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Dr. Don Rucker

National Coordinator for Health Information Technology

United States Department of Health and Human Services

330 C St. SW, Floor 7

Washington, DC 20201

January 28, 2019

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

Dear Dr. Rucker,

I am pleased to submit these comments on the Office of the National Coordinator’s (ONC’s) **Strategy on Reducing Burden Relating to the Use of Health IT and EHRs** report on behalf of the Public Health Task Force on Promoting Interoperability (Task Force). Representing local and state health agencies, the Task Force’s comments embody a broad-based perspective on federal actions that affect programs which are dependent on having vital timely and accurate health information at the individual and community level to inform the development of public health programs, provide care to individual patients, and manage scarce resources to ensure wise use of available resources.

The Task Force membership appreciates ONC’s focus on reducing provider burden regarding the use of health IT (HIT). It is critically important that there is recognition that there are significant benefits in exchanging health information and that a “reduction in burden” can be realized through many mechanisms other than eliminating collection and reporting data such as leveraging partners’ knowledge, skills, and abilities to enhance and expand the utility of the information collected. This approach to leveraging data and technologies across partners have been encouraged by the Centers for Medicare and Medicaid (CMS) and ONC through the Meaningful Use/Promoting Interoperability (PI) programs, such as inclusion of required Application Programming Interfaces, and demonstrates real value in both economic and health terms to users and patients. Public health is an important partner in interoperability and data exchange, reducing provider burden in a number of ways.

One example of the value of the reduction in burden provided to health care providers is the broad availability of individual-level immunization data through real-time Electronic Health Record (EHR)-IIS querying. This machine-to-machine interoperability significantly lowers the burden (and cost) to providers in accessing immunization records and forecasts at the point of care. This service is widely available. Currently, over three quarters of states across the country have this capability, and this functionality is in the process of being developed in the remaining states.

Another example is disease surveillance and follow-up by public health for highly infectious diseases and other notifiable conditions. Using tools like Electronic Laboratory Reporting and Electronic Case Reporting, individual practitioners and hospitals can leverage their investments in technology to automate reporting of these conditions to public health, reducing the amount of repetitive labor by the provider to manually identify and then report data to public health. Where appropriate, public health can participate in providing follow-up care for the individual, such as ensuring adherence to medication schedules for tuberculosis, further reducing the burden on the provider.

Incentive programs such as PI have significantly increased connectivity between EHRs and public health registries such as IIS. Providers have worked hard to prioritize capture and submission of patient data and have added IIS query into their workflow to support clinical care.

As a result of the PI programs, not only do providers have access to more complete data and forecasts, but IIS now have more robust data in systems that support immunization activities across the health care continuum. Systems like IIS allow aggregated data to be shared across a broad number of programs and organizations, including Medicaid, Accountable Care Organizations (ACOs), health plans conducting HEDIS measurement, clinics and health systems providing clinical care and evaluating quality measures, and public health organizations committed to preventing vaccine preventable diseases.

In addition to the comments above, The Task Force provides suggestions on the ONC report in our detailed comments presented on the following pages, organized by page number and section within the report. Please contact me, Steve Eichner, co-chair of the Task Force, at [steve.eichner@dshs.texas.gov](mailto:steve.eichner@dshs.texas.gov), with any questions you may have.

Sincerely,

(signed)

