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Don Rucker, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinatory for Health Information Technology
U.S. Department of Health and Human Services
330 C St. SW, Floor 7
Washington, DC 20201

Re: Comments on Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Dr. Rucker:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB) I submit the following comments on the U.S. Department of Health and Human Services (HHS) Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and Electronic Health Record (EHRs) ("HHS Draft Strategy"), issued November 28, 2018, designed to help reduce administrative and regulatory burden on clinicians caused by the use of health information technology (health IT). Established in 1972, the NPAIHB Tribal Organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific healthcare issues. NPAIHB operates a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center[1], and works closely with the IHS Portland Area Office.

Section 4001 of the 21st Century Cures Act, Public Law 114-255, HHS created the ONC Draft Strategy to gather input from stakeholders to improve infrastructure, interoperability, accessibility, and overall utility of health care information. The Draft Strategy represents the Administration's goal to reduce regulatory and administrative burden relating to the use of EHRs. Thank you for the opportunity to provide comments on the Draft Strategy Report.

TRIBAL CONSULTATION

The United States has a unique legal and political relationship with American Indian and Alaska Native (AI/AN) tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the federal government's trust responsibility to protect the interests of Indian Tribes and communities, including the provision of healthcare to AI/ANs. This obligation extends to HHS and its agencies. For this reason, the HHS Draft Strategy must comprehensively include and hold all agencies accountable for inclusion of tribes across all recommendations that impact AI/AN people.

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

Meaningful tribal consultation is consistent with the unique obligations that the United States has with Indian Tribes and the requirement for the federal government to work with tribes on a government-to-government basis. Under sections 8 and 9 of HHS's Tribal Consultation Policy, there is a requirement that upon HHS's identification of an event significantly affecting one or more tribes, HHS will initiate consultation on the event. Northwest Tribes look forward to meaningful tribal consultation as the HHS Draft Strategy recommendations are developed and prior to finalization.

GENERAL COMMENTS

Since 1984, the Indian Health Service (IHS) has relied on Resource Patient Management Syste (RPMS) as the health information solution. The RPMS is a government-developed health information system comprised of over 80 integrated software applications. The RPMS EHR system is the foundation of the Indian health information technology support system. The RPMS hardware, software, network, and database allows both large and small health facilities to work independently as well as within the larger network of the Indian health system.

While a significant number of tribal health clinics in the Northwest use the RPMS system, a large number in our Area have purchased a Commercial Off The Shelf (COTS) EHR system to improve such mechanisms as functionality, care management, interface, and billing. Health IT for Northwest tribal health clinics vary greatly for each site due to bandwidth challenges, staffing and capacity to utilize EHRs. Northwest tribal health clinics serve a range of users from less than 500 to over 5,000 patients.

Given the RPMS EHR system needed upgrade and expansion, NPAIHB recommends that the ONC Draft Strategy designate a section to recommend that federal agencies commit significant resources toward IHS and tribal (I/T) health clinic IT requirements, to allow IHS to either modernize the current EHR or to initiate a phase-in replacement process similar to that of the VHA.

Another barrier not included in the ONC Draft Strategy is that there is not enough robust timely health IT support from IHS to each tribal health clinic. When needed changes are identified, too much time passes before they are delivered to the user. Many small tribal health clinics do not have the capacity to fully optimize the existing RPMS EHR and would benefit from a system that has the capability to share more components, such as drug files containing all available drugs or customized menus that users may use to place orders.

SPECIFIC COMMENTS

NPAIHB provides the following specific comments:

Clinical Documentation

Strategy 1: Reduce regulatory burden and documentation requirements for patient visits.

Significant administrative burdens for clincians at I/T clinics include regulatory requirements and documentation requirements for each patient. NPAIHB supports the ONC strategy to continue to reduce the overall regulatory burden around documentation of patient encounters.

In regards to the potential waiver of documentation necessary for purposes of testing or administering Alternative Payment Models (APMs), we believe that the way IHS is funded is an alternative model itself and the documentation requirements should be waived. Currently, tribes do not participate in APMs. We believe an APM should be created specifically for the I/T system to participate as a unique payment model itself with a waiver of the documentation requirements.

Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.

NPAIHB supports a partnership between ONC and I/Ts to encourage adoption of best practices related to documentation requirements. However, we believe there must be a best practices module designed specifically for the I/T system to include all of the additional necessary complexities.

Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

Each tribal clinic has a very customized EHR system and we concur with the ONC strategy to focus on standardization. NPAIHB recommends that a portion of the ONC evaluation to address the process and clinical workflow factors associated with prior authorization include challenges for I/Ts.

The IHS Purchased and Referred Care (PRC) program is one of the most important health services for tribes and tribal clinics in the Portland IHS Area as it allows AI/ANs to access inpatient, outpatient, and specialty care services. Portland Area has no IHS or Tribal hospitals and relies on PRC funding to provide critical services to AI/AN people in the Northwest. Tribes in the Northwest are PRC dependent and have an additional layer of complexity within their workflow because of the PRC referrals process to get a prior authorization**.** Additionally, coordination efforts to advance new standard approaches supporting prior authorization must include special consideration for workflows and processes related to PRC, which is unique to I/Ts.

NPAIHB is supportive of automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers. Second, we agree that incentivizing adoption of technology can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes. Third, we concur that ONC must work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.

Health IT Usability and User Experience

The ONC Draft Strategy emphasizes that interoperability "will not be achieved for users until their experience with electronic health information and technology has been made seamless and effortless, and, as a result, truly interoperable." For ONC to adapt interoperability software to the I/T health care systems, a platform must be developed to allow I/T facilities to communicate directly with other EHR systems.

