

Emergency Response Electronic Health Record (ER-EHR)
Use Case Synopsis Feedback Form

The Emergency Response Electronic Health Record Use Case Synopsis is available for public feedback. If you would like to provide feedback about this document, please identify your organization, contact information and insert your feedback in the appropriate sections of this document.

Please save your document using the following naming convention (YRYR.MO.DY-Organization Name–Emergency EHR Feedback Form.doc)

Example: 2006.10.05-ABC Organization-Emergency EHR Feedback Form.doc.

Then please email this document to usecase@hhs.gov by the close of business on Tuesday, October 24th, 2006.

You will receive an acknowledgement email confirming that ONC has received your feedback. Disposition of all feedback received will be posted on the ONC website at the time that the final version of the synopsis is published.

Thank you.

(signed – ONC)

Organization Contact Information

Please provide the contact information for your organization

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Date Feedback Submitted	Thursday, October 26, 2006
<p>COMCARE is a national non-profit alliance with over 100 member organizations. We are dedicated to advancing emergency response by promoting interoperable emergency systems, the use of open standards and forward thinking policies and procedures to maximize their value for emergency responders and the public. Our members include a broad representation of the emergency response and healthcare communities with representation of national organizations for EMS, emergency nurses, 9-1-1, emergency management, along with many other stakeholders.</p> <p>COMCARE has worked extensively with national, regional, and local emergency response and healthcare organizations to define their information sharing needs. Through our Integrated Patient Tracking Initiative, which included over 70 organizations, practitioners developed a</p>	

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detailed set of functional requirements and essential data elements for emergency patient care, including data elements for patient identification, assessment and treatment history, and medical history, including medications, medical problems/conditions, and allergies using the Department of Homeland Security's planning scenarios. The comments submitted here represent the views expressed by these organizations.

Use Case Synopsis - Preface

Section 2: Use Case Stakeholders

Please review Section 2 and respond to the following questions:

	<i>Have we listed all of the applicable stakeholders?</i>
	We believe there are several additional stakeholders which should be included.
	<i>If not, whom should we add?</i>

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	<p>We suggest adding the following definitions:</p> <p>9-1-1/Emergency Medical Dispatch (EMD) – The 9-1-1 center is often the first point of contact the consumer/caller/patient has with the emergency response system. Trained EMD’s do the initial patient assessment, triage and, when necessary, telephone treatment of patients many minutes before arrival of the first responders. They build an electronic record of the case in their Computer Aided Dispatch (CAD) software immediately after the emergency callers access the system (which is beginning to be shared with EMS).</p> <p>Medical Transport/Air Medical Transport – EMS, Nurses, Physicians and respiratory therapists who provide emergency transportation via air or ground from the scene to a medical treatment facility, or from one facility to another.</p> <p>EMS System – The structure of organizations running an EMS System and its arrangement of people, vehicles, protocols, and procedures; as distinct from an EMS responder unit.</p> <p>Public/Private Databases – External databases not controlled by the listed stakeholders from which data may be collected and drawn from, or added to; examples include state EMS data agencies and personal health record databases.</p> <p>Electronic Medical Record Vendors – Those who have developed comprehensive health system wide electronic medical records that includes an established Emergency Department Information System (EDIS) as well as a longitudinal record of patient demographic, medication, allergy and medical problem history in their database. This core data should be integrated and incorporated throughout the continuum of care.</p> <p>We also suggest that you consider adding state Vital Statistics (Birth and Death Records).</p>
	<i>Are the working definitions of the stakeholders appropriate?</i>
	Several definitions should be changed to better describe the personnel associated with each.
	<i>If not, what should we change?</i>

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We suggest revising the current definitions in the following ways:

First Responders – Revise to say “Police, Fire, EMS, 9-1-1/Emergency Medical Dispatch, nurses, physicians, and other personnel with medical first response training”

Clinicians – Revise to say “Healthcare providers located at a Medical Treatment Facility (MTF) with responsibility for treating emergency incident victims. This includes emergency physicians, emergency nurses, and all other clinical and ancillary personnel at the MTF.”

