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January 14, 2013

Office of the National Coordinator for Health Information Technology  
Health Information Technology Policy Committee  
U.S. Department of Health and Human Services

Docket ID: HHS-OS-2012-0007

RE: Request for Comment--Stage 3 Definition of Meaningful Use in Electronic Health Records (EHRs)

Dear HIT Policy Committee:

The American Lung Association is pleased to submit comments for Stage 3 Meaningful Use of Electronic Health Records (EHRs). The Lung Association supports the expanded, meaningful use of electronic records, not only as a means to ensure improved health for patients with lung disease, but also as a resource to improve the protection of public health. Please consider these comments on the items listed below.

#### **SGRP #104:**

The American Lung Association supports asking providers to expand demographic data recorded as proposed in the Stage 3 recommendations. In addition, as mentioned in our comments under SGRP #209 and #408, these data could provide critical information for public health surveillance interventions and clinical trials.

Inclusion of occupation and industry codes in the EHR is critical to properly identifying and ultimately preventing workplace illness and injury. The ability to better understand workplace illness and injury is an important criteria to address prevention by reducing exposures to harmful substances or situations. Knowledge of industry and occupation will also facilitate diagnosis, assist in development of appropriate return to work plans, increase the use of treatment guidelines that improve outcomes, reduce health disparities, and improve reporting/surveillance activities. It will also facilitate improvement of health promotion in the workplace.

Many reasons exist for including occupational information in EHRs, as noted in the 2011 Institute of Medicine letter on this issue. For example, lack of information means medical providers often miss occupational connections to diseases or conditions, especially where they may have long latency, such as cancer. Patients may not recognize that their health problem has any relationship to their work, or be unaware that they could get some relief from the problem. The IOM letter found "occupational information could contribute to fully realizing

the meaningful use of EHRs in improving individual and population health care.”<sup>1</sup> The Lung Association agrees with that conclusion.

Inclusion of sexual orientation and gender identity is a major step forward in the coordination of care for the LGBT community. The American Lung Association makes a concerted effort to identify and address disparities in lung health that place a disproportionate burden on one group or community. In 2010, we released [Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community](#), a report that examined the increased prevalence of tobacco use in the lesbian, gay, bisexual and transgender population. One of our major recommendations in the report was that healthcare systems and provider membership organizations should offer training on LGBT health issues to increase cultural competence among providers and staff. The report highlights validated questions on sexual orientation and gender identity from the National LGBT Tobacco Control Network.<sup>2</sup> Adding these questions to the EHR will help providers better understand and address the needs of their LGBT patients. In 2011, the American Lung Association also [stated its strong support](#) for the Department of Health and Human Services’ proposal for revised data collections standard, which included adding LGBT status.

#### **SGRP #108:**

The American Lung Association supports the recommendation for tracking progress on vital sign information to improve public health surveillance interventions and coordination of care.

In future stages of the development of guidelines, we suggest consideration of new pulmonary vital signs, including lung function and oxygen saturation. For lung diseases, a baseline lung function can assist with the diagnosis and treatment. Inclusion of lung function measures is especially important if the patient has a diagnosis of asthma or COPD or a history of exposure to respiratory risk factors. In the event of an occupational exposure, measuring lung function would also be a critical measure to include to understand health status of individuals.

Further, the question of having incorporated lung function or oxygen saturation measures for a broader patient group may be important for consideration as well. One example of the benefit of a broader collection of baseline lung function has come from the nation’s recent experience in war. That experience led the Working Group of physicians and exposure scientists, in consultation the Department of Defense and Veterans Affairs, to call for the “targeted, practical medical surveillance for lung diseases” in deployed personnel.<sup>3</sup> Without baseline testing however, the loss of lung function may not be apparent. Experience in caring for military personnel provides evidence that their post-deployment lung function may be within normal range, despite the presence of serious lung disease.<sup>4</sup> Military personnel may exceed normal lung function, and even after injury or exposure may remain in the normal range. Although military health records are not part of this system, this experience raises the

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<sup>1</sup> IOM (Institute of Medicine). 2011. *Incorporating occupational information in electronic health records: Letter report*. Washington, DC: The National Academies Press.

<sup>2</sup> Scout. 2008. LGBT Surveillance and Data Collection Briefing Paper. Online publication. Downloaded from National LGBT Tobacco Control Network website at <http://www.lgbttobacco.org/files/Surveillance%20Briefing%20Paper%202008.pdf>. Last updated Sept 7, 2008.

