



January 28, 2019

Don Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator (ONC)
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Request for Information (RFI): Strategy on Reducing Burden Relating to the Use of Health IT and EHRs, Request for Comments

Response submitted via online submission <https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs>

Dear Dr. Rucker,

Please find enclosed comments from the Council of State and Territorial Epidemiologists (CSTE) on the Office of the National Coordinator's (ONC's) RFI: "Strategy on Reducing Burden Relating to the Use of Health IT and EHRs," part of the statutory requirements of §4001 of the 21st Century Cures Act.

CSTE is an organization of member states and territories representing all states and territories and over 1900 applied public health epidemiologists. CSTE and all epidemiologists at federal, state, and local public health agencies have a vested interest in the successful support and implementation of effective use of health IT and electronic health records (EHRs) in healthcare facilities across the continuum of care. While the potential is not fully realized, interoperability and EHRs have been proven to provide avenues to improve the quality of care, decrease the burden of public health reporting on providers and hospitals and improve the timeliness and accuracy of information exchange between the clinical sector and public health to improve population health and identify, monitor, and respond to events of public health importance.

CSTE provides a national voice and support for state and local health departments to conduct surveillance, outbreak investigations, laboratory testing, and prevention of communicable and non-communicable diseases and conditions. Public health action by CSTE member states has led to improvements in clinical practice, medical procedures, and the ongoing development of evidence-based policy, guidance and prevention successes. Conducting surveillance, investigating and responding to outbreaks, and harnessing the power of data to accelerate disease prevention through the use of population-based information is a critical aspect of patient health and safety with the ability to collect identifiable, patient information necessary to respond effectively, codified by state laws and regulations.

CSTE's mission is to promote effective use of epidemiologic data to guide public health practice and improve health, and advocate for epidemiologic capacity, resources, and scientifically based policy. CSTE, with close collaboration and input from the Centers for Disease Control and Prevention (CDC) and other stakeholders, also works to coordinate public health surveillance efforts across states and jurisdictions. CSTE has partnered with CDC and other stakeholders on the development of standardized surveillance, indicators and novel surveillance methods for state and local public health departments to address disease and condition surveillance challenges. Additionally, CSTE

leads, in collaboration with CDC, in determining which diseases and conditions should be under standardized surveillance and which should be designated as “nationally notifiable,” which means having codified voluntary notification of case data from states to CDC.

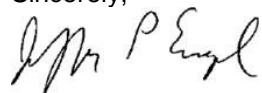
CSTE applauds the ONC for supporting interoperability efforts to improve provider care delivery by incorporating beneficial new information technologies and furthering innovation. **CSTE is an engaged partner in the Digital Bridge project, assisted in the development of the Digital Bridge comments to this RFI and is a co-signatory to the comments submitted by the Digital Bridge.**

CSTE is deeply invested in reducing the burden of utilizing health IT and to focus provider energies and effort on caring for patients while at the same time protecting and improving population health. Quality data collected and summarized at the right time lead to informed decisions, which lead to improved interventions and better health outcomes. Selected technologies should facilitate more time for clinicians to focus on clinical care, for laboratorians to perform testing and public health to focus on public health functions. **CSTE appreciates** ONC’s focus on reducing burden regarding the use of health IT; however, it is also critically important to recognize those areas where health IT brings value or can bring value if fully optimized, re-structures medical record documentation to reduce burden for providers and users, improves individual patient care and ultimately improves population health and health outcomes of future generations through effective public health efforts. CSTE offers a unique and formative perspective on public health reporting and while we acknowledge gaps remain to fully realize the benefits of health IT, EHRs and interoperability, public health, is working hard and vested in minimizing provider burden while still ensuring statutory public health requirements necessary to protect the public’s health are met.

CSTE commends the efforts of the four workgroups established by HHS to tackle difficult issues and challenges: Clinical Documentation, Health IT Usability and User Experience, EHR Reporting, and Public Health Reporting. The Digital Bridge comments supported by CSTE have relevance to all four working groups, not just Public Health Reporting. **Additionally, CSTE recommends** the overall report strategies and recommendations on page 13-14 be further modified specifically, the third bullet, to indicate the “Strategies should include actions that improve the clinical documentation experience, improve patient care *and improve public and population health.*”

Like ONC, CSTE recognizes the responsibility and increased need for public health to effectively and optimally leverage EHRs and health IT to anticipate, prevent, prepare for, respond to public health threats and improve population health. CSTE has a foundational perspective to provide comment and insight into the use of health IT and EHRs to further public health surveillance and reporting. Further, more detailed comments related to public health reporting are below. CSTE appreciates ONC’s consideration of these comments and looks forward to future collaborations with ONC including contributing to in-person meetings, listening sessions, and workgroups. We would be happy to address any questions or concerns relating to these comments by email or phone (jengel@cste.org or 770-458-3811) and we look forward to exploring new ways to work more closely together.

Sincerely,



Jeffrey P. Engel, M.D.
Executive Director
Council of State and Territorial Epidemiologists

Comments on public health reporting:

Excerpt, page 13, “Specifically, in the FY 2019 IPPS/LTCH PPS final rule and the CY 2019 Physician Fee Schedule final rule, CMS added two new measures to the Promoting Interoperability Program focused on EPCS that together support broader HHS efforts to increase the use of PDMPs.”

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 and 2.

CSTE applauds ONC for inclusion of efforts improve substance use and opioid surveillance and treatment and is supportive of this Strategy and Recommendations. While EPCS and PDMP are critical, **it remains necessary to continue to emphasize and support the benefits from previous areas of focus and to maintain existing integrations with fundamental public health areas** like electronic laboratory reporting (ELR), immunization registries, syndromic surveillance and electronic case reporting (eCR). Gaps remain and there is necessity to continue to advance the previous designated goals and their advancements. CSTE member jurisdictions can demonstrate that incentivizing clinicians through the Promoting Interoperability Programs is the most effective way to ensure the interoperability needed to share clinical data with public health. Public health has already seen great successes in the previous stages of Meaningful Use (MU) through partnerships with eligible clinicians and hospitals to report to public health.

