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April 2, 2015

Karen DeSalvo, MD, MPH, MSc
National Coordinator
Office of National Coordinator for Health IT
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Comments on *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0*

Submitted via: http://www.healthit.gov/policy-researchers-implementers/interoperability-roadmap-public-comments

Dear Dr. DeSalvo:

The American Nurses Association (ANA) welcomes the opportunity to provide comments on the document *"Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0."* As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients, their families and other caregivers as well as the public about various health conditions, wellness, and prevention, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

We appreciate the efforts of the Office of National Coordinator for Health IT (ONC) to develop a Roadmap identifying critical actions for public and private stakeholders to advance the development of an interoperable health information technology (HIT) ecosystem and facilitate the secure, efficient and effective sharing and use of electronic health information. ANA supports the broad outline of the Roadmap, particularly the person-centric vision set forth in the document. Below we address several of the questions for reviewers set forth on pages 6-7 of the Roadmap, including question 1 ("General"), question 2 ("Priority Use Cases"), question 3 ("Governance") and question 8 ("Measurement").

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[1] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

General Question - What, if any, gaps need to be addressed?

The draft Roadmap asks reviewers to consider a number of questions, including a request to identify any gaps that should be addressed in the current draft. One potential gap concerns the elements currently included in the initial list of data elements, described on page 12 of the Roadmap. We agree that it is important to improve technical standards and implementation guidance for sharing and using a common clinical data set – one of the near-term actions identified in the Roadmap. While we agree with this approach, we recommend expanding the initial list of data elements to include a voluntary, unique patient identifier to enhance privacy and data matching.

In addition, we believe it is essential to include on the list of data elements terminologies that support nursing practice and patient-centered care.[2] Specifically, we recommend adding Care Plan field(s) including patient-centered problems, goals and instructions. Registered nurses are pivotal in identifying patient-centered problems (e.g., incontinence, functional status) through standardized screening and assessments and compiling data. They provide information to other clinicians and are an essential source of information for patients, families and other caregivers. Registered nurses also have a critical role in documenting health information in current electronic health records (EHR) and providing care coordination in multiple roles, including during care transitions between units in acute care and across all care settings. Utilization of terminologies that support nursing practice and patient-centered care will ensure that the steps articulated in this roadmap will result in data that informs comprehensive patient-centered care. Data collected by nurses and entered in the EHR ensures the capture of the contributions of registered nurses, the largest group of heathcare professionals. The promise of data analytics to improve patient care and outcomes will not be fully achieved without the inclusion of this data. In addition, we recommend that a unique clinician identifier be captured across care settings for data analytics that will better inform a learning health system.

It is important that clinicians (including eligible providers and other clinicians on the team across care settings) have access to patient-centered longitudinal care plans that allow clinical teams to provide effective and efficient clinical care, including care coordination. This is important in order to provide patient-centered care and achieve improved outcomes with lower cost. ANA strongly supports ONC's vision, articulated on page 122, that "a single care plan can be captured, dynamically updated and utilized in a secure and appropriate fashion by individuals, caregivers and any member of the individual's virtual, interprofessional care team."

A potential gap concerns interoperability between regulated medical devices. In order to effectively share and use electronic health information, medical devices must be capable of communicating with each other, and the data from such devices must be accurately captured and reflected in the EHR to improve patient safety. We recommend more explicit discussion of this issue in the Roadmap.

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[2] American Nurses Association (2015). ANA's Nursing Informatics: Scope and Standards of Practice. Silver Spring, MD: Nursingbooks.org, pages 10-13.

Terminology

There is a lack of consistency in the terms used to describe the individuals who provide health care to patients. The document uses numerous terms including "provider," "care provider," "healthcare provider," "professional care provider" and "eligible professional." This inconsistent use of terms creates confusion. ANA recommends that ONC define and use consistent terminology to describe the individuals providing health care to patients. One option would be to add to the glossary (Appendix G) the definition of "eligible provider," "eligible hospital," clinician, and long term care – all terms which are familiar to stakeholders.

Furthermore, clinician-neutral language was not used throughout the Roadmap. For example, on page104 "office-based physicians" is used rather than office-based providers or ambulatory care providers. In 2012 more than 100,000 APRNs billing under their own National Provider Identifier provided health care services to 11.4 million Medicare fee-for-service beneficiaries. 17,167 of those APRNs—representing all four APRN roles—received $5.3 million in eRx incentive payments, although none of those APRNs were eligible for Medicare EHR incentive payments. On page 50 a discipline-centric lens was used when noting "Providers should have the tools they need to support a cultural shift in the way they practice medicine and use technology that supports the critical role of information sharing." Since the practice of medicine is often restricted to physicians, the phrasing should read "Clinicians should have the tools they need . . . in the way they provide health care services and use technology . . . ." ANA requests the use of clinician-neutral language and the recognition of the importance of care teams. For example, on page 136 (Appendix F) clinician-neutral language is used and the care team recognized regarding complex patient-centered needs focused on Comprehensive Medication Management (CMM). It was noted "There are four general steps in the process that require involvement of multiple members of the health care team." There is agreement across stakeholders that check box, low level measures that capture limited data, in part due to interoperability problems, has led to a persistent measurement gaps in care coordination, including CMM.

