coordination	**The medication reconciliation process is still largely manual with many independent workflows often**	**EHRA emphasizes existing HITSP-recommended standards for exchange of information. The underlying best**	**Two 2011 objectives require clarification in order to avoid ambiguity in term of**

	determined by hospital policies and procedures. The availability of an automated, electronic process for medication reconciliation in the inpatient setting will be best accomplished beyond 2011. • Alignment with the electronic prescribing process, including medication history query, will further automate the process. Exchange of clinical summary information should be evaluated and hospitals should be encouraged to use standards-based data exchange from the outset. • Interoperability standards for document exchange with a health information exchange (HIE) are best accomplished with a certified HIE using HITSP-recommended standards. There are also opportunities for standards-based exchange among hospitals and their community physicians. **It is also essential to balance the need for accelerated adoption of interoperable, comprehensive EHRs**	**practices reflected in these standards are supported and tested by our industry and adherence to these as national standards is, we believe, critical for all systems.** • Our companies currently participate in several regional HIEs so we can attest to the variety of interfacing standards we must support to meet each HIEs requirements. This is a costly and inefficient way to exchange healthcare information. We ask the Committee to support continued use of HITSP-recommended standards.	**interoperability:** • *"Exchange key clinical information among providers of care (e.g., problems, medications, allergies, test results) [OP, IP]"*. This should be HITSP standards-based information to ensure effective re-use. • For the measure *"% of transitions in care for which summary care record is shared"*, we would like to see a baseline percentage (low, 5-10%) with an associated threshold. To account for the ramp-up of connected peers. **When combining the 2013 objective: *"Produce and share an electronic summary care record for every transition in care [OP, IP]"* and the objective for medication reconciliation for each transition of care, this would imply discrete data import for medications.**

	with the need for clinicians and hospitals to implement these in a careful and non-disruptive fashion. • The requirement to provide patients with access to clinical information via PHRs should draw on both ambulatory and inpatient commercial systems' abilities to utilize the same protocols for data sharing among disparate EHRs. This would support faster adoption and deployment of either tethered or non-tethered PHRs.		
Priority 4: Improve population and public health	**The process for reporting public health surveillance and receiving alerts will require standards development in order to meet the defined objectives.** • Communication with registries requires consideration of standards and processes involving the exchange of data. • Reportable lab results are a requirement of laboratories and should not be a MU requirement for inpatient EHRs.	**Although EHRA member companies currently support the CDC standard to report immunizations to public health registries, we remain concerned about the ability of these registries to accept a dramatic increase in data feeds should this requirement be retained for 2011.** • Issues of volume in reporting already exist. We have already seen how registries were not able to accept the volume of EHR-based PQRI reporting and CMS is still working through these issues with several ambulatory EHR vendors.	**EHRA suggests that submitting electronic data to immunization registries be ambulatory-only for 2011 with limited reporting for inpatient systems (e.g., tetanus, hepatitis B on all babies). To achieve this consistently, the HITSP-recommended standards (including HL7V2 transport) should be used.** **The objective to receive immunization histories and recommendations from immunization registries should be**

		• Immunization reporting is another process like quality reporting that requires workflow analyses for successful implementation. Our experience is that such quality-enabling activities can only take place once a practice is comfortable with the new electronic workflow. We recommend that this criterion be tiered for practices that are current EHR users.	**qualified by "where required and accepted" since not all states may support immunization registries by 2013.**
Priority 5- Ensure adequate privacy and security protections for personal health information	**Whether any entity is under investigation for HIPAA or security violations should not be considered when evaluating their compliance with MU criteria.**		**The EHRA recommends compliance with privacy requirements that are understandable by consumers and effective. Privacy standards harmonized by HITSP should be leveraged.**

Contact information for HIMSS EHR Association:
Amenia Bussell, Manager
abussell@himss.org
734-477-0864