We also suggest adding more detail within the definition of **Researchers** for clarification of who is intended as a part of that stakeholder group.

Use Case - Synopsis

Section 1: Use Case Perspectives

Please review Section 1 and respond to the following questions:

Do you agree in general with the Perspectives described in this section?

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	<p>We believe that the use case begins before the starting perspective of “On-site Care (First Responders).” Data collection about a patient should start at whatever point data is first available and continue throughout the incident. Emergency information may be collected and care may be provided in a number of places, whether at the scene, in a medical treatment facility, via telephone with 9-1-1 or poison control, or elsewhere, and may be provided by licensed clinicians including nurses and physicians, credentialed EMTs, and emergency medical dispatchers. The ER-EHR Use Case Perspectives should utilize phases, where all details on the treatment administered are added to the existing patient record first created when the patient was entered into the system, or this new incident affecting them has activated a new record about them. The ER-EHR should be flexible and allow for the data set to scale up to accommodate additional information as it is needed or becomes available, regardless of who the stakeholder is or where the stakeholder is physically located in the response process.</p> <p>It is not clear that Definitive Care should be treated separately within the Emergency Response EHR Use Case. Definitive Care would use the existing, broader EHR. The categories of Definitive Care and Emergency Care should be combined into a single category. The Emergency Response EHR contains a data set of varying size that will be utilized in the field prior to transport to a MTF. The typical point of handoff for these patients will be at the MTF ED. At that time the ER-EHR will become a part of the MTF’s electronic medical record and the data collected in the field will be added to and updated as the patient is treated and dispositioned (admit, transfer, discharge).</p> <p>When access to historical information, including medications and problem list information, is needed in order to provide continuous care to a patient (e.g. when providers in evacuation centers needed access to medical histories of evacuees), the practitioner can either access the existing full EHR, or access the subset contained in the Emergency Response EHR.</p>
	<p><i>If not, what would you have added or deleted and why?</i></p>

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We believe that the use case should begin prior to when the responders first arrive on scene, **whenever the existence of a patient is first identified**. Therefore we suggest the addition of an **“Initial Care”** perspective. “9-1-1/Emergency Medical Dispatch” should be added as a stakeholder group because they are the first point of contact the consumer/caller/patient has with the emergency response system. Not only would they be initiating the data exchange for dispatch in 1.3.1, but trained Emergency Medical Dispatchers (EMDs) in 9-1-1 do the initial patient assessment, triage and they may provide protocol based telephone treatment of the patient before responders arrive at the scene. One example of this is when a baby is delivered by the father under the complete direction of the 9-1-1 Telecommunicator. Another example is of 9-1-1 telecommunicators assessing and providing treatment guidance to patients rather than having them go to the hospital during a pandemic influenza. There may also be input from decision support tools. The steps of the “Initial Care” perspective will include: Initiate Record; Integrate with Other Information; Assess, Triage, and Track Patient; and Transmit Record.

First responders in this use case will be “personnel with medical first response training and licensed emergency medical care providers.” They may include EMTs, police and fire, physicians and nurses, and others with medical first response training and/or emergency medical training, who initially arrive on scene and provide the initial assessment and stabilization of patients. They may only be able to record a minimum data set, thus this may contribute to “Initial Care” or they may build out a more detailed record in the “Field Emergency Care” phase. The distinction between the Field Emergency Care perspective and the Initial Care perspective is the data is being built upon data initially recorded about the patient; Field Emergency Care may include a greater number of data entry fields.