NPAIHB requests that tribes be included in assessments of the feasibility of EHR and other health care IT systems to improve health outcomes in Indian Country. Ineffective usability can lead to

confusion on the part of the clinician which could be detrimental to the patient. Challenges associated with usability can result from the design of the systems, how facilities customize them, unique workflows, user training, and other factors. In terms of usability safety, issues can arise due to confusing interfaces to complete clinical and administrative tasks.

Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.

NPAIHB supports the strategy to improve usability through better aligment of EHRs with clinical workflow and improve decision making and documentation tools. We believe that RPMS EHR is a prime example of what happens when too much focus is placed upon regulatory and certification requirements over usability. Since Meaningful Use (MU) started in 2011, the majority of the updates to RPMS EHR have been related to meeting ONC certification. This left little to no funding or human resources left to address any improvements in usability at all, resulting in an EHR that has fallen behind the rest of the industry in terms of usability.

We recommend that ONC assist in improving the way the provider gets the clinical information into the EHR and how it becomes available to the patient to better align the EHR system design with real-world clinical workflow. RPMS has not improved usability because regulatory requirements came at the cost of usability and clinical workflow.

Strategy 3: Promote harmonization surrounding clinical content containted in health IT to reduce burden.

NPAIHB believes this goal is of particular importance for tribes in the Northwest due to frequent staff turnover, use of locums tenens, and high vacancy rates for clinical positions. Having standardization and harmonization in basic clinical operations and displays can make it easier for clinicans to step into vacancies and feel comfortable with the EHR they are using, no matter where they are practicing. We support standardization of the following objectives: medication information, order entry content, and results display conventions within health IT.

Specifically, NPAIHB recommends that EHR systems should allow providers to be able to see the brand name and generic name of medications. Additionally, there is a need for better maneuvering of the medications that providers are able to view and interact with.

Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.

The Indian health care system as a whole is chronically underfunded, at less than half the level of need, and often extremely overburdened as a result. I/T facilities often lack the resources or personnel to make needed reforms and upgrades, or to comprehensivly meet all reporting and technology requirements. Many I/T facilities have longstanding vacancies, which includes the need for support staff and IT staff. Due to the underfunding of IHS RPMS EHR system recent efforts have focused on regulatory requirements and certification, instead of userability. NPAIHB recommends funding from HHS to implement the aforementioned changes for the I/T RPMS EHR government system.

There is a responsiveness issue with software problems. When the issue is identified, too much time lapses between the problem being reported to when the users obtain the information on a

work around or a fix is delivered. NPAIHB recommends for the standardization of more timely technical support to software issues.

It is crucial that HHS assist in making EHR systems more user-friendly. The RPMS usability enhancements have been pushed aside because all resources were focused on ONC certification of the EHR to allow participation in the Centers for Medicare and Medicaid Services (CMS) Meaningful Use incentive program (now the Merit-based incentive payment system (MIPS), patient safety, or regulatory requirements. The EHR should include a friendlier format for health care providers to highlight certain patient information and reporting for data collection purposes. It is challenging to identify and stay current with all of the most up-to-date patches and other updates to the software system. Therefore, NPAIHB recommends that IHS utilize a more user-friendly format to identify the providers if the software system needs to be updated. NPAIHB also recommends that the RPMS system include a preventative care reporting section for providers. It is a barrier for providers to enter in patient group education and documentation for preventative care.

EHR Reporting

NPAIHB recommends that ONC include IHS and tribal health clinics as partners in the forefront of the policy development process and in the creation of reporting requirements for reimbursement purposes.

Tribes have repeatedly requested reforms from HHS to reduce the administrative burden and costs of the various HHS agency reporting requirements, which would allow more resources to be directed to patient care – including data and reporting requirements. NPAIHB recommends consideration for leveraging the IHS National Data Warehouse (NDW), similar to what is being done with GPRA, so that individual clinical sites do not have to run the reports. It is beneficial because the data is automatically sent to the NDW through background processes and when the data is needed, it can be taken from the NDW and the individual clinical site is not bombarded with data requests.

Strategy 3: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

NPAIHB recommends consideration of the various reporting programs that tribes participate in for federal and state grants. We support continued alignment of measures or waivers when appropriate. Additionally, ONC must consider that tribes may identify health priorities for their own tribal members that may not align with other programs. We recommend that ONC be flexible and consider community-based measures in lieu of other requirements for programs.

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.

NPAIHB supports increased adoption of electronic prescribing through improved integration of health IT into the provider workflow. Standardization and integration are particularly important for tribes operating in multiple jurisdictions across tribal and state lines. There will be a need for

information from multiple Prescription Drug Monitoring Programs (PDMP) sources to get complete information.

Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting buden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

NPAIHB is supportive of an inventory for reporting requirements. We recommend that ONC include Tribal Epidemiology Centers (TECs) in the process to collect reporting requirements. For example, the Northwest TEC is the public health authority for the tribes in the Northwest.

The ONC guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care is of particular importance to our tribes. Our tribes are fighting the opioid epidemic and overdose deaths that are disproportionally impacting tribal members and working to coordinate care for members. Our tribes support HHS's issuance of clear guidance on the Health Insurance Portability and Accountabilty Act (HIPAA) privacy requirements and federal confidentiality requirements governing substance use disorder health information (42 CFR Part 2) in order to better facilitiate electronic exchange of health information for patient care.

CONCLUSION

We appreciate the opportunity to provide comments on the HHS Draft Strategy, and thank you for considering our written comments. For additional information please contact NPAIHB's Director of Government Affairs/Health Policy Analyst, Laura Platero at (503) 407-4082 or lplatero@npaihb.org and NPAIHB's Health Policy Analyst, Sarah Sullivan at (703) 203-6460 or ssullivan@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

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NPAIHB Chair
Colville Business Council Vice Chair