Currently CSTE is advancing multiple priorities to further population-wide surveillance efforts to assist in understanding the opioid epidemic including the development of two surveillance case definitions: (1) [nonfatal opioid overdose](#) and (2) neonatal abstinence syndrome. The development of these surveillance case definitions will supplement existing surveillance practices, as well as enhance timely and coordinated community responses to opioid overdoses. Additionally, these efforts will provide jurisdictions an agreed-upon public health approach to ascertaining, quantifying and releasing data on nonfatal opioid overdoses and neonatal abstinence syndrome across data sources and jurisdictional boundaries to accurately assess and respond to the epidemic. Previous focus areas of eCR, ELR and syndromic surveillance are a foundational component of these public health surveillance strategies needed to effectively address the opioid epidemic.

Excerpt, page 41: “Currently, public health reporting and reporting related to population health data under federal grant programs require clinicians to create and support numerous interfaces to public health entities, each of which may require custom changes to reports and/or duplicative entry into unique forms.”

Public health is an integral part of providing healthcare delivery to individuals, in partnerships with healthcare providers, as well as serving as the only health infrastructure for collecting data for evidenced based decisions that improve health for all. Clinician participation in legally mandated public health reporting requirements has been long established as necessity to improve and protect population health. Unfortunately, it is often not well understood and current reporting practices are largely manual and use of an optimally designed EHR should streamline rather than increase reporting burden. For example, instead of taking time to mail or fax information, the information already documented in the EHR can now be instantaneously submitted to public health; thus, leveraging the EHR and employing the use and re-use concept. Public health successes to reduce provider reporting burden exist: electronic laboratory reporting (ELR), syndromic surveillance, and immunization registry reporting where data is submitted to public health that are already recorded for the purposes of care and reporting or data submission occurs without provider involvement or action. Projects like the Digital Bridge and electronic case reporting (eCR) can further capitalize on these public health successes. The public health

community has worked hard to standardize, and although these efforts continue, public health has streamlined data exchange significantly.

CSTE also recognizes, there are differences in public health reporting that are driven by differences in functions needed to protect the public's health codified in state and local laws. State and local reporting represents the vast majority of the interoperability between public health and clinical care. Submission of data from state and local public health to the Federal government is often secondary to the ways public health data is used to meet state and local needs. Further streamlining Federal grant program requirements will also support state and local health department health IT infrastructure needs. Consensus-based standards are necessary, and representation needs to be included from clinical care and public health as well as the vendors responsible for creating effective implementations and products. Federal programs should support adequate funding for public health to close the digital divide providing funding for system implementation, security, and workforce development. Projects like the Digital Bridge, HL7 eCR standards and the CSTE and CDC Reportable Condition Knowledge Management System (RCKMS) can help eliminate EHR vendor challenges of state and local variability for case reporting – if they are consistently funded.

Excerpt, page 41: “Moreover, while many implementation guides advise health care providers to submit syndromic surveillance feeds to state health departments every 24 hours, certification cannot enforce this reporting timeline and some jurisdictions require different timelines.”

In a collaborative effort between the CDC, International Society for Disease Surveillance, the Syndromic Surveillance Community, and the National Institute of Standards and Technology (NIST) developed and then updated several times national electronic messaging standard that enables disparate healthcare applications to submit or transmit administrative and clinical data for public health surveillance and response. The PHIN Messaging Guide for Syndromic Surveillance provided an HL7 messaging and content reference standard for national, syndromic surveillance electronic health record technology certification as well as a basis for local and state syndromic surveillance messaging implementation guides. While this standard has continued to be balloted and amended, public health welcomes additional participation in development of the guide. Public health has also been surprised by the lack of some EHR vendor capacity to send records to public health within 24 hours of a patient encounter. Patient records generated at the time of presentation to the emergency department and recorded in an EHR are often submitted 3-4 days late. **CSTE recommends** that, in addition to development of standards documenting where and how data should be stored, transmission certification standards be developed to ensure timely communication of data necessary to support optimal patient care and public health surveillance efforts. CSTE fully supports the further integration of standards and best practices to increase the value of interoperability from EHRs.

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.

CSTE supports this recommendation. Projects like the Digital Bridge, HL7 eCR standards and the CSTE and CDC Reportable Condition Knowledge Management System (RCKMS) can help eliminate EHR vendor challenges of state and local variability for case reporting. In addition to a federal inventory, and identification of common data elements but focus should include public health representation and development of consensus-based standards to collect and transmit common data elements.

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.

CSTE supports this recommendation but cautions that some variability of reporting requirements supports distinctive needs. While further streamlining Federal grant program requirements will also support state and local health departments to streamline their individual health IT infrastructure and needs to meet those federal reporting requirements. It is also important to note some issues surrounding variation also arise from the lack of standardization in how EHR products store and share data rather than variations in public health reporting systems or the federal grant programs, as a result harmonization, efforts should also focus on EHR data storage and utilization of standards.

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.

CSTE supports providing guidance about HIPAA privacy requirements. Further education should be provided to improve coordination across healthcare providers, health IT vendors regarding data sharing governed by 42 CFR part 2 requirements with specific education and support of data sharing *with* public health. Similarities of substance use disorder and the opioid epidemic can be drawn to the early days of the HIV/AIDS epidemic. A lack of knowledge and understanding of allowable data sharing often leads to no data sharing, simply because what is allowable is not understood.