The **“Field Emergency Care”** perspective allows for more data to be entered and updated about a patient prior to the patient being transported to a MTF or discharged from the scene. Any data added and updated in the ER-EHR will be built upon the data first entered, whether it was entered by EMDs or responders on the scene; if an EHR cannot be retrieved a new one may be initiated. The stakeholders again may be the first responders identified above, including EMTs, police and fire, physicians and nurses, and others with medical first response training and/or emergency medical training who assess, triage, and treat the patient. Field Emergency Care should also include treatment provided by air and ground medical transport crews providing care while the patient is in route to a medical treatment facility. The steps of the Field Emergency Care perspective will include: Retrieve/Initiate Record; Integrate with Other Information; Assess, Triage, and Track Patient; Determine Disposition and Transmit Record. In some cases, the emergency incident victim may be evaluated, treated and released in the field.

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The third phase of data entry will be data entered and updated in the ER-EHR within the setting of a medical treatment facility. **“Medical Treatment Facility Emergency Care”** may occur in the emergency department of a hospital, at the scene in a field hospital, or other medical treatment or surge facility. The definition should be changed to “Healthcare providers located at a MTF with responsibility for treating emergency incident victims. This includes emergency physicians, emergency nurses, and all other clinical and ancillary personnel at the MTF.” The steps of the “MTF Emergency Care” perspective will include: Retrieve/Initiate Record; Integrate with Other Information; Assess, Triage, and Track Patient; and Determine Disposition. The distinction between the MTF perspective and the field perspective is the data is being built upon data recorded about the patient in the pre-MTF environment, and may include a greater number of data entry fields.

There is also an increasing potential to provide treatment guidance through telemedicine/telehealth channels, whether in a day-to-day scenario or in a mass illness event such as a pandemic. The use case perspectives and workflow should support flexibility of responder/provider type and site of care. This may either be included as a part of the other perspectives, or by adding a category for **“Virtual Triage and Treatment.”** The appropriate category may be selected depending on the treatment environment. The Virtual Triage and Treatment perspective should be defined as video, phone, Internet-based or other means of assessing, diagnosing, providing care and prescribing for a patient remotely by telemedicine or telenursing providers. There may be input from decision support tools.

It is important to note that the language used in the use case is very important. All stakeholders are providing emergency care, regardless of the location or environment in which they are administering it. Within the use case, it should not matter who is providing the care or where they are providing it. We believe that credentialed EMTs should be added to the personnel identified in the “Emergency Care” perspective, including in medical treatment facilities, just as emergency physicians and emergency nurses may provide treatment in the field. Clinicians should be referred to as “licensed clinicians,” not “credentialed clinicians.”

While it is not clear that the **“Definitive Care”** perspective belongs within the Emergency Response EHR Use Case, if it is kept in the use case, we suggest that “Definitive Care” be referred to as “Specialty Care” in order to distinguish between the emergency care provided and the longer term care of Perspective 3. We believe, however, that Definitive Care as a category should be deleted because it is covered in the definition for Medical Treatment Facility Emergency Care. In many cases, definitive treatment may be rendered at the scene of the incident or in the emergency department and the patient is discharged or released from care at that time. Making this change would better facilitate this scenario in the use case.

Do you agree with general definition of small and large scale incidents?

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	<p>We are pleased at the inclusion of both small, day-to-day type emergencies and large scale mass emergencies. It is very important that an ER-EHR be available for use in emergencies of all sizes and all hazards. This will make the widespread adoption much more likely.</p>
	<p><i>If not, why not?</i></p>
	<p>While the breadth is appropriate, it should be noted that the scale of all incidents is relative to the location and the resources of the locality responding to the event. All emergency response events should be considered as scaleable in recognition of the similarity of resources and to recognize that response systems themselves cannot be tailored to events of a specific size.</p> <p>We believe small incidents should specifically include day to day operations and emergencies (including all single patient incidents). By using the system in normal operations, users would not have to adapt to another system during a time when their resources are being overwhelmed.</p>
	<p><i>What you change and why?</i></p>
	<p>We suggest “resources of an individual city, county, or metropolitan area” specifically refer to “medical resources.”</p> <p>We suggest that single patient incidents or 9-1-1 calls be specified within the definition in order to universally utilize the Emergency Response EHR for all EMS calls. The timescale for response should be edited to reflect normal response times for routine EMS operations (single patient calls). An example of a routine EMS call will help clarify this.</p>
	<p><i>Do you concur with the steps in the workflow?</i></p>
	<p>We believe changes should be made to reflect the proposed changes in perspectives.</p>
	<p><i>If not, what would you change and why?</i></p>

