January 28, 2019

Dr. Donald Rucker, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator (ONC)
200 Independence Avenue, S.W.
Washington, DC 20201

Regarding: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Dr. Rucker:

We are writing on behalf of the Association of Public Health Laboratories and the unique role it plays in facilitating interoperability between healthcare and public health in the United States. APHL operates the APHL Informatics Messaging Services (AIMS), the pre-eminent public health shared services platform that has been developed with assistance from the Centers for Disease Control and Prevention (CDC).

The AIMS platform supports Promoting Interoperability - compliant data exchange and transformation services for public health and for clinical care to connect to public health. AIMS currently exchanges more than 25 million messages monthly and is working with over 80 data exchange partners in including all States.

AIMS pays a central role in supporting electronic Case Reporting (eCR) and electronic laboratory reporting (ELR) and other important public health initiatives. AIMS offers a single, consistent interface for clinical care and Electronic Health Records (EHRs) to connect to public health agencies and thus supports the needs of the clinical care and public health communities.

We appreciate the opportunity to submit comments on ONC’s draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, a part of the statutory requirements of §4001 of the 21st Century Cures Act.

Electronic Health Records (EHRs) have greatly increased the ability to appropriately and quickly share health information and enhance the ability of public health agencies to promote, protect, and preserve population health in our communities. Rapid reporting of diseases allows for early detection and the prevention. Without electronic exchange, clinicians are burdened with manual reporting processes. Manual reporting is often incomplete, and providers then need to respond to follow-up investigation and additional data needs.
Public health is sympathetic to the burden that providers of care feel subsequent to the rapid adoption of Electronic Health Records (EHRs). And there are complex rules and regulations that have been put into place to try to help create a nationwide electronic infrastructure that can support the betterment of the health of the population. Public health, for its part, is working hard to minimize provider burden while still meeting statutory public health requirements and essential goals for protecting population health.

We write to commend the efforts of all the working groups created to tackle these difficult problems and to suggest that framing some of the issues more specifically will be helpful for all of the working group areas: Clinical Documentation, Health IT Usability and User Experience, EHR Reporting, and Public Health Reporting. We believe these comments have relevance to all working group threads and that separating these activities actually adds to provider challenges.

True Provider Burden

- The Strategy should tease out the burden of healthcare providers from the effort of EHR vendors. There are interconnections between the two, but the substance of each differs and strategies to address them need to be considered separately.
- Most electronic public health efforts automate the accomplishment of statutory reporting requirements and, when fully implemented, actually ease provider burden of what otherwise is difficult and time-consuming manual reporting. Real-time interoperability not only lowers burden but brings value to providers by supplying information such as consolidated immunization records and forecasts at the point of care.
- Without more detailed analysis in the Strategy, anecdotal statements such as the one in Public Health Reporting Strategy 2 Recommendation 1 that “Public health–related activities are known to contribute to administrative burden for physicians” are unclear and not constructive. Despite organizational separation in the United States, many public health activities are critical to population health and the functioning of our healthcare “system.”
- Actual provider burden is minimized when programs like electronic Case Reporting (eCR), electronic laboratory reporting (ELR), immunization reporting, and syndromic surveillance: 1) work off of data that are already recorded for the purposes of care, 2) are consistently implemented, and 3) minimize or eliminate provider manual data entry and reporting.
- Perceived provider burden is also ameliorated by useful information and demonstrable value being returned to providers. Returned value like immunization forecasting, the electronic Case Reporting “Reportability Response” and others can help address perceived burden if their programs are fully advanced.
- One connection between provider burden and EHR vendor burden is the cost to providers of adding optional interoperability modules for public health. These costs can, and should, be driven out of the system by simplifying the current variability of implementation and making statutorily required public health data exchange a requirement of all EHRs and not an option. Appropriate reporting and response capabilities should be an included capability of every basic EHR. As a required component, providers should not incur add-on charges for meeting requirements for activities that are required by law.

EHR Vendor Challenges

- Many issues for EHR vendors arise from the variations in the way their products store and share data more than variations in public health systems. We commend the recommendations in the report that
encourage more consistent coding of data in EHRs which would, in turn, have a significant positive impact on decreasing the effort of all kinds of data exchange.

