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THE AMERICAN HEALTH QUALITY ASSOCIATION
7918 Jones Branch Drive
Suite 300
McLean, VA
www.ahqa.org

Don Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW
Floor 7
Washington, DC 20201

Dear Dr. Rucker,

Thank you for the opportunity to comment on the draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*.

Our organization, the American Health Quality Association (AHQA), represents the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their quality improvement partners throughout the United States, Puerto Rico, the Virgin Islands, and the outer Pacific Islands. Our association's goal is to make health care better, safer, and available at a lower cost.

As organizations charged with working with providers, beneficiaries, families, and stakeholders to improve health quality practice and delivery, QIN-QIOs are keenly interested in the advancement and alignment of health IT across the healthcare continuum.

Below are our comments regarding the draft strategy.

CLINICAL DOCUMENTATION

Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.

Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.

The strategy of implementing a single pay rate for E/M level 2 through level 4 visits seems to be a simple solution to a complex process. The concept is similar to the HMO capitation model of the 1980s and early 1990s, which, in our experience, presented challenges for providers. Most significantly, physicians were unable to manage complex patient care costs on minimal per-patient compensation and struggled to sustain profitable businesses based on capitative payments.

Our understanding is that the proposed model will allow providers to bill for lengthier visits and thereby differentiate itself from the single payment/capitation comparison. However, we are concerned that this won't meaningfully reduce the regulatory burden but, rather, displace it. For example, although there would be less documentation required of the provider to meet E/M level guidelines for the complexity of the visit, the bulk of the burden would then fall on the billing and coding administrators to decipher the length of time of the visit, determine appropriate time codes, and add them to the claim.

We believe a more effective solution would need to be built into the electronic medical record (EMR) to have a seamless and minimal "clicking" workflow to easily document time spent with a patient and avoid transferring the burden from provider to administrative support.

Recommendation 2: Leverage data already present in the EMR to reduce re-documentation in the clinical note.

We agree with the recommended strategy to leverage the data within the EMR to reduce repetitive clinical information. For example, clinical notes are filled with medical history that is not relevant to the current visit. Reducing re-documentation will allow providers to focus more fully on the current medical issue and reduce time spent taking patient history and reading previous notes.

In addition, simply indicating that information can be found elsewhere within the record will help eliminate notes included solely for billing purposes. Lastly, allowing providers to review, update, and sign off on previously documented data will reduce the burden on providers when writing and reviewing notes.

Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.

We strongly support the recommendation to obtain ongoing stakeholder input about updates to documentation requirements. Implementing a collaborative, representative task force that includes stakeholders from various sectors will enable better communication and should result in meaningful change for all. We believe that this continuous stream of communication will help stakeholders understand how updates and other changes affect providers and work collaboratively to develop innovative solutions to overcome provider challenges.

Recommendation 4: Waive documentation requirements as may be necessary for purposes of testing or administering APMs.

We are unclear how this recommendation will reduce the burden on providers, and we request additional information on how it will accomplish this goal.

Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.

Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.

We strongly support this recommendation. Developing clinical documentation best practices and guidelines is imperative. Many organizations have specific expectations of their clinicians and providers that may or may not align with the requirements of quality reporting programs and may lead to undue burden.

For example, providers should not be permitted to copy and paste data within the clinical note or other documentation elements. In addition, erroneous data that adds to confusion, creates excessive note length, and can result in poor patient outcomes should be eliminated where possible. CMS/ONC should identify avenues for standardizing the basic constructs of clinical documentation to remove inconsistencies and variation that lead to errors.

For the best outcomes, we recommend that the clinical workflow processes be incorporated into the design and construction of the EHR systems by vendors. More seamless matching of the process to the

documentation tool would reduce burden and opportunities for errors and increase overall satisfaction and quality for providers.

Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.
We strongly support utilizing CMS technical assistance (TA) infrastructure and models to disseminate best practice information to providers. The various CMS TA networks, such as the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), provide clinicians and organizations with education and assistance in transforming their clinical practices to meet the needs of patients, providers, regulatory bodies, and compliance organizations. Through this work, CMS TA contractors meet providers and organizations where they are in the quality/process improvement cycle, identifying ways that providers can meet their reporting requirements (often through the careful evaluation of current processes and workflows) without over-burdening the system and resources available. CMS TA contractors determine measures and activities that meet the provider's needs and align with the patient panel/practice type of the provider or organization with whom they are working. Moreover, CMS TA contractors often offer multiple modalities for the dissemination of learning materials and content, such as webinars, sharing calls, web-hosted learning modules, newsletters, direct technical assistance, screen sharing, in-person training, and collateral materials derived by organizational request or through participant feedback and needs evaluations.