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We feel that changes in sections 1.3, 1.4, and 1.5 should be made to reflect the proposed changes to the perspectives. Perspective 1 should be Initial Care, Perspective 2 should be Field Emergency Care, and Perspective 3 should be Medical Treatment Facility Emergency Care, following the different phases of data entry and exchange. A fourth perspective, Virtual Triage and Treatment, may be included as a separate perspective or combined with 1-3. We propose deleting the Definitive Care perspective, as it is included in MTF Emergency Care and it is redundant as a separate category.

We believe there should not be a distinction between “On-site Care Record” in 1.3 and “Emergency Care Record” in 1.4, but rather both should be referred to as the “Emergency Response Electronic Health Record.”

The use case should begin with Emergency Medical Dispatch/9-1-1 because they have the first information about a patient, they can make the first assessment and triage of the patient, and possibly provide telephone treatment of the patient. Input from predictive algorithms and/or decision support tools should be integrated throughout the process, from the initial call, and will vary depending on the steps that are taken or the changing status of the patient. There should be an Initial Care perspective in which the Emergency Response EHR is initiated, where patient identification and demographic information (including patient full name, date of birth, age, gender, and social security number) may be entered along with assessment, triage, and possibly treatment information may be entered. It should also allow for emergency medical dispatch Computer Aided Dispatch information to be included in the ER-EHR. Additionally, external data may be sent to 9-1-1 (e.g. OnStar) providing an initial set of data.

In each perspective, especially in the pre-MTF perspectives, language should be included stating “once a patient is identified, the core data for the ER-EHR is downloaded from a data repository.” Step 1.3.3 should be eliminated since it could occur in either 1.3.1 or 1.3.2; and the wording could be incorporated into one or both of these steps. Similarly 1.4.3 could be eliminated and incorporated in step 1.4.2.

The steps to record data in the record (1.3.5, 1.4.5) should be incorporated into the “Assess, Triage and Treatment” steps prior (1.3.4, 1.4.4). In each perspective of the use case, wherever the workflow contains language regarding the responder recording information, including assessments, observations, and treatments rendered, the option for automatic feeds of this information into the ER-EHR should be included as well. An example of an automated feed would be from a blood pressure monitoring device.

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	<p>In the present workflow sequence, the transfer of patient information from on-site (1.3) to emergency care (1.4) is not brokered through emergency management systems as currently stated, nor would it be in the future. Emergency management would “sniff” the system for body counts and triage statuses to coordinate resources and personnel. In section 1.3.5, patient destination, mode of transport, and priority would be coordinated through medical control or the EMS/Medical Sector of Emergency Management, not through emergency management systems. Similarly, in 1.4.1, an emergency care facility would not receive the patient information from emergency management systems. While emergency management systems are not defined in this use case, we believe them to include the systems, processes and tools used by emergency management to coordinate an incident on a broader scale. Medical control or the EMS/Medical Sector of Emergency Management coordinates patient destination, transport, facilities, personnel, etc. In step 1.3.6 terminology regarding communications from the field to Medical Control should be included in order to capture the decision-making and data exchange relevant to transporting the patient to a specific MTF. Also in this step demographic information may be updated/corrected. Step 1.4.1 should be changed to “Coordinate between the field and the MTF.” The MTF should always receive notification of an inbound patient, and in the use case, it should include the transfer of the “Emergency Response EHR.” The receiving facility should receive patient demographics so they can determine if an additional prior health record is available.</p> <p>Step 1.4.2 should have the heading “Initiate the MTF EMR.” The EMR should have the transferred information from the ER-EHR. Once patient identity is confirmed, data from the Emergency Response Electronic Health Record should be merged/appended to the patient’s existing record if available. If this information is not available, and new record may be initiated.</p> <p>1.4.4 should state that the patient is received from the EMS transport, final pre-MTF data is shared and downloaded and handoff is completed between EMS and the MTF. The key language from 1.4.5 can be incorporated into step 1.4.4, and 1.4.5 can be eliminated.</p> <p>Step 1.4.6 could be eliminated or refer to the process of ensuring that the key data elements of the Emergency Response Electronic Health Record are in the EMR and feed back into the data repository where the ER-EHR data was downloaded from.</p>
	<p><i>Are there any laws or policies (federal, state, or local) which would affect the work flow? (Please describe how)</i></p>

