

September 10, 2007

Robert M. Kolodner, MD
National Coordinator for Health Information Technology, HHS
Mary C. Switzer Building
330 C Street S. W., Room 4080
Washington, DC 20201

Subject: AHIC Successor White Paper Comments

Dear Dr. Kolodner:

On behalf of the 51,000 Health Information Management (HIM) professionals who are members of the American Health Information Management Association (AHIMA), I would like to thank you and the American Health Information Community (Community) for your continued leadership in the goal to achieve a standard electronic health record (EHR) and a nationwide health information network (NHIN), both of which will improve the effectiveness and efficiency of healthcare delivery in the United States. It is through your personal involvement, time, and leadership, and the federal involvement the Secretary has commanded since taking office, that the healthcare industry has achieved its goals thus far for an interoperable EHR and NHIN.

We are pleased to offer our comments on the development and implementation of a successor to the current Community. Please regard our comments as the beginning of AHIMA's involvement in the formation and implementation of the AHIC successor.

AHIMA offers the following recommendations:

- AHIC 2.0 must be a public-private entity, and the federal government must play a significant role as a leader, a committed participant, and a financial supporter of this entity.
- AHIC 2.0 must work with the Secretary of Health and Human Services and the National Coordinator to develop a vision that will transform healthcare in the United States. Further, the successor to the current Community must be empowered to request operating rules and standards to be developed, and to enforce them once harmonized. It is only through significant federal government involvement and such empowerment of the AHIC successor that uniform compliance to standards, and the goals for interoperability and administrative simplification, will be reached.
- As part of the transformation of healthcare, the AHIC 2.0 must align the primary and secondary uses of data. The goal is to provide high quality, effective care to consumers and increase the efficiency of healthcare professionals in delivering and monitoring the quality of care. This requires AHIC 2.0 to be fully committed to linking the collection of data to increase the efficiency of healthcare professionals in delivering and monitoring the quality of

care. This requires AHIC 2.0 to be fully committed to linking the collection of data to support patient care (primary data use) with the needs of quality and performance measurement and reporting, population health, research, and other administrative uses (secondary data use). This “collect once, repurpose many times” principle will simultaneously improve the quality of care, increase the efficiency of healthcare professionals, and advance the goals for an interoperable EHR.

- Operating rules and technical requirements are necessary but insufficient for achieving interoperable health records. To succeed, policy is also needed to provide direction to the industry and governance of the process. AHIC 2.0 must involve all stakeholders, including consumers, employers, government, clinicians, payers, vendors, and health information management and technology professionals, in the governance process.

We commend the recent approach by the Agency for Healthcare Research and Quality (AHRQ) to define a national healthcare data steward entity to coordinate the collection and use of secondary data. Such an entity must have a relationship to AHIC 2.0 to coordinate the efforts to align primary and secondary data use.

Similarly, AHIMA and the American Medical Informatics Association (AMIA) recently released a white paper entitled, “*Healthcare Terminologies and Classifications: An Action Agenda for the US.*” Among the recommendations in this paper was the formation of a public-private entity to coordinate the various terminology and classification standards and standards bodies in the US. Such an entity also must have a relationship with AHIC 2.0.

Through the efforts of ONC and the Community, we have seen the formation of the Health Information Technology Standards Panel (HITSP), the State Alliance for eHealth (SAeH), the various organizations involved in the Health Information Security and Privacy Collaborative (HISPC), and the Certification Commission for Healthcare Information Technology (CCHIT). These bodies must also have a relationship with AHIC 2.0.

A considerable amount of work in the area of health information management, informatics, and technology standards has been completed, or is still being conducted by, various groups and standards development organizations (SDOs) via a massive volunteer effort. However, there is still much more work than these volunteers can bear. To continue, if not accelerate, the pace of standards development, we must consider the use of paid staff to support the various standards efforts. To date, ONC has provided significant coordination not seen in this industry before ONC’s origin in 2004. CCHIT has displayed a model of both paid staff as well as industry (volunteer) involvement at several levels. A similar model is needed for AHIC 2.0 to succeed.

As suggested by the State Level Health Information Exchange (SLHIE) initiatives in my January 12, 2007 letter and testimony to the current Community, AHIC 2.0 must interact with state level health information exchange or RHIO efforts. These organizations, or a representative of these organizations, must be involved in the development of policy and technology so that health information exchange can succeed locally and nationwide.

The above paragraphs have focused on the private sector. Regarding the public sector, there is considerable expertise in the federal government (e.g., the National Library of Medicine (NLM), the National Center for Health Statistics (NCHS), and the National Institute of Standards and Technology (NIST)) that should be mustered and involved in AHIC 2.0 projects.

- Funding is the fundamental issue that must be addressed and will be impacted by the governance model adopted. There must be a viable business model for AHIC 2.0 to succeed. AHIMA believes that both the public and the private sectors must provide funding for AHIC 2.0 because both will reap its benefits. Funding can come from multiple sources, so that no single source bears the entire cost for interoperable health records and health information exchange. Funding, including the necessary federal portion, must be reliable.

In addition to the investments from the public and private sectors, funding may be found from other sources. The SLHIE projects have identified some state initiatives for HIE development and maintenance that could be useful models. Other funding might be based on potential savings within the community. For example, based on the findings related to data accuracy requirements for EHR systems, approximately 3% to 10% of healthcare expenditures are lost to payments of fraudulent, or inadvertent but still erroneous, claims. These dollars can amount to \$50 billion to \$170 billion dollars. Capturing a substantial portion of those dollars and reinvesting them in the healthcare system will provide significant support for AHIC 2.0. Now is the time to build a viable business model for public and private funding. Now is the time for creative thinking.

It will take a considerable effort and the collective experience of the industry to put all of the ideas you receive into the development, adoption, and maintenance of AHIC 2.0. AHIMA has demonstrated a strong commitment to effective collaboration in advancing change and can be a key partner to the change process necessary for AHIC 2.0 to exist. We intend to be fully engaged in supporting the formation of AHIC 2.0.

Sincerely,



Linda L. Kloss, RHIA, CAE
Chief Executive Officer

cc. Judy Sparrow, ONC