

May 7, 2012

The Honorable Kathleen Sebelius, Secretary of Health and Human Services  
U.S. Department of Health and Human Services 200 Independence Ave, SW Washington, DC

Marilyn Tavenner, Acting Administrator and Chief Operating Officer  
Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD

RE: 42 CFR Parts 412, 413, and 495 [CMS-0044-P] RIN 0938-AQ84  
Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2  
Comments submitted electronically

Dear Secretary Sebelius and Administrator Tavenner:

The [Alliance for Nursing Informatics](#) (ANI) advances nursing informatics leadership, practice, education, policy and research through a unified voice of nursing informatics organizations. We transform health and healthcare through nursing informatics and innovation. ANI is a collaboration of organizations that represents more than 5,000 nurse informaticists and brings together 28 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and works in collaboration with the more than 3 million nurses in practice today.

Nurses constitute the largest single group of healthcare workers, including experts that serve in leadership positions on national committees and interoperability initiatives focused on standards and terminology development, standards harmonization, and electronic health record (EHR) adoption, as well as certification of EHR systems. Further, nurses are active in the research, education, implementation, integration and optimization of information systems throughout the healthcare system to improve patient safety and health outcomes. In that spirit we offer the following comments as a resubmission of the comments previously submitted by the Alliance for Nursing Informatics on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2.

**Category -Improving quality, safety, efficiency, and reducing health disparities**

*Objective:* Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.

*Measure:* More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

With respect to the Department's request for public comment, CPOE should be performed by healthcare professionals with practice authority, including medical assistants operating under clinical decision support (CDS) protocols. We oppose the concept of order entry by clerical staff (including scribes) and recommend that clerical staff should not be included as authorized providers in this measure. Expanding this measure to allow for scribes defeats the purpose of computerized provider order entry, is beyond

the scope of practice of unlicensed personnel, and would create an additional risk of transcription error. Furthermore, this would contradict the requirement to allow for the use of clinical decision support protocols. Clinical decision support rules at the time of order entry support the decision making process of licensed professionals.

**Category – Improving Quality, safety, efficiency, and reducing health disparities**

**Department and CMS Requirement as identified in the NPRM**

Objective: Use clinical decision support to improve performance on high-priority health conditions  
Measure: Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period.

We agree with the use of clinical decision support not merely as a means for data collection, but as a mechanism for improving care. We also agree with replacing the term “rule” with “intervention.” An appropriate evidence-based intervention that is triggered within context of the patient situation may provide more relevant and efficient clinical decision support. Clinicians need evidence-based clinical guidance that is presented in a standardized, user friendly format.

Regarding the attributes of the clinical decision support intervention, we are concerned with the amount of detail at each intervention level within the Certified EHR Technology (CEHRT). Rather, each identified clinical decision support intervention should be linked to an evidence-based source(s) (content vendor and/or academic source), along with an identified date of release/revision.

Again, we agree that interventions must be presented via the CEHRT to a licensed healthcare professional who will exercise judgment about the decision support intervention before the action is processed. We reiterate that this includes decision support rules incorporated as part of the order entry process. We request explicit clarity and understanding that a “licensed healthcare professional” is any member of the interprofessional team for which the intervention is relevant to their scope of practice; for example the following licensed healthcare professionals are identified with the current clinical quality measures: registered nurses, pharmacists, RN lactation specialists, and respiratory therapists.

We suggest that a broader definition of CDS should be used that includes some of the following intervention types:

- Diagnosis or condition-specific order sets that are tied to patients’ admitting or current diagnoses. For EP’s – this could include evidence-based order sets used for evaluation of patients’ current problems.
- Dosing guidance given during the ordering process: this could include renal dosing, dosing adjustments related to drug interactions.
- Documentation forms that are specific for diagnoses conditions; including forms/templates that prompt users based on previous responses (i.e. requiring justification reason when VTE prophylaxis is not ordered).
- Display of relevant patient-specific clinical information during the ordering or data entry process. Examples include: displaying BSA (body surface area) during the ordering of

chemotherapeutic agents; display of maximum temperature during documentation of antibiotic administration.

**Category – Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.**

Objective: EP: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and medication allergies) within 4 business days of the information being available to the EP. EH: Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.

We strongly agree that patient-specific health information and education should be provided to patients and should be documented in the CEHRT. We support removing the phrase “as appropriate” since all hospitalized patients have identified clinical problems and care plans that indicate patient-specific teaching resources are needed. We also recommend increasing the threshold of this measure from 10% to 25% for Eligible Hospital/CAH Measures as patient access to health information and education is critical for improving patient safety and reducing hospital readmissions.

