American Hospital Association

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April 4, 2007

Robert Kolodner
Interim National Coordinator for Health Information Technology
Department of Health and Human Services
Mary E. Switzer Building
330 C Street, SW, Suite 4090
Washington, DC 20201

Re: Medication Management Prototype Use Case

Submitted by email.

Dear Mr. Kolodner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to comment on the Office of the National Coordinator's (ONC) Medication Management Prototype Use Case released on March 26, 2007.

As we understand it, the Use Case will be used as the basis for standards harmonization by the Health Information Technology Standards Panel and for development of certification standards by the Certification Commission for Health Information Technology (CCHIT). As such, these documents are very important.

The goal of the Use Case process — to develop standards that will promote patient safety and support relevant aspects of the medication management cycle with better interoperability and efficiency — is laudable and stands to benefit hospitals. However, the AHA is disappointed with the process used to develop feedback on the Use Case. To our knowledge, ONC did not seek guidance from the Electronic Health Records (EHRs) Workgroup on the content of this Use Case before it was developed, or share a draft with Workgroup members for comment before it was released. In addition, the extremely short public comment period (less than two weeks) limits the ability of interested parties — including end-users such as hospitals, which are the main beneficiaries of this work — to provide constructive input. **We urge you to provide, at minimum, a 30-day comment period for future iterations of the Use Case to ensure that affected parties have adequate time to gather and provide thoughtful input.**

We have restricted our comments to the inpatient medication reconciliation scenario. The AHA appreciates the Use Case's focus on medication reconciliation in the inpatient setting, as accurate medication reconciliation is a National Patient Safety goal. As such, the Joint Commission expects hospitals to meet medication reconciliation requirements as part of the current accreditation process (the complete requirements can be found in the 2007 Hospital Accreditation Standards). Hospitals are working diligently to meet these requirements and implement strategies that promote safety and quality, and having EHRs that support the medication reconciliation process is crucial.

The AHA recently encouraged CCHIT to include numerous medication reconciliation criteria in the 2007 certification process. Given that hospitals must meet the JCAHO requirements today, they should not have to wait for the standards harmonization process to be completed before EHRs support medication reconciliation. This Use Case must not slow down CCHIT's current work in this area. ONC may want to consider a two-stage process whereby EHRs can provide medication reconciliation immediately, in the absence of standards, with a transition plan for achieving a standards-based solution in the future. To pursue this approach, short-term strategies for data integration (using technologies like XML), rather than true interoperability, could be pursued.

ISSUES AND OBSTACLES (SECTION 3.0)

This section outlines some of the policy and other issues that must be addressed before health information exchange can become the norm and the full benefit of the Use Case can be realized.

The discussion of confidentiality, privacy, security and data access should be expanded. Medication reconciliation in the inpatient setting ideally involves collecting information on patient's medication history from multiple sources upon admission and sharing information from the inpatient stay with the patient and his or her care team after discharge. *The Health Insurance Portability and Accountability Act* provides a framework for data sharing among covered entities, but variations in state laws and the possible roles of health information exchanges or personal health record companies that may not be covered entities raise additional questions that must be addressed.

Patient identification, lookup and matching are crucial to ensuring that complete and accurate data are available for clinical decision-making. The Use Case states that "providers would benefit from the ability to accurately identify" patients and unambiguously match them with their records. In fact, providers must be able to do so to ensure the safety and quality of care. Routine health information exchange will not be feasible without addressing this issue. **We urge the administration to address the issue of patient identification directly.**

We suggest that you refine the discussion of the need for a standardized terminology for allergies to medications and other allergens to also include adverse drug reactions (ADRs). Many existing systems are designed to address allergies but not ADRs, creating

the potential for medication errors. For example, when a patient develops severe hyperkalemia while on an ACE-inhibitor, a physician will likely document this as an ADR, not an allergy. Therefore, electronic alerts that detect only drug allergies would not pick up this important piece of information. **We urge you to include the standardization of terminology for allergies and ADRs in the Use Case.**

INPATIENT MEDICATION RECONCILIATION SCENARIO (SECTION 5.1)

This section summarizes the medication reconciliation process in four steps. We recommend including an additional step as number three: Ensuring that the inpatient admission orders are compatible with the patient's current medications. This step conforms to the Joint Commission's National Patient Safety Goal #8A, as described on their Web site: "There is a process for ***comparing*** the patient's current medications with those ordered for the patient while under the care of the organization."

As you develop the Use Case, much more detail will be needed regarding the actual data and information that will be exchanged across applications and systems. The Use Case also will need to consider how information is presented to the clinician user. One critical challenge facing clinicians today is that relevant information is spread across multiple applications and not easily viewed and documented in an integrated view.

ROLE OF PHARMACISTS (SECTION 2.0, 6.1.4, AND 6.2.1)

Medication reconciliation involves many actors, each of whom plays an active role in ensuring the safety and quality of care. The role of the pharmacist seems to be minimized in the Use Case, limited almost to the functions of a pharmacy technician. Clinicians and pharmacists often consult one another during the process of order fulfillment. Therefore, the information flows stemming from placing (Section 6.1.4) and receiving (section 6.2.1) a medication order should be bidirectional.

We greatly appreciate ONC's hard work in developing this Use Case. If you have any questions, please contact Chantal Worzala, AHA senior associate director for policy, at (202) 626-2319 or cworzala@aha.org.

Sincerely,

Carmela Coyle
Senior Vice President, Policy