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May 26, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 314-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-3310-P Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3, proposed rule

Dear Mr. Slavitt:

The Association for Professionals in Infection Control and Epidemiology (APIC) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for Electronic Heath Record (EHR) Incentive Program -- Stage 3. APIC is a nonprofit, multidisciplinary organization whose mission is to create a safer world through prevention of infection. We applaud the CMS for building on the groundwork established in the Stage 1 and Stage 2 rules, specifically in improving alignment of Stage 3 with other quality reporting programs and national quality improvement efforts, and the promotion and improvement of interoperability and health information exchange. APIC believes that our mission aligns with the overarching Federal Health IT mission to reduce cost, improve access and improve quality in healthcare through information technology. Infection preventionists (IPs) have been using and sharing data to improve patient outcomes and protect public health and would greatly benefit from more efficient and integrated systems. We provide the following information for your thoughtful consideration.

Objective 7: Health Information Exchange

The EHR contains a wealth of health information that impacts patient safety, but has not been widely integrated outside of acute care settings. IPs in all healthcare settings – acute care, long-term care, behavioral health, ambulatory care and public health – will benefit through improved communication and coordination of care, especially as interoperability of systems across the care continuum are improved. Without interoperable systems across all domains of care, advances made in prevention and control in one care setting are lost as care transitions occur without communication of key information. Information such as transmission-based precautions, the presence of resistant microorganisms, vaccination history, and antibiotic utilization are often overlooked when communication relies on verbal or paper-based dissemination of information. Thus, we believe it is critical that the inclusion of infection-related data including, but not limited to antibiotic usage, transmission-based precautions, presence or history of antibiotic resistant organisms or other communicable disease or conditions, indwelling devices at the time of discharge, and vaccination status are included in the summary of care document. We are encouraged by inclusion of these three measures, as this will improve patient safety and outcomes through better provider-to-provider communication.

Objective 8: Public Health and Clinical Data Registry Reporting

We appreciate the intent to bring every user and provider to the same EHR standard and the enhancement of public health reporting as it pertains to immunization, lab reporting, syndromic surveillance, and registry reporting. We recognize that while some registries like the National Healthcare Safety Network (NHSN) are capable of accepting electronically submitted data from EHRs, many state public health departments and registries do not have the infrastructure in place to allow for electronic data exchange with EHRs. Thus, it may be difficult for some eligible professionals (EP), hospitals, and critical access hospitals (CAHs) to meet some of these measures.

We also appreciate using NHSN as a mechanism of meaningful use; however, despite the growing number of infection prevention and control measures that IPs have to report to various regulatory and public health registries, EHRs have been developed and purchased without consideration of infection surveillance needs, and therefore lack interoperability with NHSN. As such, IPs are still often hand collecting and collating numerator and denominator data before uploading into NHSN. Including the ability to reliably collect and query such data from the medical record should be criteria of meaningful use, as this will allow infection preventionists to focus on staff and patient education and prevention efforts within their institutions. In addition, NHSN has introduced an antimicrobial use module which can provide risk adjusted inter- and intra-facility benchmarking of antimicrobial usage and can evaluate usage trends over time at the local and national level. Given the serious threat of emerging resistant organisms, important information regarding trends in usage patterns at the local and national level is of utmost importance. Because of the complexity of the multiple data sources required for this module, manual entry is not available. Providing this essential information to the CDC cannot be accomplished without IT interoperability.

We thank CMS for the opportunity to comment on the Stage 3 EHR Incentive Program proposed rule. In summary, to meet regulatory requirements and benefit from federal incentive programs, IPs have been required to electronically submit data to the NHSN since January 2011. This has primarily been without organizational IT support and has been achieved through manual data entry rather than through electronic data feeds. An interoperable EHR will only improve the provision of healthcare at all levels. APIC welcomes the opportunity to work with CMS as this effort continues.

Sincerely,

Mary Lou Manning, PhD, CRNP, CIC, FAAN, FNAP
2015 APIC President