We suggest that consideration be given to ensuring adequate training for technical advisors so that such a program can be successful.

Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

Recommendation 1: Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.
We support this recommendation. Electronic documentation is often siloed in its approach, whereas clinical workflows tend to be more fluid. There has been some effort by EHRs to streamline these workflows; however, there is more work to be done in this area, not only by the EHR vendors but also by providers and staff. Realizing the benefits of a truly integrated and seamless prior authorization system will take some effort and time by the providers and staff, in collaboration with EHR vendors, to make the EHR workflow fluid and seamless.

We applaud CMS for focusing not only on standardizing electronic transactions but also on how prior authorization is implemented. Developing and disseminating best practices for optimizing electronic workflows and prior authorizations will make the process easier and, hopefully, reduce errors.

Recommendation 2: Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers.
We support increased automation of ordering and prior authorization processes. In addition, continued partnership with providers to standardize claims submissions and prior authorization requirements would greatly improve the efficiency of the pre-authorization process. However, we believe there needs to be thought devoted to how these templates and standardized items fit into the workflow of a clinic to ensure it does not inadvertently increase documentation burden for providers.

Recommendation 3: Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes.
In theory, we support the idea of incentivizing adoption of technology, which was a successful catalyst for mainstream use of EMRs. However, we are concerned that this could potentially create confusion with other incentives currently in effect, such as those associated with the movement to value-based payment systems. We recommend that any technology adoption-related incentives align with the existing Promoting Interoperability program.

Recommendation 4: Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.
We support this recommendation. Standardized healthcare EHR language currently exists, so we recommend that the focus of these processes be on the utilization of the existing standardized, hard-coded language sets rather than the creation of a new template or form. We also recommend that HHS explore existing models for ordering, such as electronic prescribing, and follow similar processes to avoid undue burden on EMR development or provider documentation requirements.

HEALTH IT USABILITY AND USER EXPERIENCE COMMENTS

Strategy 1: Improve usability through better alignment of EHRs with the clinical workflow; improve decision making and documentation tools.
We appreciate the strategy to improve usability through better alignment of EHRs regarding workflows and agree that this will serve to improve the efficiency, experience, and satisfaction of end users. However, we are concerned about the feasibility of harmonizing clinical content and interfaces.

First and foremost, we are concerned that the proprietary nature of the EMRs will serve as a barrier to this goal. In other words, how can standardization be achieved while still allowing vendors to offer "unique" services that differentiate them from other vendors? Additionally, how can standardization be achieved across settings, taking into account the different needs of primary care providers versus specialists? We recommend that CMS consider these questions as it develops its IT systems.

Recommendation 1: Better align EHR system design with real-world clinical workflow.
We fully support the recommendation to align workflows and for health IT leaders to take the lead by working with stakeholders as they prioritize functions during the development stage. We suggest grant funding or other alternative funding be provided to incentivize not just vendors but also stakeholders in this critical but time-consuming endeavor. We recommend that the grant structure allow for feedback and evaluation of the ongoing process and the stakeholder voice in that development.

Recommendation 2: Improve clinical decisions support usability.
We strongly support this recommendation. We suggest standardizing alerts across vendors and engaging the same stakeholders in the prioritization of those alerts. Limiting the number of priority alerts could serve to make providers more cognizant of their importance and decrease alert fatigue.

The federal government has already provided a model for the harmonization and standardization of alerts in commercial aircraft cockpits under an FAA Advisory Circular. The FAA's approach coordinates color, audible warnings, and other tactics between manufacturers of cockpit information so that pilot workload is reduced and various alerts are organized into categories or tiers. Similarly, the Office of the National Coordinator could provide standardization guidance for EHR vendors and potentially consider

this under the EHR certification program. This work, using the FAA model, may be underway for hospital ICUs where many and varied alerts occur.

Recommendation 3: Improve clinical documentation functionality.
We agree that less burdensome methods of capturing data in the EHR are imperative. Other technology industries could be leveraged to improve the capture of this information. Copy-and-paste functionality has become a "work around" that is employed far too often. This is an opportunity for QINs to establish guidelines and processes and to assist facilities with implementation. Greater emphasis on providing technical assistance with EMR workflows and functionality should be considered in the next Statement of Work.