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	<p>In some states there are confidentiality regulations or statutes which would affect access to the data.</p> <p>It has been our experience and that of others that the perception of laws by health systems may be the greater challenge. Clear direction by Federal and State Government supporting the sharing of health information should be provided.</p> <p>State Medical and Nurse Practice Acts define the scope of practice for licensed practitioners (physicians and nurses) as well as for physician extenders (nurse practitioners and physician assistants) and non-nursing personnel (techs, EMTs, paramedics) who fall under the supervision of licensed practitioners. These regulations define the scope of practice within the MTF through language specific to practice and delegation in the state regulations defining the practice acts. This has implications for language used in the Use Case itself with regard to the delivery of care within the MTF. In order to develop a concise and viable use case, we recommend the following:</p> <ul style="list-style-type: none"> • The principal personnel listed in each of the phases of the use case should be those who interact at some level with the Emergency Response Electronic Health Record since this is the primary focus. • The principal personnel listed in each of the phases of the use case should also be those providing the majority of the interactions in the use case. For example, the personnel in the field (first-responders) would include EMTs, fire and police personnel. In the MTF, the primary personnel would be the emergency physicians and emergency nurses since they comprise the majority of the staff who assess and treat the emergency incident patients as well as interact with the Emergency Response Electronic Health Record.
	<p><i>Do the data exchanges look reasonable and are they are the right places?</i></p>
	<p>A number of changes to the data exchanges may be necessary to reflect the suggested changes to the perspectives and workflow steps. The ability to query information specific to the stakeholder's needs at the time that information is needed should be added. Information may also be used to generate responses based on decision support tools.</p> <p>Sometimes a patient is not identified in the field or after treatment has begun in the ED (e.g. trauma patient). The patient may have data in the repository but since they are not identified, it is not initially available. After the patient is identified, the ability to merge the new record with prior EHR data is needed.</p>
	<p><i>If not, what should be changed?</i></p>

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	<p>Some specific changes to the data exchanges include:</p> <p>1.3.2 mentions patient data will be downloaded if available, but there is no data exchange within that section and no identification of where the data may be downloaded from. Data may be provided by external sources such as OnStar, Personal Health Records, and others.</p> <p>1.3.5 states that data is sent to emergency management systems, when this should be sent to the EMS/medical sector of emergency operations management, and/or to medical control. Emergency management would be interested in data pertaining to the number of patients or fatalities in order to coordinate resources and personnel.</p> <p>In 1.3.6, data would also be transmitted to public/private databases, including those of state EMS systems and NEMESIS.</p> <p>1.8.1 In addition to repositories, public health may also “sniff” in near real-time from a number of sources to identify trends in complaints prior to that data being downloaded into a repository.</p> <p>We have also noted that throughout the different perspectives of the use case, there is no mention of patient identification and matching of medical records or the identification, authentication and authorization of responders/practitioners in order to access and/ update the data.</p>
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Section 2: Use Case Perspective Interactions

Please review Section 2 and respond to the following questions:

	<p><i>Does the graphic adequately display the work flow by perspective as listed in section 2?</i></p>
	<p>We feel that the graphic does not clearly display the workflow in a linear step-by-step fashion. We suggest restructuring the graphic to reflect the flow of patient data and the flow of the patient. It should also include the electronic and data elements involved in the Emergency Response Electronic Health Record. Changes should be made to reflect the suggested changes in perspectives and workflow thus far.</p> <p>Particularly confusing is the Emergency Operations Management column because it includes Emergency Notification and Dispatch, Public Health, and Long Term Health Registries, which are all separate entities.</p>
	<p><i>Do you agree with the process flow of the graphic?</i></p>
	<p>We do not believe the process flow in the graphic is clear enough to illustrate the workflow and needs revisions as suggested below.</p>

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	<i>If not, what needs to be changed and why?</i>
	<p>The graphic should be updated to reflect the changes we have suggested in the prior sections. Changes reflected in the diagram would include the modified and additional perspectives, the addition of external algorithms and external public/private databases. The flow should reflect the different phases of data entry as described earlier, showing how information collected in each phase builds upon the data which was collected before it. It should also illustrate the different uses of the data.</p> <p>Again we suggest you consider including vital statistics such as birth and death records and narrow down the comment “those performing research” to a more manageable level.</p>

Appendix A: Perspective Definitions

Please review Appendix A and respond to the following questions:

	<i>Do you agree with the descriptions listed for the perspective definitions?</i>
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	<p>We feel that the changes in categories as described earlier should apply here. As mentioned earlier, we believe the perspectives should begin with Initial Care. This should be defined as initial emergency medical care provided by emergency medical dispatch and personnel with medical first response training. This may include telecommunicators and dispatchers off-site, as well as EMTs, fire fighters, police officers, nurses and physicians, and other rescuers who arrive on the scene and are trained to provide emergency medical assistance.</p> <p>The Field Emergency Care perspective allows for more data to be entered and updated about a patient prior to the patient being transported to a MTF or discharged from the scene. Any data added and updated in the ER-EHR will be built upon the data first entered; if an EHR cannot be retrieved a new one may be initiated. The stakeholders again may be the first responders identified above, including EMTs, police and fire, physicians and nurses, and others with medical first response training and/or emergency medical training who assess, triage, and treat the patient. Field Emergency Care should also include treatment provided by air and ground medical transport crews providing care while the patient is in route to a medical treatment facility.</p> <p>Medical Treatment Facility Emergency Care includes data entered and/or updated in the emergency department of a hospital, at the scene in a field hospital, or other medical treatment or surge facility. The definition should be changed to “Healthcare providers located at a MTF with responsibility for treating emergency incident victims. This includes emergency physicians, emergency nurses, and all other clinical and ancillary personnel at the MTF.”</p> <p>The perspective of Virtual Triage and Treatment may be defined as treatment guidance provided through telemedicine/telehealth channels, whether in a day-to-day scenario or in a mass illness event such as a pandemic. Virtual Triage and Treatment may be administered through video, phone, Internet-based or other means of assessing, diagnosing, providing care and prescribing for a patient remotely by telemedicine or telenursing providers.</p> <p>A.1.3 - Definitive Care should be combined into Medical Treatment Facility Emergency Care.</p> <p>A.1.4 - Examples of Medical Examiner/Fatality Management should also include DMORTs.</p> <p>A.1.5 - Emergency Management has two functions related to this use case: one function is purely medical; another is support to medical and includes the coordination of resources. Both may occur in multiple places. The term Patient Regulator should be replaced with EMS Director.</p>
	<p><i>Are there terms that need to be added to the glossary?</i></p>

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	<p>Yes. In addition, the term Patient Regulator should be removed because it is not a term commonly used by the stakeholders. Medical Control or EMS Director is more appropriate in this reference. The term "Casualty Collection Point" should be replaced with "Triage Treatment Area/Station."</p>
	<p><i>If so, what are they and the associated definition?</i></p>
	<p>EMT – Emergency Medical Technician; encompasses all categories of credentialed emergency medical technicians and is commonly used to refer to all levels of EMT certification.</p> <p>EMT-B – EMT trained to provide basic life support</p> <p>EMT-P – EMT Paramedic with extensive training in advanced life support</p> <p>EMS System - The structure of organizations running an EMS System and its arrangement of people, vehicles, protocols, and procedures</p> <p>Electronic Health Record (EHR) – (from HIMSS online HIT dictionary) The electronic health record (EHR) is a longitudinal electronic record of patient health information generated in one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.</p>