As a proud partner in the ONC’s “I Pledge to Empower Individuals to be Part of the Healthcare through Health IT Program,” we support patients’ engagement in their healthcare. Nurses are the most-trusted health professionals and have a long history of patient advocacy. We expect nurses to have a significant impact on consumer participation in health IT to increase the understanding and use of personal health records and patient portals from just 10% today to over 25% in the next two years. Nurses serve as patient advocates for encouraging adoption of these collaborative practices.

Patients and their families also need health education services delivered in a patient-appropriate learning environment and format. Nurses have extensive knowledge of patient education methods and tools. A key recommendation of the [IOM Future of Nursing Report: Leading Change, Advancing Health](#) states that interoperable EHRs linked with personal health records and shared support systems will influence how collaborative care teams work and share information about clinical activities. Personal health information is a valuable resource to individuals, their families, and the doctors, nurses, and other healthcare professionals who provide treatment and care. The ultimate goal is to help licensed clinicians offer a wider range of considerations and options for patients, while also providing resources that encourage proactive behavior and empower patients to be active partners in their health plan.

**Additional Areas for Consideration**

***Patient Centered Care Delivered by Inter-Disciplinary Teams***

As highlighted in our previous comments on Meaningful Use, we encourage the expansion of the definition of “meaningful user” to encompass support of all healthcare professionals in an integrated healthcare community including registered nurses, advance practice nurses (APRNs), and other licensed clinicians as well as expanding the definition of care delivery to include patient centered care delivered by interdisciplinary teams.

We recognize that patient care invariably requires collaborative interactions among multiple clinicians from a broad array of specialties, often in different locations. As such, “meaningful use” should strive for nothing less than an integrated healthcare community, including the healthcare consumer, where enabling technologies promote usable, efficient and seamless information flow. Including information-rich, patient-centered documentation within the definition of “meaningful use” can enhance cross continuum communication, thereby enabling improved safety, quality, and processes of care delivery. [According to the Department of Labor](#) registered nurses constitute the largest number of healthcare professionals in the United States, representing approximately [54% of healthcare workers](#). Registered nurses are licensed professionals who practice using a body of knowledge and cognitive framework that is unique to, overlaps with, and is supportive of and complimentary to medicine. Non-overlapping elements are often missing in the design of health information systems leading to systems that are deficient in their ability to adequately support the practice and measure of nursing practice. The inclusion of nurses as well as other interdisciplinary healthcare partners in the definition of “meaningful use” will help to support the advancement of systems that meet the needs of dynamic healthcare systems staffed by a multitude of diverse disciplines.

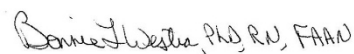
### ***Pressure Ulcer Risk & Prevention Clinical Quality Measure for Stage 2 & Stage 3***

We are disappointed that the proposed rule did not include any Nursing Sensitive Quality Measures for Stage 2 Meaningful Use. We see this as an oversight and strongly encourage the inclusion of Nursing Sensitive measures. We would specifically point to several National Quality Form endorsed measures including NQF 141 - Patient Falls, NQF 202 - Patient Falls with Injury, NQF 201 - Pressure Ulcer prevalence; hospital acquired and NQF 203 - Restraint prevalence among others. One of the 12 interventions that the Institute for Healthcare Improvement (IHI) recommends for its 5 Million Lives Campaign is “[Prevent Pressure Ulcers](#) . . . by reliably using science-based guidelines for their prevention. The development of pressure ulcers is a painful, expensive, and unnecessary harm event that is all too prevalent in American hospitals. The prevention of pressure ulcers is a key intervention that is not new, not expensive, and has the potential to save thousands of patients from unnecessary harm.” Therefore ANI, in collaboration with the American Nurses Association (ANA), supports a call for the addition of pressure ulcer risk and prevention as a new Clinical Quality Measure for Stage 2 and Stage 3 Meaningful Use under the domain of Patient Safety, as highlighted in [our previous public comments](#) to the HIT Policy Committee Quality Measures Work Group.

Thank you for this opportunity to provide comments. We look forward to our ongoing conversation, and to working with you to engage the nursing community in your efforts.



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## The Alliance for Nursing Informatics (ANI)

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  - Center for Nursing Classification and Clinical Effectiveness (CNC)
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- Delaware Valley Nursing Computer Network (DVNCN)
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*Also affiliated with the American Nurses Association*