American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

April 4, 2007

Robert Kolodner
Acting 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: Quality 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) Quality Prototype Use Case released on March 26, 2007.

As we understand it, the Use Case being developed will be used as the basis for standards harmonization by the Health Information Technology Standards Panel and development of certification standards by the Certification Commission for Health Information Technology. As such, this document is very important. The goal of the Use Case process — to develop standards that will help to automate the calculating and reporting of quality information — is laudable and stands to benefit hospitals. If automation is done correctly, the current burden of quality measurement and reporting can be lessened, and the availability of quality data can be improved.

However, the AHA is disappointed with the process followed to develop the Use Case and receive feedback. To our knowledge, the ONC did not seek guidance from the Quality Workgroup on the content of the Use Case before it was developed, or share a draft with Workgroup members for comment before it was released. Given the Workgroup members' breadth of experience and expertise, this seems like a missed opportunity to gain valuable insight. In addition, the extremely short public comment period (less than two weeks) limits the ability of interested parties, including end-users

like hospitals, 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.**

Our comments address the scope of the Use Case and the hospital-based care scenario. We do not address the scenario regarding reporting quality information on clinicians.

USE CASE DESCRIPTION AND SCOPE (SECTIONS 1.1 AND 1.2)

Within hospitals, electronic health records (EHRs) are first and foremost a patient care tool. Thus, data needed for quality measurement needs to flow out of clinical use and be designed to minimize the need for clinician involvement in data capture. This perspective *must* be kept in mind when considering secondary uses of EHRs, such as quality measurement and reporting.

The discussion on the scope of the Use Case includes an inherent contradiction: It states that the Use Case will help achieve the goal of widespread EHR adoption, but later states that the Use Case assumes the presence of EHRs within health care delivery systems. It is unlikely that the automation of the quality measurement and reporting process would be sufficient motivation for hospitals to implement these costly and complex systems. **We urge the administration to consider additional incentives, such as Medicare payment adjustments, to increase EHR adoption.**

This section states, "Separate AHIC processes will determine the initial and subsequent quality measures to be used." We urge you to consider the sustained efforts of the Hospital Quality Alliance (HQA) to involve all stakeholders in developing a uniform set of quality measures. **The AHA opposes including any hospital measures of performance outside of those endorsed by the HQA in this Use Case.**

HOSPITAL-BASED CARE QUALITY INFORMATION COLLECTION AND FEEDBACK FLOW (SECTION 6.0)

This section attempts to map the actors, actions and data exchanges involved in collecting and reporting quality information. It does not make clear whether the ultimate objective is to automate existing processes for measurement and reporting of quality measures or to provide a vision of a less burdensome future state. The feedback loops and multiple actors suggest that the current process is the model for automation. However, it may be beneficial to consider how an ideal system might function and use that as the basis for automation.

While the Use Case does outline the process of measurement and reporting, it does not speak to the content of what is being measured and reported. It is clear from the work of HQA and other quality organizations that a key obstacle to automation is a lack of standards for the core data elements used in the quality measures. This includes relatively simple data elements such as temperature; classifications such as allergies; and

data structures such as the discharge summary. Automation of quality reporting will require standardization of these elements. Without standardization of data elements across many source systems – including billing, laboratory, pharmacy and clinical systems – the accuracy of measures, the timeliness of reporting will be less than optimal, and the costs of measurement and reporting will be considerable. **We urge you to include the standardization of needed data elements in the Use Case.**

Standardization of data elements and automation of the measurement process will limit, but not eliminate, the need for translation across source systems, which is a major driver of the time and resources needed for reporting. Therefore, ONC must not underestimate the magnitude of the task or overestimate its impact. Given the multiple source systems and actors involved in the process, standardization will be hard to achieve. Until it is, "real-time" reporting to clinicians, payers (including the government) and the public will not be possible.

We greatly appreciate the hard work that ONC has put into 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