The lack of current interoperability across EHR and between medical devices are not discipline-centric problems. Rather a broad view of interoperability issues currently affecting interprofessional teams is needed. Registered nurses, advanced practice registered nurses, physicians, physical therapists, and other clinicians are critical to providing patient-centered, holistic care as part of interprofessional teams across care settings, including home and community-based services.

Measuring Success

ANA does not support limiting near-term measurement to one group of eligible providers using a subset of a core set of measures. It is important that an evaluation of the capability to exchange data in an interoperable manner include all clinicians on the interprofessional care team, particularly as it relates to care coordination, including transitional care. ANA agrees with inclusion of organizations in long term care and behavioral health settings with the capability to exchange. This is essential to improve patient safety and reduce excessive cost due to avoidable health care acquired conditions and 30-day readmissions. We agree that the exchange of data between providers and all health care settings is essential. Data warehouses are developed to

exchange essential EHR data on patient safety, electronic clinical quality measures (eCQMs) and essential structural data (e.g., workforce structural measures). The work of the National Quality Forum-convened Health Information Technology Safety Steering Committee will develop a framework for measuring HIT safety. This work should inform the near-term evaluation, as patient safety is paramount and is one of the six National Strategy for Quality Improvement in Health Care (National Quality Strategy) priorities.

ANA agrees that critical actions include "the expansion of data availability to include data from a variety of relevant sources in the calculation of eCQMs will be important to guiding the transformation of the delivery system to a learning health system" (page 50). Moreover, ANA agrees that data should be created and collected automatically during the routine provision of care, alleviating the need for duplicate entry of data.

Nursing has been a leader in eCQM development, creating an eMeasure exemplar that was recognized at the recent eCQM Kaizen event hosted by Centers for Medicare and Medicaid Services (CMS) in December, 2014. Interoperability is essential for broad uptake of eCQMs agnostic of EHR system or version used to support national quality improvement systems. Interoperability permits the broad update of eCQMs with: less data collection burden, harmonized measures across care settings to allow for standardized comparisons, real time clinical decision support, and enhanced diffusion of evidence-based practice to inform a learning health system. Improvement of diffusion of evidence-based practice by all clinicians on care teams is essential to achieve the National Quality Strategy aims and goals. Evolution to clinically-enriched eCQMs made feasible by interoperability holds great promise to close the gaps in under-reporting of safety events and better inform data analytics and best practices, resulting in improve outcomes for specific populations at risk.

Priority Use Cases

The draft Roadmap also asks reviewers to consider a question concerning the Priority Use Cases that appears in Appendix H of the document. Commenters were asked to review the list in Appendix H and identify three examples from this list that should inform priorities for the development of technical standards, policies and implementation specifications.

Two of the listed Priority Use Cases concern transitions of care and coordination of care. Priority Use Case number 3 states "*The status of transitions of care should be available to sending and receiving providers to enable effective transitions and closure of all referral loops,*" while number 4 states "*Federal, State, provider and consumer use of standardized and interoperable patient assessment data to facilitate coordinated care and improved outcomes.*" These concepts are interrelated. We believe that both Priority Use Cases should inform priorities for the development of technical standards, policies and implementation specifications, as both are essential to improving and advancing the delivery of health care. They also further the tri-part aims of the National Quality Strategy (NQS) (better care; better health; and reduced costs) as well as the six NQS priorities (making care safer by reducing harm caused in the delivery of care; ensuring that each person and family is engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;

working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models). Health IT can foster the ability to collect, share and analyze data. It can reduce or eliminate redundant care. And it can increase the accessibility of health information for providers, patients, families and caregivers.[3] As we discussed in our comments on ONC's Strategic plan,[4] we believe it is essential to have a mechanism to capture data elements addressing care coordination, including transitional care. Further, the development of such mechanisms should be in alignment with Health Level Seven (HL7) Standards identified in the Care Plan Group[5] and the recommendations from the National Quality Forum for advancing health IT data infrastructure to support quality measurement of care planning during transitions of care.[6] As priorities are identified for the development of technical standards and implementation specifications concerning care coordination including transitions of care, we urge ONC to ensure that terminologies that support nursing practice and patient-centered care are recognized and incorporated as part of interoperability so that nursing data is represented more fully in the EHR, data warehouses and other repositories. This is essential to a learning health system.

