



October 17, 2018

Donald Rucker, MD, National Coordinator for Health IT
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: EHR Reporting Program Request for Information
Mary E. Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Dear Dr. Rucker:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the [request for information](#) regarding the Electronic Health Record (EHR) Reporting Program published by the Office of the National Coordinator for Health Information Technology (ONC) in the August 24, 2018 *Federal Register*.

The AAFP welcomes the opportunity to comment on EHR Reporting Program issues and appreciates that ONC is “especially interested in feedback targeting users in ambulatory and small practice settings, where providers typically do not have substantial time and resources to conduct broad market research.” The AAFP offers the following feedback to questions asked by ONC in the RFI.

Cross-Cutting Topics Existing Data Sources

What, if any, types of information reported by providers as part of their participation in HHS programs would be useful for the EHR Reporting Program (e.g., to inform health IT acquisition, upgrade, or customization decisions)?

Distribution of users based on Merit-based Incentive Payment System (MIPS) metrics and electronic clinical quality measures (eCQMs) would be useful data for the EHR Reporting Program. A distribution would allow potential customers and users of a product to see (1) the possible outcomes achievable and (2) how likely achieving a specific level may be. While distributions would vary based on the specific demographics of clients, seeing a smaller standard deviation versus a larger one would help inform potential customers regarding the influence of the Certified Electronic Health Record Technology (CEHRT) in improving outcomes.

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The AAFP would also urge ONC to develop a control group of similar practices using other products. For example, using CMS data, ONC could find a cohort of eligible professionals in the same practice settings and sizes.

What data reported to State agencies (e.g., Medicaid EHR Incentive Program data), if available nationally, would be useful for the EHR Reporting Program?

The AAFP would urge ONC to expand reporting of MIPS/eCQM distributions (see above).

Data Reported by Health IT Developers versus End-Users

What types of reporting criteria should developers of certified health IT report about their certified health IT products: That would be important to use in identifying trends, assessing interoperability and successful exchange of health care information, and supporting assessment of user experiences?

ONC should develop a set of defined, standards-based exchanges. CEHRT developers should report transaction counts for each standards-based exchange. CEHRT developers should also report the percentage of installations where the volume of the standards-based exchange is at least one standard-deviation below the mean. Finally, the CEHRT developer should be required to report the minimum version of their software needed to execute the standards-based exchange and if additional customization is required.

What would be valuable to those acquiring health IT in making health IT acquisition, upgrade, or customization decisions that best support end users' needs?

Those acquiring health IT need to be able to understand what the CEHRT is capable of, what the CEHRT can accomplish without customization, and what the CEHRT is highly likely to support. Some interoperability tasks are beyond the capability of CEHRT products. But more importantly, there are interoperability tasks that are within the capability of a CEHRT product only with customization and substantial effort during implementation and use (which can contribute to physician/provider dissatisfaction and burnout, especially if it involves a task related to either the critical window of the physician-patient interaction at point of care, or a high frequency task). These are the scenarios that those acquiring health IT need to be able to discern. Requiring CEHRT developers to provide transaction volumes and the percentages of installations that perform a significant volume would provide some data to potential health IT customers as to the likelihood that a particular transaction could be expected to work without significant effort or modification. For example, if a family physician notes that many CEHRT products have a high transaction volume but this particular CEHRT product has a low volume and a low percentage of installations performing the transaction routinely, the doctor may decide to look at other products or learn more about that product/developer.

The AAFP also urges ONC to encourage the Health IT Advisory Committee's Annual Report Workgroup to pursue their considered approach, to deliver and publish a 3-D crosswalk (as opposed to a 2-D crosswalk) on priority target areas (such as interoperability) and the factors influencing progress in those areas. The Annual Report Workgroup's 2-D construct of priority areas and spheres of influence on such includes influencing factors of ONC's objectives, benchmarks and Health IT Advisory Committee (HITAC) charges. The third dimension being considered by the Annual Report Workgroup for addition to this construct is that of stakeholder groups and their influence on progress in priority areas such as interoperability. The AAFP urges the Annual Report

Workgroup to indeed include stakeholder groups as the third dimension in such a cross-walk. Progress to remove barriers toward interoperability will be achieved more slowly without identification of the existing challenges precluding progress. Permitting voluntary stakeholder group input about challenges being experienced which preclude progress in ONC priority areas is one means of elucidating existing product challenges styming progress toward interoperability and other key priority areas. A voluntary disclosure or reporting process for stakeholder groups about CEHRT capabilities would expose product challenges, as well as useful contextual insights, to enable identification of cross-cutting themes in challenges reported by various stakeholder groups, as well as a more inclusive 360-degree view of cross-cutting challenges. In any case, physician reporting of these challenges should be voluntary.

User-Reported Criteria

The Cures Act calls for collecting EHR Reporting Program reporting criteria information from health care providers, patients, and other users of certified EHR technology, as well as from developers. As addressed in the EHR Compare Report, there are currently private sector resources where users can provide and view reviews of health IT products. However, the resources may be improved upon because they are not comprehensive, reflective of verified users' views, nor accessible and affordable to all. ONC is interested in input about what user-submitted information would make the EHR Reporting Program a valuable addition to the existing landscape of market research and analysis. ONC is also interested in feedback on what factors might influence end users' decisions to report more easily.

