RE: [Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs](https://www.google.com/url?q=https%3A%2F%2Fwww.healthit.gov%2Fsites%2Fdefault%2Ffiles%2Fpage%2F2018-11%2FDraft%2520Strategy%2520on%2520Reducing%2520Regulatory%2520and%2520Administrative%2520Burden%2520Relating.pdf)

MetaStar, Inc. is an independent, nonprofit, quality improvement organization (QIO) based in Madison, Wisconsin. MetaStar represents Wisconsin in the Lake Superior Quality Innovation Network. As a 501(c)3 organization, MetaStar receives funding from federal and state government contracts to advance our mission and health care transformation goals. We receive funding to provide technical assistance to providers and health care organizations in our area for programs including the Medicaid Promoting Interoperability (PI) Programs and the Quality Payment Program. Our health care improvement and consulting services address the need for system-wide innovation and consistent evidence-based approaches across settings of care. We work with communities, providers, and insurers to transform care with a vision of optimal health for all.

On behalf of Wisconsin’s providers, please consider the following comments:

**Health IT Usability and the User Experience**

We recommend electronic health record (EHR) vendors be held to strict standards and timelines for the creation, accuracy and availability of EHR user guides and provide adequate, ongoing staff training, not only to optimize user interfaces, but also to better support clinical staff. In our work with Medicaid providers in Wisconsin, we have found that EHR user guides and training varies greatly and are a source of frustration especially for small, rural clinics with limited information technology (IT) resources. EHR vendors should be required as part of the certification process to have user guides and workflows made readily available for the most recent Certified Electronic Health Record Technology (CEHRT) version as well as any upgrades that effect workflows.

We recommend leveraging the Electronic Health Record Reporting Program which is part of the 21st Center Cures Act to help evaluate the level of usability and evaluate user experience. We maintain that Health IT usability and presentation of data is best determined by the health care providers actually using the technology. Each healthcare setting and specialty have different needs so setting standards is particularly difficult. Flexibility is key and providers must be empowered to understand and use their data for quality improvement leading to improved patient outcomes. We support recommendations to better align EHR system design with real-world clinical workflow. We especially promote user interface and usability to properly integrate into the clinician’s workspace to minimize distractions to create a patient-centric clinic visit, rather than a health IT-centric clinic visit.

For patients utilizing EHR-based patient portals, and health IT resources, EHR vendors must be accommodating for patients who are multilingual, health illiterate, or unfamiliar with health IT resources. Programs such as the Merit-Based Incentive Payment System (MIPS) and Promoting Interoperability (PI) Performance Category of the Quality Payment Program and Medicaid Promoting Interoperability Program must make accommodations for providers who care for these special populations.

In our past work as the Regional Extension Center (REC) for Wisconsin as well as our work in the Health IT Extension Program for Medicaid Enrolled Providers, we have seen firsthand the burden of continuous pop-ups and non-clinically relevant pop ups in poorly designed clinical decision support (CDS) tools. Many smaller, rural, safety net providers lack the IT resources necessary to adequately customize CDS tools, thus chose whatever default CDS tools are available from vendors. We have encountered vendors who seemed more interested in selling a “Certified” EHR system than making sure that the CDS tools were even clinically relevant to the specialty. One example, is a prominent certified EHR for dental providers that offered flu shots as a default CDS intervention.

We support the frameworks such as those outlined by The National Academy of Medicine’s publication [“Optimizing Strategies for Clinical Decision Support”](https://www.healthit.gov/sites/default/files/page/2018-04/Optimizing_Strategies_508.pdf) especially the development and adoption of technical standards for CDS tools and establishing a national CDS infrastructure. We also support the adoption of [AHRQ CDS Connect](https://cds.ahrq.gov/cdsconnect) project which links clinical guidelines into computable content for interoperable CDS. However, the responsibility to conform to these standards must lie directly with the EHR vendors and CDS tools must be clinically relevant to the clinicians served. Unnecessary pop-ups and alerts for irrelevant conditions lead to dangerous user fatigue.

We highly support standardization of medication information, order entry content and results display conventions. Through our work we have seen firsthand the struggle many providers have when moving from one system to the next. Standardization and optimization using ONC’s Safer guides or a similar framework will reduce medication and order entry errors as well as make results more readable from one EHR to the next.

We fully support promoting nationwide strategies that further the exchange of electronic health information especially through the ONC’s Health IT Certification program. Vendors vary greatly in their offerings. Also, many times providers and small heath care organizations may not realize limitations or the hidden costs of interfaces to the state HIE. Support for small, rural practices to join HIE is very much needed for both technical assistance as well as subsidized cost. We also support projects that expand interoperability across health care and community-based settings.

