



August 10, 2020

Dr. Donald Rucker
National Coordinator
Office of the National Coordinator for Health Information Technology
330 C Street, SW
Floor 7, Switzer Building
Washington, DC 20024

Re: Electronic Health Record Reporting Program

Submitted electronically at: EHRfeedback@urban.org

Dear Dr. Rucker:

Thank you for the opportunity to provide feedback on the Electronic Health Record (EHR) Reporting Program.

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

We offer the following responses to questions posed by the Urban Institute.

Which draft criteria would you prioritize for inclusion in the EHR Reporting Program, and why?

AHIMA agrees with much of the criteria that has been proposed for the EHR Reporting Program. However, we would like to prioritize two key areas for inclusion in the program: documentation and data analytics.

Proper documentation can be facilitated through the effective use of structured EHR templates. Structured templates can support the capture of clinical content in a standardized and structured manner. Leveraging structured templates will not only improve clinical documentation, thereby leading to a higher quality of care, but can improve the design of clinically robust algorithms and better tracking of outcomes of care. Given the importance of structured EHR templates to enhancing proper documentation and improving quality of care, documenting the ease in which stakeholders use such structured templates is critical to understanding how such functionality may be improved within EHRs and health IT systems.

Data analytics is also a key priority for inclusion in the EHR Reporting program for AHIMA. As the volume, velocity and variety of health data continues to grow, making better use of it has huge potential

for lowering costs and improving quality in healthcare. Understanding the ease in which EHRs and health IT systems may be used for data analytics purposes is important to not only improve clinical and administrative operations but also for research, public health, and evidence-based medicine.¹

That said, two key criteria are missing from the EHR Reporting Program that we believe should be prioritized. First, we believe the inclusion of social determinants of health (SDoH) functionalities should be prioritized for inclusion in the program, including whether an EHR or health IT system supports SDoH-related data collection and the extent to which patients can be referred to community resources including social services. AHIMA recently conducted a survey of its membership and found 50 percent of respondents reported that lack of discrete EHR fields and/or functionality was a major challenge in collecting SDoH data.

Complete, accurate, and timely health data, including SDoH data, can help identify opportunities “to create social and physical environments that promote good health for all.”² There are challenges in standardizing SDoH data in EHRs and for that reason AHIMA and our members are active participants in the Gravity Project. However, according to ONC, as of December 2019, 72 health IT developers had voluntarily certified 93 unique products to an SDoH-oriented certification criterion, and these 72 developers offer technology to nearly half of all office-based clinicians and nearly a third of hospitals.³ Indeed, in AHIMA’s recent SDoH membership survey, we found that approximately 56 percent of respondents’ organizations collect SDoH data. For that reason, we believe it is appropriate that SDoH functionalities be documented as part of the reporting program.

The second criteria that is missing from the EHR Reporting Program that should be prioritized is patient matching. This is particularly disappointing given that patient matching (when exchanging data with nonaffiliates) is listed as a “High Priority Measure Topic” that was identified by stakeholders in the report, [*What Comparative Information is Needed for the EHR Reporting Program: Priorities Identified through the Stakeholder Engagement Process*](#).⁴ The ability to accurately match an individual to their health information is fundamental to achieving the promise of nationwide interoperability but more importantly it is necessary for patient safety. EHRs and health IT systems can vary in accuracy and sophistication in matching patients to their health information given the use of different standards and algorithms. Allowing users to document their EHR or health IT system’s patient matching performance would encourage transparency and allow stakeholders the ability to examine comparatively how different EHRs and health IT systems perform.

Which draft criteria should be rephrased, reworded, or removed?

Question 5.1: Ease of exchange with clinicians who have a different EHR/health IT product

AHIMA recommends question 5.1 be clarified to include both intra-organizational exchange and electronic exchange external to the organization. HI professionals continue to struggle with intra-organizational exchange given the use of downstream systems that may be a different EHR or health IT

¹ Available at: <https://link.springer.com/article/10.1186/2047-2501-2-3>.

² Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

³ Available at: https://www.healthit.gov/buzz-blog/interoperability/advancing-interoperable-social-determinants-of-health-data#_ftn1.