<sup>3</sup> Rose C, Abraham J, Harkins D, et al. Overview and recommendations for medical screening and diagnostic evaluation for postdeployment lung disease in returning US warfighters. *J Occup Environ Med* 2012. 54(6): 746-51.

<sup>4</sup> King MS, Eisenberg R, Newman JH, et al. Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan. *New Engl J Med* 2011: 365: 222-30.

question of whether other occupations may benefit from baseline lung function testing, including those with high fitness requirements, such as firefighters, who may also be exposure to work-related hazards.

**SGRP #109:**

The American Lung Association supports the maintenance of a record of tobacco status—not just smoking status—for patients 13 years old or older. Tobacco status can change between visits. EHRs should include tobacco use status to improve care coordination and to ensure that healthcare providers are prompted to ask about the status of smoking and other tobacco use at every visit. In addition, this measure will improve public health surveillance of tobacco use status.

In addition to individual tobacco use status, we request consideration of an added measure to ask if the individual is exposed to secondhand tobacco smoke. Secondhand smoke has well-established health impacts for many conditions. Knowing the exposure to this, particularly in home environments, will improve care coordination.

**SGRP #113:**

The Lung Association recommends that chronic obstructive pulmonary disease (COPD) and asthma be included under the chronic diseases targeted for tracking management interventions. Both diseases affect millions of Americans. COPD has emerged as the third leading cause of death in the United States, killing nearly 134,000 Americans in 2009.<sup>5</sup> Approximately 12.7 million adults had COPD and 25.9 million Americans currently had asthma.<sup>6</sup> The National Asthma Education and Prevention Program has established treatment guidelines that can be used in development of interventions to track for asthma management. Over 7 million children have asthma in this country and unlike other chronic lung diseases, asthma hospital discharges are very common among the pediatric population.<sup>7</sup>

**SGRP #119:**

While we support the increased threshold of questions about family history, we are concerned that setting the next threshold at 40 percent may be too low. There is no discussion of the long-term intention for this question, although family history is a critical risk factor for many diseases. For example, family history data is critical in the diagnosis and management of asthma. Also, since exposure to secondhand smoke can increase the risk of many long-term health risks, the measure should include a questions regarding childhood exposure to secondhand smoke.

**SGRP #209:**

Clinical trials are essential for research and important for individuals living with lung diseases such as asthma, COPD and lung cancer. We would support EHRs identifying clinical trial registries so that the patients can learn about potentially relevant trials. While patients may independently seek out clinical trials when diagnosed with some diseases, such as cancer, they may not be aware that clinical trials exist for other diseases. As an organization that has long supported research, the Lung Association would welcome such assistance in helping researchers identify potential participants for their trials.

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<sup>5</sup> Centers for Disease Control and Prevention. National Center for Health Statistics. National Vital Statistics Report. Deaths: Final Data for 2009. June 2012; 60(03).

<sup>6</sup> Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Raw Data, 2011. Analysis performed by American Lung Association Research Division using SPSS and SUDAAN software.

<sup>7</sup> National Center for Health Statistics. National Hospital Discharge Survey, 1989-2010.

Office of the National Coordinator for Health Information Technology  
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U.S. Department of Health and Human Services  
Docket ID: HHS-OS-2012-0007  
January 14, 2013 · Page 4

**SGRP #408:**

The American Lung Association supports the proposed future stage rule of the ability of EHRs to send adverse event reports to the Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA). This will benefit the population being tracked.

Furthermore, the Lung Association supports the consideration of sharing more de-identifiable data on disease diagnosis and treatment outcomes with the CDC and the National Institutes of Health. Data that are not personally identifiable could significantly enhance the nation's research and public health surveillance system, particularly if it could include the demographic points already collected, such as age, sex, occupation, sexual orientation and ethnicity. Any surveillance system would need to ensure that the structure data is transmittable for public health surveillance in accordance with HIPPA rules and regulations.

If there are questions about any of these comments, please contact Barbara Kaplan, MPH, CHES, Director, Asthma Education at [Barbara.Kaplan@Lung.org](mailto:Barbara.Kaplan@Lung.org) or Janice Nolen, MS, Assistant Vice President, National Policy, [Janice.Nolen@Lung.org](mailto:Janice.Nolen@Lung.org).

Again, thank you for this opportunity to provide comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Janice Nolen". The signature is fluid and cursive, with the first name "Janice" being larger and more prominent than the last name "Nolen".

Janice E. Nolen, MS  
Assistant Vice President, National Policy