- It is also important to separate out issues that may originate in activities associated more with information blocking than from substantive technical or operational challenges to implementation. Anecdotal assertions of burden without a more detailed analysis of causality does not help either healthcare or public health.

- EHR and health IT reporting infrastructure in clinical care can be better coordinated / standardized to further minimize the effort needed to report to payers, government agencies, public health and others. All of these reporting efforts can share more standards and EHR infrastructure and resultantly minimize effort.

- Public health is working in the HL7 standards development organization to try to coordinate reporting tools and infrastructure. Programs like the Da Vinci healthcare payer project and government quality reporting can be brought together with public health to use common EHR reporting approaches and tools. Moving forward, automated interface development is quite possible under the HL7 FHIR API standards and would further reduce EHR vendor effort if supported.

- Public health is also working hard to also be sensitive to the EHR vendor challenges of jurisdictional variability. Immunization information systems have made tremendous progress in making standardizing interoperability requirements, facilitating both submission of data and query of the consolidated record at the point of care. The electronic Case Reporting “all condition, all jurisdiction” HL7 eCR standards and the Council of State and Territorial Epidemiologists (CSTE) and Centers for Disease Control and Prevention (CDC) Reportable Condition Knowledge Management System (RCKMS) can help eliminate all EHR vendor challenges of State and Local variability for case reporting – if they are consistently advanced.

Promoting Interoperability Measures

- These burden-reducing public health programs need the help of the Promoting Interoperability Measures and other incentive programs to be consistently advanced going forward. Menu option programs are not consistently implemented, they cause problems because of these irregularities, and existing implementations will lose clinical care participants when EHRs are upgraded / changed if they do not have ongoing support.

- The public health Promoting Interoperability measures have proven to be an effective tool for advancing the exact kind of nationwide consistency that is identified as being needed in this Strategy. Continued support of these measures will allow both public health and clinical care to further benefit from the significant investments made to date in exchanging health data.

- The implementation of the Promoting Interoperability measures is unduly complex. Complicated formulas, menu items, and inconsistent implementation are problematic.

- We support the Strategy’s call for the significant simplification and a focus on interoperability for Promoting Interoperability. We believe that this can be achieved, in part, by making the core public health measures required, eliminating the complex formulas, and making sure that all EHRs implement the systems needed to support statutorily required reporting.

- Continuing to advance the Promoting Interoperability measures can also be used to recognize the accomplishments of those that already report.

Beyond an Inventory
• Public health reporting is an activity that involves State and Local public health agencies and clinical care as well as the Federal programs recognized in the strategy.
• Other, more inclusive and action-oriented strategies beyond a new Federal inventory will be important to enduring solutions:
  o Consensus-based standards play an important role when there are so many different EHRs, clinical care organizations, and public health agencies.
  o State and Local public health agencies should be better supported in standard development organization participation
  o Federal programs should be required to support the development of consensus-based standards for all data “asks” so that manual provider data entry is minimized and the broad value of real-time interoperability can be realized.
  o APHL provides input on use cases and workflows to HL7, whose responsibility is to provide a framework and related standards for the exchange, integration, sharing and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services.
  o APHL holds laboratory leadership roles in advancing the way computer systems in healthcare share information with IHE (Integrating the Healthcare Enterprise).
• There is now a CDC Data & IT Transformation strategy that should be considered too get faster, better health data because current IT and data collection systems are failing and we are in danger of losing our ability to defend our nation’s health. Connecting to EHRs is a critical part of this strategy.
• Just as elsewhere in healthcare, there are real challenges to interoperability that need to be addressed. But from a provider burden perspective, the Strategy should focus on: advancing interoperability through consistent clinical data, data reuse, efforts like the USCDI that can establish a base for electronically available clinical data, and adding provider value through bidirectional communications.

We will be pleased to discuss these strategies to help make ONC’s Strategy as successful as possible. The national public health associations want to reduce burden wherever possible for all the participants in the nation’s health system.

Sincerely,

Scott Becker, Executive Director
Association of Public Health Laboratories