Another possible policy lever to encourage problem solving with regard to how data is captured is to look at how ONC promotes app development with code-a-thons, including awards to the best apps that result from these. A facilitated gathering of vendors, 3rd party app developers, and industry experts by the ONC to discuss and brainstorm data capture approaches could be one step toward addressing this.

Recommendation 4: Improve presentation of clinical data within EHRs.
We strongly support this recommendation and believe that, in particular, there should be an emphasis on longitudinal care management in AAPMs (such as Comprehensive Primary Care Plus) and medical home models. However, as stated above, we have concerns about how this will be accomplished across vendors.

Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.

Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.
We strongly support this recommendation and encourage directing resources toward this effort. Many states have already done this with grant funding, and their best practices should be reviewed and considered. One suggestion is that CMS could require vendors to provide a basic package that includes standardization of some items, such as those mentioned below. If providers require or desire additional functions, they would have the luxury to upgrade services to suit their specific clinical setting and workflow. Examples of functionality that health IT developers could standardize might include the following: medication reconciliation; medication, laboratory and imaging ordering; results review; problem list interaction; medical history interaction; and clinical documentation and review. If these functions were standardized, the impact on patient safety would be significant, and the usability and efficiency of the EHR would be profoundly improved.

Recommendation 2: Promote and improve user interface design standards specific to health care delivery.
We support this recommendation and believe this is another area where ONC could use its position to gather experts and facilitate targeted solutions. While vendors will continue to compete on the basis of product differentiation, we are moving toward a world of standardized, normalized data that can be pushed and pulled from the EHRs using API functionality. One consideration would be for public dollars to support a project conceptually similar to "Blue Buttons" to establish the ability to pull and display patient data through standardized screens. This would enable providers to have a standard view at any facility (especially when they are not trained in a particular EHR). The concept would utilize API and patient data mobilization to the benefit of the provider to reduce burnout from site to site where different EHRs are in place.

Additionally, there are standards being developed around Clinical Decision Support (CDS) called "CDS Hooks." The idea is that the EHR employs contextual-driven CDS support using APIs by sending out data to a 3rd party app, and that app returns CDS recommendations in the form of "cards" (recommendations that appear in the workflow) that the provider can consider or ignore (thus not increasing provider burden). Each EHR vendor could "plug" their system into CDS apps and integrate them into the clinical workflow without having to build and maintain the decision support tools themselves. It would create a dynamic marketplace of CDS query/response functionality and accelerate the adoption of best practice, assistive CDS capability while rapidly reducing implementation and deployment time.

Another approach to consider is based on the common complaint that EHRs are tools that were (and sometimes remain) driven by the need to capture data to satisfy back-end services billing. The ONC could look at countries where EHRs are used to drive clinical care rather than collect data for payment for successful examples.

Recommendation 4: Promote proper integration of the physical environment with EHR use.
We support this recommendation and believe the QIN-QIO community is uniquely positioned to aid facilities as they design and construct their healthcare environments. The QIN-QIOs offer our assistance to CMS in the development of best practice guidance.

One recommendation for sustaining better integration of the EHR into the physical environment is to create a pipeline and forum for best practices observed by technical assistance experts, such as the QIN-QIOs. A repository of best practices that we could all contribute to and evaluate for suitability at facilities with which we work would help organizations avoid common pitfalls. Most importantly, it should be combined with similar EHR optimization efforts and not become a stand-alone repository or topic.

Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.

Recommendation 1: Standardize medication information within health IT.
We believe that this recommendation is critical to patient safety. We encourage CMS to review the interface work that is already in process between EMR vendors, as well as state initiatives that are already underway. We believe careful consideration should be given to determining which agency or organization will establish the standards. We encourage the standardizing agency or organization to engage with stakeholders as standards are being developed.

Recommendation 2: Standardize results display conventions within health IT.
We fully support this recommendation. The implementation of this recommendation would serve to improve user experience significantly. (See Strategy 2, Recommendation 2)

Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.

