



Health IT Standards Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

March 26, 2013

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Mostashari,

Beginning on September 7, 2012, ONC began releasing the 2014 Edition Draft Test Method in waves (seven total waves). Following the posting of each wave, there was a two week public comment period per wave. At the end of each public comment period, ONC provided a summary of the comments to the HIT Standards Committee's (HITSC) Implementation Workgroup (IWG) for review. From this summary, the IWG prepared recommendations that were not captured in the public comments. No recommendations were provided if the public comments were comprehensive for a specific certification criterion. From October 12 – December 10, 2012, the IWG reviewed waves one through four which included 36 of the 47 test procedures. The IWG 2014 Edition Draft Test Method recommendations below were presented to the HITSC on December 19, 2012 and accepted for transmittal to the National Coordinator.

Wave 1 Comments

Computerized provider order entry

- Although an order change can be accomplished by cancelling an order and entering a new one, we recommend that the criterion allows the user to change an existing order without cancellation.
- Recommend listing medication by generic name in addition to brand or trade name.

Vital signs, body mass index, and growth charts

- Recommend changing the growth charts test data, so the EHR will plot a chart for a late pediatric patient, not an adult. Although the CMS meaningful use objective's age range is 0-20-years-old, growth is usually complete between 16-18-years-old. (This is reflected in test procedures)
- *Stage 3: Recommend lowering the upper age boundary for plotting of growth charts.*

Smoking status

- Recommend clarifying that an EHR can map to the 8 smoking statuses (including Current every day smoker; Current some day smoker; Former smoker; Never smoker; Smoker, current status

unknown; Unknown if ever smoked; Heavy tobacco smoker; Light tobacco smoker) based on a more granular level of data entered by the user (e.g. cigarettes per day, pack-years, etc.).

Patient-specific education resources

- Recommend clarifying that an EHR function, not Infobutton, selects a patient. (This is reflected in test procedures)
- Recommend disallowing certification testing in which the three data categories (problem list, medication list, laboratory tests and values/results) can be tested in combination to identify education resources (i.e. this test would only allow the identification of resources based on one category at a time). (This is also reflected in test procedures)

Immunization information

- *Stage 3: The test procedure and data assume that the provider documenting an immunization is the provider who administered the immunization. Recommend allowing physicians the ability to record immunizations administered by other providers. Since this information would likely be supplied by the patient, the test data set would differ as the patient may not know the immunization specific information such as lot number, expiration date and/or manufacturer.*

Wave 2 Comments

Demographics

- Recommend clarifying how to test that all languages, as defined by the standard, can be recorded within the EHR, if display of each language is not required.

Preamble language:

- “...we are adopting ISO 639-2 constrained by ISO 639-1. This will constrain ISO 639-2 to only the active languages in ISO 639-1.”
- “...EHR technology is not required to display all the languages of the standard...[b]ut, it must be capable of recording...all of the languages in the standard.”
- Recommend specifying a character encoding according to a standard that will support the indicated languages (e.g. ISO 8859-15).
- *Stage 3: Recommend capturing birthplace in future iterations of this certification criterion.*

Family health history

- *Stage 3: Recommend accounting for adopted individuals in future iterations of this certification criterion.*

Wave 3 Comments

Drug-drug, drug-allergy interaction checks

- Agree that the test procedure should include CPOE as described in the certification criterion. Criterion language: “Interventions. Before a medication order is completed and acted upon

during CPOE, interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindication based on patient's medication list and medication allergy list.”

- Recommend considering drug-drug and drug-allergies identified by the patient (i.e. how to accommodate the drug ordered, given and taken as generated by the patient).

Clinical decision support

- Recommend that demographics and vital signs be tested in combination with the other listed data elements, as the test procedure allows, to trigger an intervention.

Image results

- Recommend clarifying that the vendor can determine the format, structure, and access method for images and results test data (e.g. DICOM is permitted but not required).
- Recommend clarifying how to test that the image and results are “complete and accurate” (i.e. clarify definition of “complete and accurate”).
- Recommend allowing providers to choose components used to display images and not allowing vendors to “hardwire” EHRs to a specific image viewer.
- Recommend allowing a link or image to persist.

Electronic medication administration record

- Recommend clarifying how assistive technology can/will be used and requiring that the test be directly observable by the tester. Recommend defining acceptable methods in which a tester can/will observe the use of assistive technology during the certification testing process (i.e. ensuring a “real scenario” in a test environment).
- Recommend clarifying specifically how all the rights will be tested especially right route.

Clinical summary

- Recommend clarifying if historical data (e.g. vital signs) should be included in the clinical summary.
- Recommend clarifying the Care Plan Section as it does not align with the certification criterion (e.g. the criterion describes the care plan as a narrative of goals and instructions; however, the test data defines specific elements with structured data including LOINC, SNOMED CT and CPT codes). (Reflected in test procedures)
- General: Recommend industry support to assist with C-CDA adoption. This could include an on-going forum, led by an ONC or industry group, where vendors and users can continue to improve and enhance the adoption of C-CDA throughout its evolution.
- *Stage 3: Recommend allowing a user to import individual elements of a C-CDA into an EHR.*
- *Stage 3: Recommend including past history (e.g. surgical, illnesses, etc.) in clinical summary and the C-CDA. Recommend clarifying what should be included in a past history as, currently, the elements likely differ between specialties.*

Wave 4 Comments

Data portability

- Recommend not certifying for the severity of medication allergy. Note that this also applies to the Transitions of care certification criterion. (Reflected in test procedures)

Transmission to public health agencies – syndromic health

- General: The testing should mimic a “real scenario” in a testing environment; however, the testing will be limited by the ability of the public health agency (or testing representation of this agency, such as a test tool) to receive the data.
- *Stage 3: Recommend exploring transport standards or facilities specific to syndromic surveillance.*

Sincerely yours,

/s/

Jonathan Perlin
Chair, Health IT Standards Committee

/s/

John Halamka
Vice Chair, Health IT Standards Committee