January 28, 2019

RE: Public Comment on the Office of the National Coordinator for Health Information Technology's Draft Strategy on Reducing Burden Relating to the Use of Health IT and EHRs

Submitted online at https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

This comment is submitted on behalf of the Fenway Institute at Fenway Health. The Fenway Institute works to make life healthier for those who are lesbian, gay, bisexual, and transgender (LGBT), people living with HIV, and the larger community. We do this through research and evaluation, education and training, and policy analysis. We are the research division of Fenway Health, a federally qualified health center (FQHC) and Ryan White Part C HIV clinic in Boston, MA. Fenway was founded in 1971 and currently serves about 32,000 patients each year.

We have long shared ONC and HHS's vision about the promise of leveraging health IT to build a nationwide, interoperable, value-based, person-centered health system. We have participated in Meaningful Use and EHR certification rule-making processes, supported the *Nationwide Interoperability Roadmap*, have commented on every version of the *Interoperability Standards Advisory* (ISA), and have provided feedback on the *Draft Trusted Exchange Framework and Common Agreement* (TEFCA). For almost a decade, we have trained health centers on EHR utilization and organizational transformation to collect sexual orientation and gender identity (SOGI) data to improve quality of care for LGBT patients. We also share HHS's commitment to reducing burdens associated with the utilization of EHRs and health IT for providers and healthcare organizations.

To this end, the continued and increased inclusion and availability of SOGI standards in health IT product certification requirements and public health reporting mechanisms can constitute a reduction in burden for healthcare organizations, providers, and the entire healthcare system.

Mature SOGI standards are included in 2015 base EHR certification criteria and in the ISA. Additionally, all FQHCs and community health centers are required to include SOGI data in annual Uniform Data System (UDS) reports to HRSA's Bureau of Primary Health Care (BPHC). As recommended by the Institute of Medicine,[1] The Joint Commission,[2] and the Centers for Medicare and Medicaid Services (CMS) Equity Plan,[3] providers having access to patients' SOGI data is essential to providing high-quality, patient-centered care to all patients.

As the nationwide health IT infrastructure continues to grow, expand, and become increasingly interoperable, SOGI data and other patient data should populate in patient records and be used in clinical decision support and anatomical inventory forms, thus becoming immediately useful as actionable

and clinically-informative data.[4] This will lead to improved quality of care and reduced clinician and data utilization burden and fragmentation of data. Further, health IT systems such as patient portals, Health Information Exchanges (HIEs) used to populate data in patient charts, and electronic patient reported outcomes (ePRO) tablets provided to patients at intake can all help ensure that providers and informatics teams have access to patient demographic data, including SOGI, in ways that do not increase provider burden and in fact reduce overall burden on healthcare organizations. When providers do discuss a patient's sexual orientation or gender identity during a clinical visit, this can facilitate discussions of preventive screenings, risk reduction, family and social support, behavioral health concerns, and other topics critically important to patient-centered care.

Because SOGI are already included in the 2015 Base EHR definition and in the UDS instrument required by all FQHCs, there is a growing amount of high-quality SOGI-inclusive demographic data in the increasingly interoperable health IT ecosystem. However, as ONC notes on pp. 41-42 of the burden reduction strategy ("Inconsistent Public Health and Grant Funding Requirements across Federal Agencies"), FQHCs and safety net providers are currently burdened with filing multiple different reports to federal funders. Many of the demographic criteria in these reports – e.g. the UDS and the Ryan White Service Report filed with HRSA's HIV/AIDS Bureau – are not in alignment.

Lack of alignment in both reporting and eCQMs among CMS, HHS and other payers has created a significant burden on both non-clinical and clinical staff. As an FQHC, we receive funding from several HHS departments who each have differing reporting requirements, structures and submission processes; consequently, current reporting is extremely time consuming and burdensome on HIT staff whose efforts alternatively could be directed in supporting patient care. HHS should develop reporting systems that can ingest consolidated clinical document architectures (CCDAs) or fast healthcare interoperability resources (FHIR) so data could be submitted through an automated process using HIT. A system like Electronic Medical Record Support for Public Health (ESP) could serve as a model for future development of systems to monitor and submit reportable information.[5,6]

The reduction goals described on pp. 41-42 are aimed at helping FQHCs, community health centers, and safety net providers reduce public health reporting burdens. Since all FQHCs are already required to fill out UDS reports, we recommend utilizing the demographic elements in the UDS as the baseline for harmonizing reports required by different HHS and public health funders. Along with demographic elements included in 2015 EHR certification criteria, using UDS demographic elements as a baseline for public health reporting would assist health IT developers in developing consistent demographic templates. This would reduce burden in generating data reports for informatics teams and would increase the amount of high-quality demographic data, including SOGI, in the interoperable health IT ecosystem. These data can then easily be used to reduce health disparities and improve the quality of care for LGBT people and all patients.