We believe it is also essential to identify and utilize a Priority Use Case that drives patient engagement. Effective patient engagement is increasingly recognized as fundamental to an efficient and effective health care delivery system, and access to information is essential to empower and engage patients and caregivers.[7] A number of the listed Priority Use Cases do touch on patient engagement, including number 20 ("Patients, families and caregivers are able to use their personal devices such as smartphones, home BP cuffs, glucometers and scales to routinely contribute data to their longitudinal health records and use it or make it available to providers to support decision-making"), number 35 ("Individuals have electronic access to an aggregated view of their health information including their immunization history"), and number 36 ("Individuals integrate data from their health records into apps and tools that enable them to better set and meet their own health goals"). However, the most comprehensive Priority Use Case is perhaps number 18, "Patients have the ability to access their holistic longitudinal health record when and where needed." Priority Use Case number 18 seems to encompass this issue, as

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[3] Cipriano, P., Bowles, K., Dailey, M., Dykes, P., Lamb, G., & Naylor, M. (2013). The importance of health information technology in care coordination and transitional care. Nursing Outlook, 61(475-489). http://www.nursingoutlook.org/article/S0029-6554(13)00187-5/abstract (accessed April 2, 2015).

[4] See http://www.nursingworld.org/DocumentVault/ANA-Comments/Federal-Health-IT-Strategic-Plan-20152020.pdf (accessed April 2, 2015).

[5] See http://wiki.hl7.org/index.php?title=Care_Plan_Project_-_PCWG (accessed April 2, 2015).

[6] National Quality Forum. (2012). Critical Paths for Creating Data Platforms: Care Coordination. http://www.qualityforum.org/Publications/2012/11/Critical_Paths_for_Creating_Data_Platforms__Care_Coordination.aspx (accessed April 2, 2015).

[7] Nursing Alliance for Quality Care Whitepaper (2013), Fostering Successful Patient and Family Engagement: Nursing's Critical Role. http://www.naqc.org/Main/Resources/Publications/March2013-FosteringSuccessfulPatientFamilyEngagement.pdf (accessed April 2, 2015).

a holistic longitudinal health record would necessarily incorporate elements of Priority Use Cases 20, 35 and 36. We believe it is important that a more comprehensive Priority Use Case concerning patient engagement inform priorities for the development of technical standards, policies and implementation specifications.

Another important Priority Use Case is number 26, which states: "All providers in a care team will have unique access, authorization and auditing functionality from health IT systems necessary to fulfill their role on the care team." In developing technical standards, policies and implementation specifications associated with this Priority Use Case, it is important to ensure that registered nurses are included among the providers utilizing a unique identifier for access, authorization and auditing purposes.

Governance

The Roadmap notes that one critical near term action is to establish a coordinated governance framework and process for nationwide health IT interoperability. The roadmap calls on ONC to "ensure the establishment of (1) a governance framework with overarching rules of the road for interoperability of health IT, (2) a public/private process for addressing implementation or operational-level issues and (3) a method for recognizing the organizations that comply with the rules and hold them accountable for continuing to do so." The Roadmap anticipates that public and private stakeholders will work through a coordinated governance process to develop policies on business practices and technical standards concerning interoperability.

ANA supports this public/private process and encourages ONC to ensure that nurses have a voice in the governance framework and appointed representation on the Governance Workgroup. Standardized data capture, reporting and use, and interoperability among HIT systems are critical to establish data aggregation to capture nursing's contributions to patient outcomes. These critical data inform a learning health system and help to fully evaluate the quality of health care provided by care teams within and across all health care settings. Nurses offer an essential and critical voice in promoting the standardization and interoperability of HIT to improve nursing knowledge representation and patient outcomes.[8]

Guiding Principles

ANA agrees with the addition of the following three guiding principles for national interoperability to make patient centricity more explicit and highlight inequity to reduce disparities in care. These additional principles were presented by the Consumer Workgroup to the ONC Policy Committee on March 10, 2015:[9]

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[8] ANA (2014). Standardization and Interoperability of Health Information Technology: Supporting Nursing and the National Quality Strategy for Better Patient Outcomes. Accessed 0/01/2015 at: http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Standardization-and-Interoperability-of-Health-Info-Technology.html.

[9] See http://www.healthit.gov/facas/calendar/2015/03/10/hit-policy-committee (accessed April 2, 2015).

- Leveraging health IT to empower consumers in their own health and care, and empower family caregivers with information and tools they need to support their loved ones in health care transition, medication management, treatment and recovery.
- Equity– for consumers and providers. How health IT can increase health equity and reduce disparities, and how we must ensure equitable adoption among provider populations that serve our most vulnerable individuals, including individuals of limited financial means and those with limited English proficiency.
- Using health IT to improve patient and family experience of care and ensure care is concordant with the personal goals of the patient.

We appreciate the opportunity to share our views on this matter and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Kelly Cochran, Policy Advisor, Health Information Technology kelly.cochran@ana.org or 301.628.5040.

Sincerely,

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Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
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