Steve Eichner

Co-Chair, Public Health Task Force on Promoting Interoperability

Attachment: Detailed Comments

## Comments on the ONC Report: Strategy on Reducing Burden Relating to the Use of Health IT and EHRs

| **Page Number** | **Excerpt** | **Comment** |
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| Pg. 13 | The primary burdens in this section relate to: a lack of automated, standards-based public health reporting requirements across federal programs; burden related to electronic prescribing of controlled substances (EPCS); and insufficient interoperability between state prescription drug monitoring programs (PDMPs) and EHRs. | Public Health, health care providers, and vendors have worked hard to improve interoperability and adopt standards to facilitate exchange and provide stability. While this effort continues, we have improved and streamlined data exchange significantly. In recent rule-making activities, the Task Force proposed an approach intended to enable data sharing while recognizing the challenges providers face with constant technology changes. Public health, and the Task Force, is well-prepared to play a role in guiding the development and adoption of standards that can be used with state prescription drug monitoring programs (PDMPs). |
| Pg. 13 | 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. | While EPCS and PDMP are extremely important and worthwhile programs, it is critical that there continue to be focus on completing implementation of interoperability for areas that have been working on advancing electronic exchange of data for some time, such as Electronic Lab Reporting (ELR), Electronic Case Reporting (ECR), IIS, and others. We want to maintain the outstanding level of connectivity achieved from years of previous investment and move further towards 100% participation. |
| Pg. 42 | Within one public health jurisdiction, different transport requirements may be required for different public health options. For example, Simple Object Access Protocol (SOAP) web services may be required for immunization reporting while secure File Transfer Protocol (FTP) may be required for syndromic surveillance. | While, ideally, transport methods would be identical across different use cases, the business needs within each public health program, and the associated technology costs, often drive each program’s standards. For example, IIS-EHR bidirectional exchange supporting forecasting requires real-time synchronous interoperability, which is best served with SOAP/Web Services. Syndromic data flows unidirectionally from the care provider to public health, so secure FTP (sFTP) is satisfactory. The volume of data exchanged during any one transaction may also impact the choice regarding transport. Syndromic data could be more voluminous and batched in overnight, while forecasting may be for individual patients with a real-time need for data. Business needs should not be overlooked solely in favor of uniformity. |
| Pg. 42-43 | Although much of the data collected for WIC pertains to social services and food products supplied to clients, there are numerous clinical data elements related to well-child visits and immunizations that must be manually entered into the WIC system. | Many states have instituted electronic data exchange relationships between IIS and WIC; ideally, this allows WIC to query and import the most complete and accurate immunization records directly from their jurisdiction’s IIS, lowering the manual entry burden and saving time for both WIC staff and recipients. |
| Pg. 61 | **EHR Reporting:**  **Recommendation 1:** Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.  **Recommendation 2:** Adopt additional data standards to makes 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. | Having worked (and continuing to work) to integrate standards and best practices across the public health agencies, the Task Force fully supports the further integration of standards and best practices to increase the value and lower the burden of interoperability from the EHR perspective. |
| Pg. 65 | **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. | We support the emphasis on data exchange with state PDMP systems. We strongly encourage the use of non-proprietary standards such as HL7’s FHIR and US Meds Implementation Guide that will soon include content directly related to PDMP integrations. The public health community has helped substantially from the early adoption of interoperability standards, and we encourage this early focus across PDMP as well. |
| Pg. 66 | **Public Health Reporting**  **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.  **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. | Although the Task Force supports harmonization wherever possible, it is important to recognize the very different (and essential) functions provided by public health programs and the value they bring to our population as a whole. For example, in the case of immunization data, the value is not only to providers (readily available immunization data at the point of care), but to the general population through the analysis of registry data.  Public health entities generally seek to leverage available, structured clinical data and streamline reporting requirements, minimizing the need for manual reporting or double data entry. When properly implemented, this approach should also improve the quality and timeliness of actionable data.  It is critical that state and local public health organizations be included in any assessment, inventory, and harmonization to ensure that their data needs are being met appropriately. The ability to exchange information continues to improve, and the adoption of the Trusted Exchange Framework and Common Agreement (TEFCA) may further opportunities to exchange information. It is vital, however, that appropriate federal funding be made available to support participation by local and state public health organizations.  The Task Force would welcome the opportunity to provide input on this future body of work. |
| Pg. 66 | Based on an understanding of all EHR-related data requirements across federally funded public health and health care programs that impact most health care providers, HHS can examine and harmonize common data elements and transport standards across reporting requirements. | It is important to recognize that state and local reporting represents the vast majority of the interoperability between public health and clinical care. Given the relative absence of public health law to- and direct reporting of- data to the Federal level, it is critical that local and state public health organizations take part in any harmonization activities to ensure that data collected is sufficient to meet the needs of all data users.  Any discussion of harmonizing transport standards should also include local and state public health, as well as other entities, to ensure the adopted approach meets all requirements, such as appropriate support for bi-directional communication as well as what may be efficient for the health care provider. |
| Pg. 66 | Agencies should then adopt a common standards-based approach to reporting EHR-captured data as a part of their modernization of reporting systems across relevant government programs. | If changes are needed across public health organizations, it will be critically important to increase funding for public health at the federal, state, and local levels to support design and implementation of these changes. In recent years, an immense increase in volume- in both the number of providers taking part in exchange as well as the absolute amount of data reported, has been seen in public health reporting due to inclusion in federal incentive programs. A primary obstacle to advancing the use of standards is the limited funding that public health receives to implement improvements.  We strongly back continued regulatory support for reporting in the areas of immunization, syndromic surveillance, vital records, case report, disease and clinical registries and other areas critical to public health. Federal support for public health reporting must remain strong and should continue to be included in Promoting Interoperability. |