**EHR Reporting**

We fully support recommendations to simplify Promoting Interoperability scoring and incentivize innovative uses of health IT and interoperability. MetaStar provides technical assistance to the Medicaid Promoting Interoperability (PI) Program for Eligible Professionals (EPs) via funding through the Wisconsin Department of Health Services and to the Quality Payment Program (QPP) through Centers for Medicare & Medicaid Services’ Quality Improvement Organization Program As we transitioned many providers to the Quality Payment Program, we continue to work with Medicaid-enrolled providers who are still receiving incentives in the Medicaid Promoting Interoperability Program. Some are dual eligible. It would be ideal to provide one reporting method for both programs.

Currently, the Medicaid PI Program objectives and measurements are not aligned with the QPP Promoting Interoperability Performance Category thus causing burden on providers and healthcare organizations who need to report to both programs. Although 2021 is the final year EPs can receiving incentive payments in the Medicaid PI Program, it would be helpful to transition them to a program more aligned with the QPP Program. Also, some EPs, especially specialist did not participate in the EHR Incentive Programs for a variety of reasons. Many are not required to participate in the QPP either. One example would be behavioral health specialists. Although these specialists could benefit greatly from interoperability and other Health IT functions, they lack familiarity and resources needed to adapt to new functionality. Incentives and technical assistance must be available to help these providers adapt into the increasingly interoperable healthcare environment. Subsidizing the cost of onboarding to a local health information exchange (HIE) for safety net providers would also help reduce health disparities and expand interoperability.

We wholeheartedly support the recommendation to continue providing states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers. Medicaid health care providers are widely safety net providers providing health care to the state’s most vulnerable populations. Many of these health care organizations lack the resources, IT staff and the funds to implement advanced health IT systems on their own. Much work remains to be done. Efforts to establish truly interoperable health information exchange will be thwarted without this vital funding.

We support promotion of the CMS’ Meaningful Measures framework with a focus on improved health outcomes. Quality reporting needs to be made easier and less costly. Many Medicaid providers do not have the resources for data extraction beyond EHR capabilities.

An EHR vendor’s shortcomings should not inhibit providers from being able to successfully participate in such programs such as MIPS/MACRA or Promoting Interoperability. The burden for the accuracy of EHR reporting must be placed on the vendor. We have worked with clinics who have diligently tracked performance all year long, only to find out in the last quarter of the year that the EHR reports are inaccurate which even once fixed put receiving incentive payments and performance bonuses at risk.

**Public Health Reporting**

We recommend expanding efforts to integrate Prescription Drug Monitoring Program (PDMP) data into EHRs. Currently not all PDMPs are utilizing the same messaging standards. This hinders integration into EHR technology because an EHR has to integrate to a state’s individual requirements.  It would be very beneficial if an effort was put forth to work on setting a national standard similar to the Immunization Information Systems (IIS) community so that there is a single base standard. This standard could be utilized by all EHRs to be able to interface with the PDMPs with little to no customization being needed to be made at the EHR level. This would also lower the cost of integration between the PDMP and the EHR. Additionally, best practices could be developed in regards to specific workflows to reduce provider burden. This would be beneficial for the EHR so that the PDMP information could be reported into their system correctly and at the optimal point of care.

Another barrier to integration has been 42 CFR Part 2 which mandates confidentiality of alcohol and drug abuse patient records. We urge HHS to provide additional guidance on this topic. Continued outreach and further expansion of educational opportunities need to be provided not only to healthcare providers, but health IT vendors. More expansive education on privacy, and technical standards and technologies is of utmost importance including sharing of best practices.

We see a benefit to creating an inventory of reporting requirements for federal health care and public health programs. An inventory of data elements that are available for capture in those systems would help to convey these elements to the EHR vendors. In turn, this would provide information on EHR systems to be able to educate providers on the necessary information to input into the public health reporting registries.  This could also help to create interfaces similar to the bidirectional query messaging that EHRs utilize with IIS currently.

We agree that there should be continued efforts to streamline the reporting process across public health so that it is less burdensome for the provider.  As long as the required information is provided in the EHR to interface with a public health system, no further provider action would be required in regards to reporting since the data would be captured automatically.  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. This should help EHR vendors understand more specifically what is needed for the reporting and can be worked into the workflow accordingly by requiring the information or presenting warnings or messages to the provider when information is not present or further action is needed to be taken to the providers for these reports.

MetaStar applauds ONC’s recognition of the real-world burden that is an unintended consequence of programs using Health IT. It is our hope that working together we can improve efficiently leverage the benefits of health IT to deliver efficient patient-centered care and improved outcomes with the vision of optimal health for all.