Appendix B: Emergency Response Electronic Health Record Definition

Please review Appendix B and respond to the following questions:

	<p><i>Have we captured what you consider to be the essential data set?</i></p>
	<p>The data set should be able to capture who provided treatment and their credentials and organization, what the responder saw during treatment, what treatment was administered, how the patient responded to the treatment, the patient's vital signs, and then the responder's following steps. Each time data is entered or updated it must also be date and time stamped, and an incident identifier should be included in the record. The record should be expansive and all inclusive, with the flexibility to use the record as required by each responder to each individual incident.</p>
	<p><i>If not, what do you recommend that we add or delete and why?</i></p>

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	<p>The categories of data elements within an ER-EHR should include:</p> <ul style="list-style-type: none">(a) Patient Identification and Demographics (including name, age/approximate age, gender, date of birth, social security number, patient identifying characteristics)(b) Allergies(c) Medications (current)(d) Patient Problem List (historical)(e) Field Assessment and Treatment Data (beginning from the time you engage with the patient; includes field triage/acuity level, current problems, vital signs, field treatments, status updates, provider information)(b) Patient Location and Transportation Data(c) Triage Category(d) Advance Directive Status <p>“Pre-existing Conditions” should be referred to as “Patient Problem List,” which is consistent with the reference to problem list information in the Use Case Recommendation text (1.2).</p> <p>“Treatment History” may imply past medical history previous to the current incident. We suggest using the category “Field Assessment and Treatment Data” in place of “Treatment History” and “Present Episode” to be clearer and more comprehensive.</p> <p>“Demographics” should be “Patient Identification and Demographics.”</p> <p>Emergency Medical Dispatch CAD information should be included within Treatment History.</p> <p>We recognize that advanced directive data is desirable, but determining a ‘source of truth’ for this data will be difficult. The question to consider is whether or not in the case of major incident, if information on advanced directive would be utilized in the field.</p> <p>Also, with the inclusion of first responder and emergency management, one may consider a category for response/incident information. Also a category that provides information on outcome, such as final diagnosis, would allow for loop closure for researchers and public health.</p>
	<p><i>Will recording this information on an ER-EHR facilitate workflow and mitigate against errors?</i></p>

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	<p>Yes, the proposed ER-EHR would allow better continuity of care, facilitate communications and improve patient care and safety across the continuum of emergency care, from the field to the medical treatment facility. Many of these requirements were validated through the Integrated Patient Tracking Initiative ({ HYPERLINK "http://www.patienttracking.org" }).</p> <p>An ER-EHR based on a core data set of patient specific longitudinal data from a common or networked repository would provide the foundation for these improvements in emergency care delivery. All medical responders would have access to the history and enhanced information at each treatment node so that they can provide the right treatment to the right patient at the right time. By providing a scalable tool, the ER-EHR used in day-to-day single patient incidents are likely to perform better during a crisis situation. Recording information electronically throughout the process would enable the ability to audit the process as well as offer patients the knowledge of whom accessed their records.</p>
	<i>If not, why not?</i>
	These benefits exist only if the additional information mentioned would be included in the use case.
	<i>Are there any laws or regulations (federal, state, or local) which would prohibit the collection of this data?</i>
	Patient information should be protected through role-based access control so that only those who are authorized to see the patient data may do so. This should be a shared “core service” available to all entities and system users, rather than a separate rights management service for each individual application.
	<i>If so, what area(s) do they affect?</i>
	(Insert feedback here)

Additional Feedback

If you have additional feedback that does not pertain to a specific section of the Synopsis please include them here:

	<i>Do you have any additional feedback that does not pertain to a specific section of the Synopsis?</i>
	(Insert feedback here)