AMA-convened

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Written Comments
Clinical Documentation Hearing
Meaningful Use and Certification and Adoption Workgroups
ONC Health Information Technology Policy Committee
February 13, 2013

Panel 3: Role of Clinical Documentation for Secondary Uses of Data

Good afternoon, I am Marjorie Rallins, Director Measure Implementation and Informatics and staff to the AMA-convened Physician Consortium for Performance Improvement (AMA-PCPI). The AMA-PCPI appreciates the opportunity to provide comments on the role of clinical documentation for secondary uses of data.

The PCPI is nationally recognized for measure development, specification and testing of clinical quality measures, and enabling the use of measures with data collected from electronic health records (EHRs). In those efforts we bring together 81 national medical specialty societies and a wide variety of stakeholders including healthcare organizations, 4 federal agencies and groups interested in improving the quality of health care.

My comments today draw from our experience with the significant growth and change of the health care quality improvement realm since the inception of the PCPI in 2000. The greater demand for outcome measures, the trend toward complex themes such as care coordination, shared decision making and a patient centered perspective have a significant impact on the clinical documentation needs and functionality of EHRs.

My testimony today will address those questions pertinent to our experience and through the lens of clinical quality measures.

Describe the disconnect between data needed for secondary use and data collected in an EHR (clinical documentation). What challenges do you face and what solutions have you identified to overcome them so that you can use data collected by providers in an EHR?
The linkage of data collection with the natural workflow of the physician and health care team is critically important to achieve effective clinical decision support and quality measure reporting. At times, the linkage of data collection with workflow is challenging in instances where the typical location for a piece of information is in an unstructured field. Relevant data for care coordination and shared decision making are frequently stored as unstructured free text or scanned reports from imaging or other diagnostic systems that are difficult to query, therefore limiting the utility of this information for automated quality reporting. For example, imagine that the care of the patient post-discharge was appropriately coordinated, and that the patient's preferences were factored into the treatment plan, but because the data are unstructured, it is difficult to assess retrospectively and through automated quality reporting that these actions occurred. We believe a solution to this challenge could be reached through collaboration among measure developers, EHR vendors, providers and other stakeholders to identify a set of standardized common data elements that are or can be integrated into workflow and also enable automated quality reporting that accurately reflects the care that was delivered to the patient.

Fundamentally we believe that capturing data in structured data fields is optimal for secondary uses of data. However realistically we know that a certain amount of unstructured fields will remain in EHRs and other electronic media such as clinical registries. Again, we recommend collaboration amongst a spectrum of stakeholders to identify a common data model so that the context of use for unstructured data is understood, leveraged and able to be analyzed with

structured data. Additionally we believe it is critically important to align clinical models for quality reporting, EHRs and clinical registries to facilitate the reporting of outcome measures and quality improvement efforts

Finally, while quality measures rely on data related to clinical documentation, they also benefit from the metadata around the data elements in EHRs and clinical registries. For example, for a closing the referral loop measure, we need to know whether the ordering physician reviews the consult report and when it was reviewed, not just that it was received by the practice that initially made the referral. Assessing whether the process of reviewing the consult report, can be done via metadata, which then relieves the ordering physician from selecting a check box to indicate that the review was performed. We could simply have the system track data like this and be able to report on it.

Discuss the role of inference in capturing data for secondary use of data (i.e. using data from clinical notes to infer a condition, etc.).

We need to be able to infer clinical decision making from the information that is actually documented in the EHR. For example, triggers related to abnormal lab values could indicate further investigation and/or used to diagnose undiagnosed conditions. Inference can also be helpful to explicitly express actions that did not happen which is often important in reporting results of overuse measures or measure exception reporting. For example, a documented note may state “did not order an ACE/ARB for this patient despite their heart failure due to inability to tolerate the medication,” Currently we use negation in our measure logic to capture this type of information. However we believe a more cogent solution is achieved through an inferential approach.

Again thank you for the opportunity to comment. I look forward to discussing these important issues further with the experts that you have convened for this panel.

Respectfully Submitted,

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