Recommendation 1: Increase end-user engagement and training
We believe that this recommendation is critical to achieving maximum efficiency from an EHR, but also recognize that this is a huge undertaking, especially in resource-limited rural facilities. There are varying

degrees of experience and learning capability from facility to facility as well as specific types of care provision. We recommend that there be more incentive-based learning for office staff in EMR workflows and functionality. Technical assistance experts, such as the QIN-QIOs, should be utilized to develop best practices for implementing and sustaining EHRs and supporting facilities in that work. For example, the QIN-QIOs could assist facilities in determining the leanest, most meaningful way to achieve the ongoing training necessary to fully utilize an EHR.

Recommendation 2: Promote understanding of budget requirements for success.
We support transparency in pricing as well as in needed functionality of an EHR. We feel that CMS should establish EHR transparency guidelines. These should not only include lifespan cost, but also clearly communicate current and future functionality and additional "modules" or features needed for reporting or to enhance care delivery functions (such as longitudinal care management).

EHR REPORTING STRATEGIES

Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.

Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.

Strategy 3: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.
We commend CMS for moving to the simplified Promoting Operability category measure set and scoring methodology. While this category still provides challenges for clinical and quality staff to meet 100% performance, the reduced number of measures and a scoring methodology that is more aligned with the previous Meaningful Use program will assist organizations and clinicians in reporting. Additionally, we appreciate that CMS is not requiring specific performance thresholds for each measure in the first year of this new measure and scoring methodology.

We also believe that moving to the required implementation of a 2015 certified EHR demonstrates the CMS/ONC desire to increase the accessibility and transmission of patient electronic health data between providers and settings of care.

However, numerous organizations have experienced challenges with the implementation of 2015 CEHRT, namely the cost and time allocation required to upgrade or install a new system. Additional support, such as resources to assist with implementation, should be considered.

Lastly, there is a need to develop new health IT measures that focus on interoperability and the relevance of the measure to clinical practice and patient improvement, thus ensuring that electronic data collection aligns with a clinical workflow.

Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.

We fully support this recommendation. Offering specific bonuses for the use of HIEs could assist in reducing provider burden and enhance and emphasize the role of HIEs as they promote effective clinical data exchange. CMS/ONC could also consider collaborating with vendors to develop and make available a national HIE that would more seamlessly and affordably allow eligible clinicians and organizations to share patient data. The current system, with many players, multiple touchpoints, and overly burdensome interface requirements, makes this challenging and often impossible.

We strongly recommend that CMS/ONC establish base certification requirements for increasing interoperability and require vendors to include these in their foundation base system so there isn't an additional fee for their implementation/installation or use.

Additionally, it is important to note that the progressive implementation of the Quality Payment Program and associated MIPS reporting requirements has enabled eligible clinicians and organizations to identify meaningful measures and activities on which to report. Incrementally increasing the performance threshold demonstrates CMS' awareness and willingness to allow these eligible clinicians and organizations to prepare and initiate workflows and processes within their practices or organizations. This will assist providers in meeting reporting requirements without mandating immediate and overarching changes.

The options for Promoting Interoperability measure reweighting due to exclusions are valuable because they provide eligible clinicians and organizations alternatives for earning points if a given workflow or process is not one they regularly complete. However, there is some confusion about the manner in which each measure is reweighted; there is also a lot of movement between measures and opportunity for confusion on the part of eligible clinicians and organizations seeking to determine preliminary performance. We recommend that CMS provide clarification around measure reweighting to providers.

We commend CMS for recognizing the unique challenges of small practices and offering solutions accordingly. For example, we support the provision of a hardship exception for the Promoting Interoperability category for small practices. We further believe that establishing a timeline of graduated steps (much like the graduated steps of the cost category) for small practices would be helpful to ensure they are moving toward interoperability and awareness of expectations.

Lastly, many small practices are using direct messaging for interoperability. We recommend establishing a national directory to help provide greater support for these small practices. Retrieving direct e-mail addresses in rural areas is one of the biggest challenges providers face. With a national directory, vendors could feed and update it directly, which would decrease the burden on the provider and help move the needle forward toward the goal of interoperability.

Recommendation 3: Reduce the burden of health IT measurement by continuing to improve current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow.

We strongly support this recommendation. CMS and the ONC have done an exceptional job reducing the number of required Promoting Interoperability measures and more closely aligning these measures with the need to increase patient-to-provider and provider-to-provider data sharing and engagement. Additionally, the inclusion of the two opioid-related measures demonstrates the national need to identify and monitor opioid users and their history of, or potential for, opioid dependence.

