surescripts

July 31, 2017

The Honorable Donald Rucker, MD.
National Coordinator for Health Information Technology
Department of Health and Human Services
Submitted electronically to: https://www.healthit.gov/policy-researchers-implementers/interoperability/Proposed_Interoperability_Standards_Measurement_Framework_Public_Comments

Re: Proposed Interoperability Standards Measurement Framework Public Comments

Dear Dr. Rucker:

Thank you for the opportunity to submit comments regarding the Office of the National Coordinator for Health Information Technology's (ONC) Proposed Interoperability Measurement Framework.

Surescripts operates the nation's largest clinical health information network. Founded in 2001 by pharmacies and pharmacy benefit managers to enable e-prescribing, the company has moved beyond that product and today offers a wide portfolio of clinical messaging services. We now serve providers and patients in all 50 states and the District of Columbia and deliver over 700,000 clinical health transactions every hour. Every day, more than 70 percent of all office-based providers use our services on behalf of over 3 million patients. We connect to over 99 percent of all retail pharmacies and most mail order pharmacies in the country, and we delivered over 1.6 billion prescriptions and 1 billion medication histories to providers this past year. Our provider directory contains over 1,000,000 prescribers and our Master Patient Index covers 270 million insured lives.

Over the past several years, Surescripts has made considerable research and development investments in products that will enable providers to deliver the high-value care envisioned in ONC's Shared Nationwide Interoperability Roadmap (the Roadmap) and the Medicare Access and CHIP Reauthorization Act (MACRA). As just one example, we are using the network assets we have developed over the past 15 years while operating within the nationwide Carequality Interoperability Framework to create a National Record Locator Service (NRLS) that will offer providers a fast and easy way to obtain historical patient visit locations and retrieve clinical records, regardless of geography or EHR systems. NRLS already includes 230 million patients and more than 4 billion clinical interactions by referencing historical Surescripts network activity. NRLS is now live and transacting in 12 metropolitan areas across 28 health systems. To date, NRLS has received 15 million requests for patient location information and has provided 9 million location summaries to our customers.

We strongly support your effort to create a set of uniform and trackable nationwide interoperability measures and we look forward to participating in the development process. We have a long history of collaborating with ONC in its effort to track and measure adoption and utilization of certified HIT. In the early stages of the Meaningful Use program, ONC used our e-prescribing transaction data as a proxy to measure EHR adoption rates. ONC subsequently employed our data to identify areas of need and to more efficiently deploy resources in support of providers who had not yet adopted. We look forward to continuing our collaboration as your organization works to build a measurement framework consistent with the goal of delivering relevant data to the clinical setting where and when it is needed for the patient.

The measurement framework approach you have outlined is a good foundation but in future iterations it will be important for ONC and those of us in the stakeholder community to focus on the quality and usability of the data that is being exchanged. As Surescripts has learned over 15 years of delivering patient-level medication history and eligibility to the point of care, timing is critical to the value of data exchange. Learning whether data exchange is occurring in near or real time and in a form that is actually used by providers in clinical settings should be at the heart of any effort to measure the progress towards improving patient care and achieving an interoperable learning system.

Attached are responses to questions outlined in the RFI. We have limited our responses to items we can address based on our experience managing a national interoperable network built on transaction data measurements for interoperability. Once again, we appreciate the opportunity to share our recommendations in response to the RFI. It has been our privilege to collaborate with the Office of the National Coordinator over the past 15 years, and we look forward to continuing our work with you.

Sincerely,

Mary Ann Chaffee
VP, Policy & Federal Affairs

(Q) Is a voluntary, industry-based measure reporting system the best means to implement this framework? What barriers might exist to a voluntary, industry-based measure reporting system, and what mechanisms or approaches could be considered to maximize this system's value to stakeholders?

(A) A voluntary reporting system should be attempted as a first choice. In order to encourage participation, ONC must provide explicit assurances to the industry regarding how the information will be used and how proprietary concerns will be addressed. Depending on the reporting burden, incentives may be necessary to encourage participation. Aligning the reporting model with existing reporting systems could reduce that burden.

(Q) What other alternative mechanisms to reporting on the measurement framework should be considered (for example, ONC partnering with industry on an annual survey)?

(A) We caution against overreliance on national surveys. In our experience, national surveys can be a poor indicator of both volume and quality of data exchange. As an example, during the first phase of the Meaningful Use program, health service researchers published a number of studies based on survey data that reported lower HIT adoption and use rates among ambulatory providers in rural areas than among their counterparts in urban areas. Surescripts data, based on actual transactions, reflected the opposite: transactions on our network actually showed higher rates of adoption and use among ambulatory providers in rural areas relative to urban providers. We recommend that national survey data be part of a broader menu of information sources. Use of qualitative, survey-based data should be paired with transaction-based data to meet MACRA's requirements that both exchange <u>and</u> use be measured.

(Q) Given that it will likely not be possible to apply the measurement framework to all available standards, what processes should be put in place to determine the standards that should be monitored?

(A) In the initial phase, ONC should focus on standards named in any Federal regulation.

(Q) What, if any gaps, exist in the proposed measurement framework?

(A) As mentioned in our general comments, we recommend the use of qualitative and quantitative data and a broader focus that would address usability and utility of data exchange in the clinical setting. Learning whether data exchange is occurring in near or real time and in a form that is actually used by providers in clinical settings is critical to measuring progress towards improving patient care and achieving interoperability that is valuable to patient care.

(Q) How should ONC work with data holders to collaborate on the measures and address such questions as: How will standards be selected for measurement? How will measures be specified so that there is a common definition used by all data holders for consistent reporting?

(A) ONC should engage the Standards Development Organizations to identify the standards to be reported and should collaborate with the stakeholders who will be asked to report regarding clear definitions of those standards. Defining what is meant by "transaction" will be critical to the success of this effort as will a common understanding of measurement definitions.