⁴ Available at: https://www.urban.org/sites/default/files/publication/102087/what-comparative-information-is-needed-for-the-ehr-reporting-program_4.pdf.

product or version. While numerous larger health systems continue to move toward a single platform/vendor, many systems continue to utilize a host of different EHR vendors, products, and versions. Clarifying question 5.1 would enable a more meaningful survey response and allow stakeholders to more meaningfully consume the survey data.

Question 5.5: *Ease of exchange with payers*

“Electronically exchanging health information with payers” should be further clarified in Question 5.5. Today, exchanging clinical data with payers may involve sending the information via paper/fax, sending the information via mail on a CD, uploading the information to a payer’s portal, using an automated HIPAA transaction standard, or providing direct electronic access to a subset of records. In each of these instances, multiple formats may be used for a single patient stay or encounter and can involve multiple back-and-forth exchanges. Phone calls may also be needed to check status and address additional questions. We are concerned that question 5.5 as currently drafted oversimplifies the complexity involved in electronically exchanging data between providers and payers and could skew responses by attributing some of the challenges associated with exchanging clinical data for administrative purposes to an EHR or health IT system when such challenges may be beyond the scope of the product or system.

Question 7.2: *“Has an intuitive workflow”*

AHIMA recommends that ONC adopt the language in Table 2: Usability Draft Criteria, “aligns with practice workflow” versus “has an intuitive workflow” as currently drafted in question 7.2. We believe the language in Table 2 is clearer and easier to comprehend.

Question 7.4: *“Produces clinical benefits for the practice”*

AHIMA recommends that question 7.4 be revised to state “produces *measurable* clinical benefits for the practice.” This clarification would more accurately capture whether the EHR or health IT system did in fact produce clinical benefits for the practice (regardless of the size of the actual benefit.) Furthermore, from a stakeholder’s perspective of using the EHR Reporting Program, such a clarification would offer more meaningful information in assessing available products.

Should the voluntary user-reported criteria cover only the most recent version of a certified health IT product or all versions of the product?

To reduce confusion and to mitigate unnecessary burden on providers, the voluntary user-reported criteria should cover the edition of CEHRT in use by the Promoting Interoperability Programs and the Merit-based Incentive Payment System (MIPS). Should the PI programs or MIPS allow the use of more than one edition or a combination of both, the user-reported criteria should cover both.

What certified health IT users are most likely able to report on the criteria (e.g.—clinicians, administrators, IT specialists)?

HI professionals are strategically well-placed to report on the program’s criteria. HI professionals are active participants in the entire EHR lifecycle, leveraging their expertise in data governance, privacy and security, workflows and health information exchange to capture, maintain and produce accurate, timely and complete quality data. Furthermore, because HI professionals are primarily tasked within their institutions with understanding the flow of where and when health information needs to travel and the

integrity of that information, they have a clear understanding of the certified health IT products in use and the performance of these products as they relate to interoperability and usability. Because HIM departments work closely with IT departments on the implementation of certified health IT products, they also have a deep understanding of the implementation process itself, related product support, and upgrades and maintenance.

What could motivate end users to voluntarily report on certified health IT products?

To motivate end users to voluntarily report on certified health IT products, AHIMA suggests that ONC work closely with specialty societies and other professional organizations. Working closely with these organizations will not only encourage reporting under the program but help ensure that the data reported as part of the EHR Reporting Program are credible and verifiable.

AHIMA also recommends offering end users financial incentives to enhance survey responses. Such incentives could include offering bonus points under the Promoting Interoperability Programs and MIPS upon completion of the EHR Reporting Program survey. The extent to which the survey could be integrated into existing reporting requirements for these CMS programs would help to limit administrative burden for stakeholders and streamline such reporting requirements.

We appreciate the opportunity to submit comments on the Electronic Health Reporting Program. We hope that you will continue to engage extensively with stakeholders on the reporting program and we look forward to working with you to ensure its successful launch and implementation. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Vice President, Policy & Government Affairs, at lauren.riplinger@ahima.org and (202) 839-1218.

Sincerely,



Dr. Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer
AHIMA