Another critical aspect of EHR utilization that is necessary to reduce provider burden is the marriage of documentation requirements with the clinical workflow. It seems that all too often, clinicians have to navigate between many unnecessary screens to get to the data or tool they need to document their patient encounter. We recommend that vendors identify ways to give clinicians and organizations the flexibility to easily manipulate their EHR systems to meet clinical workflow needs while still meeting the discrete data documentation requirements for reporting.

Recommendation 4: To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers.
We support this recommendation but believe it should be expanded. Under the state-based Medicaid Promoting Interoperability funding, clinicians and organization could receive funding to adopt, implement or upgrade their EHR system. This was incredibly beneficial, as it provided funds to help get a very costly and resource-intensive system in place.

As part of the QPP low-volume threshold exclusions, many of the clinicians and organizations that would have been eligible for Medicaid funding are unable to receive Medicare payment incentives to offset the cost of their EHR system installation, maintenance, etc. These continued exclusions from participation do not assist these clinicians and organizations, but rather set them back. Consideration of an alternative means for the acquisition and disbursement of funding to support EHR system installation, upgrade, and maintenance is needed if there is to be universal interoperability.

Recommendation 5: Revise program feedback reports to better support clinician needs and improve care.
We fully support this recommendation, especially for the MIPS Promoting Interoperability & Cost categories.

More timely and actionable feedback is imperative. Current feedback reports are available only once per year, and the data provided is already many months old. Offering clinicians and organizations a means of receiving real-time (or as close to it as possible) reports on their performance would benefit their work.

Additionally, offering the ability to get more granular data, whether it be for a specific clinician, TIN or patient, would also be useful in quality improvement and process improvement initiatives.

Recommendation 6: Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.
Data mapping issues are not uncommon, particularly as there is no universally approved data dictionary or data governance protocol. Differences between vendors in coding discrete data elements has led to issues related to the transmission of C-CDA documents and their ability to be easily integrated into the EHR. While the use of standardized languages is required (e.g., SNOMED-CT, LOINC, RxNORM, ISO-9000,

etc.), more needs to be done to ensure that all systems are operating under the same guidelines and providing their customers with the same level of adaptability while maintaining structure.

We also recommend that CMS consider requiring that EHR vendors provide these updates at low or no cost.

Recommendation 7: Adopt additional data standards that make access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.
We support this recommendation and believe the incorporation of HIEs into this process may be very beneficial. The institution of HIEs as "mediators" and "facilitators "of data could function as a great mechanism to continuously foster effective data exchange.

Vendors must be held to a higher standard to offer "ready to use" clinically appropriate quality and patient data reports. Major strides have been made with the increased use of data repositories, but many organizations and clinicians are still not able to easily pull data reports, which limits their visibility into performance or improvement opportunities.

Recommendation 8: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.
We support this recommendation. CMS should consider the mechanisms by which provider data is housed and maintained. NPPES and PECOS often take many weeks to update, and these updates then take several more months to reach other data sources, such as the QPP Participation Look-up Tool or CMS QPP Portal. Due to this lack of timely updates, there is often a great deal of confusion on the part of the clinicians and organizations working to determine participation and clinician requirements. Utilizing an open API system would make it easier to update and provide access to data, which is not currently available.

Recommendation 9: Consider the feasibility of adopting a first-year test reporting approach for the newly developed electronic clinical quality measures.
We support this recommendation. The primary challenge with reporting on newly developed eCQMs is the ability of vendors to integrate necessary workflow elements into the newly developed measure algorithm or process. With these measures being released so close to when the reporting period is slated to begin, vendors have limited time to develop, code, test and implement necessary changes. Including a test reporting period for newly developed eCQMs would likely increase the quality and accuracy of data reported on these measures as well as allow time for vendors and organizations to establish more consistent and cohesive workflows.

First-year test reporting would allow time for implementation by end users or "incentivized field-testing" of participants prior to adoption or requirement in program. This will be especially helpful to clinicians in which there are few eCQMs available in their specialty, so the increase in available measures could move quickly requiring a faster pace in adoption.

Recommendation 10: Continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project.

Following the Meaningful Measures initiative, it will be essential for CMS/ONC to evaluate the number, clinical focus/domain and measure requirements of all existing and newly developed eCQMs. Many of the eCQMs do not allow for various provider specialties to select applicable measures, and vendors are also not enabling report generation functionality that meets user needs. Evaluating the landscape should demonstrate the need for a more robust and clinically applicable eCQM measure set, but also one that is not overly complex and burdensome.