In addition to the above recommendations, we also would like to comment on the following:

- Prior Authorizations: Obtaining prior authorization and insurance verification is a manual and time-consuming process which sometimes results in the delay of treatment or additional health care expenses to a patient. We support automation in obtaining prior authorization as well as verifying patient insurances in order to reduce burden on both non-clinical and clinical staff. Receiving automated notification in the EHR, along with denial reason(s), would be a significantly reduce burden on staff. Additionally, a central repository should be created that contains prior authorizations that are required by each insurer. EHR systems could validate against this database to inform care.

- Confidentiality of Substance Use Disorder (SUD) Patient Records (pg. 43) - 42 CFR Part 2: In regards to 42 CFR Part 2, it is critical to ensure that disclosure occurs only with patient consent. Currently, EHR systems do not have a mechanism to protect the confidentiality of SUD records. This is particularly critical in light of the opioid epidemic where this could be a barrier to someone accessing care. We support the use of HIT to protect and prevent unauthorized use of information being shared.

- Clinical Decision Support (CDS):
  1. A major challenge is the lack of standardization across EHRs for how clinical decision support is implemented, structured and maintained within EHRs. The development of such tools should come from the ONC as opposed to individual EHR vendors to developing their own tool. An *Office of the National Coordinator* for Health Information Technology (ONC) certification requirement is needed in order to ensure all EHRs use an identical structure for CDS. Creating a certification standard that includes specifications and certification criteria adopted by all EHRs will enable the use of a centralized clinical decision support repository regardless of vendor. Additionally, EHRs should have a pre-built interface connecting to the central repository.
  2. Given the volume of CDS measures, being able to identify the most pressing measures for a patient can be challenging for a clinician given time constraints and competing demands during visits. A coding system that has visual cues indicating prioritization of preventive screening, tests, and other care needed based on a patient's profile will assist clinicians in identifying the most important issues to address with their patients.
  3. Establishing a central repository for CDS measures is critical. This will allow technical staff to have one reliable and up-to-date location for all measures. Additionally, measures from CMS or other governing bodies should be co-located in the central repository. When an update is made to an existing guideline, it will be crucial to have the updates easily identifiable to the end-user so they can understand the implications of how this will impact screening,

eligibility criteria, clinical workflows, and/or cost. Changes or updates to clinical guidelines need to be easily discernable within both a central repository and an EHR.
4. A more comprehensive vocabulary is needed in LOINC and SNO-MED in order to ensure that clinical guidelines can be trigger correctly within EHR systems.
5. Updating a guideline or CDS tool alone is insufficient. EHRs need to develop automation where a lab test would automatically be prioritized or ordered to a list of labs a patient is due for that visit. Systems that can replace a manual process with an automated process will have a high degree of impact on clinicians, and ultimately, patient outcomes. This will increase the likelihood that a patient who meets certain screening criteria will actually get the lab done.
6. Improve visibility of clinical guidelines and CDS for various roles in health care organizations. Screening rates have a higher likelihood of increasing if they are visible to all clinical staff (e.g. Medical Assistants, Clinical Assistants, Nurses, etc.) and not just mid-level or higher clinical staff.
7. Future evaluation of CDS would benefit from analyzing patterns of both compliance and non-compliance with the implemented measures. Interviewing a select group of clinicians to understand both the facilitators and barriers that contributed to different patterns of utilization and compliance rates will also provide invaluable insight.

Should you have any questions, please contact Sean Cahill, Director of Health Policy Research, at scahill@fenwayhealth.org or 617-927-6016. Thank you for considering our comments.

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[1] Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities; Board on the Health of Select Populations; Institute of Medicine. 2011. The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People: Building a Foundation for Better Understanding. Washington, DC: National Academies Press.

[2] The Joint Commission. (October 2011). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender Community: A Field Guide. http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf

[3] Office of Minority Health. (September 2015). The CMS Equity Plan for Improving Quality in Medicare. Centers for Medicare and Medicaid Services. https://www.cms.gov/about-cms/agency-information/omh/omh_dwnld-cms_equityplanformedicare_090615.pdf

[4] Chris Grasso, Michal J McDowell, Hilary Goldhammer, Alex S Keuroghlian; Planning and implementing sexual orientation and gender identity data collection in electronic health records, *Journal of the American Medical Informatics Association*, Volume 26, Issue 1, 1 January 2019, Pages 66–70, https://doi.org/10.1093/jamia/ocy137

[5] Birkhead GS, Klompas M, Shah NR. Uses of electronic health records for public health surveillance to advance public health. Annual Review of Public Health. 2015 Mar 18;36:345-59. doi: 10.1146/annurev-publhealth-031914-122747. Epub 2015 Jan 2. PubMed.

[6] Vogel J, Brown JS, Land T, Platt R, Klompas M. MDPHnet: Secure, distributed sharing of electronic health record data for public health surveillance, evaluation, and planning. American Journal of Public Health 2014;104(12):2265-70. PubMed.