Standardization of an eCQM calculation engine that vendors could potentially "hook into" (preferably) or incorporate and align with existing data standardization would reduce time on vendors, which in turn reduces time and expense for practices. We commend the participants in the eCQM Strategy Project.

Recommendation 11: Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.
We support this recommendation. Additional time, training and after-sales experience with the EHR vendor, in addition to technical support, is lacking with some systems, which creates a need for less burdensome and time-consuming options for practices.

Additionally, we recommend that CMS require EHR vendors to provide the eCQM reports quarterly for review at a cost-neutral fee versus presenting them in one annual report.

PUBLIC HEALTH REPORTING

Strategy 1: Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.

Recommendation 1: Federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules, to improve timely access to medication histories in PDMPs. States should also leverage funding sources, including but not limited to 100 percent federal Medicaid financing under the SUPPORT for Patients and Communities Act, to facilitate EHR integration with PDMPs using existing standards.
We highly support integration of EHRs into PDMPs while recognizing a number of barriers that need to be addressed. One of the challenges is the lack of the use of common industry standards between the various groups that use PDMPs. Also, PDMPs are maintained at the state level, so there are variances from state to state. Every effort should be made to help make this data interoperable and minimize the state-to-state variances so that PDMPs are able to show an accurate account of prescription opioids, no matter the state in which the patient has filled the prescription.

In addition, not all PDMPs are utilizing the same messaging standards. This can hinder integration into EHR technology because the EHR may have to conform to several different states' individual requirements. An effort to work on setting a national standard similar to the Immunization Information Systems (IIS) community would be very beneficial, so that there is a single base standard that can be utilized by the EHRs to be able to interface with the PDMPs without extensive customization. Best

practices on workflows could also be developed so EHR vendors could implement the PDMP information back into their system in a meaningful way.

We highly recommend expanding successful projects that promote the integration of PDMPs into EHRs, such as the PDMP Electronic Health Records (EHRs) Integration and Interoperability Expansion (PEHRIIE) Program. This program demonstrated success in all nine original project states. Expansion of this project to other states will further reduce burden as well as address the opioid epidemic.

Recommendation 2: HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.
While we support this recommendation, it is important to consider that the SUPPORT Act also requires DEA to update multi-factor authentication requirements that will permit biometrics and modern approaches to authentication that can be more easily integrated into provider workflows. While this technology can be extremely useful, actual implementation and ease of use vary from one vendor to another. We recommend universal requirements that incorporate best practices from a provider perspective.

Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

Recommendation 1: HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.
We agree that key stakeholders should convene to inventory the specific Public Health Reporting Registries that are set up and review data elements that are available for capture to convey these elements to the EHR systems. This inventory would provide an easier manner for providers and EHRs to educate the providers about the necessary information to report correctly to the Public Health Reporting Registries. If there is also data that the public health systems utilize that would be useful within EHR systems, it may be beneficial to create interfaces that might help the EHR systems as well (similar to the bidirectional query messaging that EHRs utilize with IIS currently).

Recommendation 2: HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.
We agree that there should be continued efforts to streamline the reporting process across public health so that it is less burdensome for the provider. As long as the required information is provided in the EHR to interface with a public health system, the provider should not have to do anything additional. Recommendation #1 above should help EHR vendors understand more specifically what is needed for the reporting and can be worked into the workflow accordingly by requiring the information or

presenting warnings or messages to the provider when information is not present or further action is needed to be taken.

Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.

We urge HHS to provide additional guidance about the federal confidentiality of alcohol and drug abuse patient records regulation (42 CFR Part 2). Outreach and education are very much in need for both health care providers and health IT vendors. A forum to share best practices on complying with 42 CFR Part 2 would also be very much welcomed. Education on the availability of new technical standards and technologies to enable privacy and data segmentation of health information is also needed. Technical assistance is especially needed to help small, rural healthcare providers and organizations use existing health IT solutions to protect patient privacy and manage patient consent.

Thank you for the opportunity to comment above on the draft strategy. We believe our observations, comments, and recommendations are aligned with and in support of ONC, as well as the long history and demonstrated successes of the QIN-QIOs in partnering with HHS to achieve substantive improvement in health care quality.

Regards,

Alison Teitelbaum, MS, MPH
Executive Director