User-reported criteria should be used sparingly and utilized only for critical criteria that cannot be captured another way. **The AAFP appreciates that the first question in this section regards collecting information without creating or increasing burden. A process that adds burden to physicians would make this endeavor a failure.** Physicians are already heavily burdened while using their EHR and that burden needs to be significantly decreased, not amplified. Additionally, CEHRT cannot be easily substituted due to the current lack of interoperability, complexity of use, and significant costs of acquisition. This means that practices and hospitals cannot easily shift from one CEHRT product to another if the new product is marginally better. Therefore, the benefit of the EHR Reporting Program to existing users of CEHRT is limited. Hopefully market pressures will encourage CEHRT developers to improve their current products, but dramatic improvements in EHRs have not yet materialized from the certification process.

How can data be collected without creating or increasing burden on providers?

Where possible, all reporting should be automated and integrated within the CEHRT product. Criteria should include minimum data collection required to answer the question. For those criteria that create physician burden, ONC should err on the side of not including the criteria. Finally, user reporting should be voluntary.

Describe the value, if any, in an EHR Reporting Program function that would display reviews from existing sources, or provide a current list with hyperlinks to access them.

Those looking to acquire CEHRT would find value in the creation of one web-based resource that aggregates and catalogues all known information about CEHRT products and developers. Many small practices have neither the staff nor time to compile information about appropriate products or developers. One resource would decrease the burden of collecting the information needed to make an informed purchasing decision.

Discuss the benefits and limitations of requiring users be verified before submitting reviews. What should be required for such verification?

While there is benefit in permitting various clinical and nonclinical users of CEHRT to comment on a product's functionality, offering feedback reporting mechanism(s) only for physicians or providers (via quick pass-through validation of NPI # for example) would be especially beneficial. The experience of those with similar workflows and needs can better inform purchasing decisions and decrease avoidable burden, thus leaving more time for high quality patient care. To be most helpful, reported physician/provider feedback should be voluntary and feedback should be identified by provider type, specialty, and practice demographics (such as size, rural versus urban, FQHC, etc.). Verification to confirm the identity of the commenter should be based on valid NPI number, must be instantaneous and also permit immediate pass through to an efficient means of reporting feedback.

What reporting criteria would require customization across different provider types and specialties, including small practices and those in underserved areas?

Usability data should be customized or segmented by provider type, specialty, and practice demographics (such as size, rural versus urban, FQHC, etc.). Potential purchasers of CEHRT should have available information regarding usability for similarly-situated physicians.

For what settings (e.g., hospitals, primary care physicians, or specialties) would comparable information on certified health IT be most helpful? If naming several settings, please list in your order of priority.

The highest priority for AAFP is specialties with smaller practice sizes, of which primary care specialties would be included. Smaller practices often do not have the resources to fully vet a CEHRT product/developer without assistance. The lack of easily accessible and useful data to inform purchasing decisions for small practices has significantly greater residual impacts. Solo and small practices are most often unable to afford to switch CEHRT based on poor performance or usability.

How helpful are qualitative user reviews (such as 'star ratings' or Likert scales) compared to objective reports (e.g., that a system works as expected with quantifiable measures)?

Star ratings for the product in general are often not helpful for specific physician practices. Instead, star ratings for specific functions or capabilities can be helpful. For example, a star rating linked to ease of e-prescribing, finding information or documenting a type of visit would be more valuable. In any case, ratings should be segmented by specialty, practice demographics and practice setting.

How could HHS encourage clinicians, patients, and other users to share their experiences with certified health IT?

HHS should demonstrate the feedback's link to specific improvements in CEHRT products. HHS should also act to ensure that family physicians and providers are protected from retribution from developers for negative reviews or feedback.

Health IT Developer-Reported Criteria

If you have used the certified health IT product data available on the ONC Certified Health IT Products List (CHPL) to compare products (e.g., to inform acquisition, upgrade, or customization decisions), what information was most helpful and what was missing? If providing a brief list of the information, please prioritize the information from most helpful to least helpful also considering their grouping into categories in Section IV.

In CHPL, while there is a substantive amount of data, data detailing usability testing completed by developers is sparse, and only 262 products present usability testing data under “Safety Enhanced Design.” Vendor attestations are prevalent. The Usability data that is present in both .pdf and .csv formats is not easily accessible by physicians and is not formatted in a way to facilitate comparison across products. Compounding these problems, most physicians would not know to explore the SED data. While many developers have employed a NIST usability testing standard, physicians are not widely involved in testing. The types of providers and physicians involved in usability testing appear highly variable with frequently few to no physicians included. Potential purchasers will find information regarding the setting and conditions under which a product’s usability was tested insufficient to provide useful insights. Physician specialty is often not delineated within easily consumable portions of reports. Instead, the .pdf version of available reports might potentially summarize the types of settings in which the usability testing was completed, which may include a family practice setting. Reports fail to consistently identify any physicians or providers involved in testing by specialty as well as other relevant practice demographics. Put simply, while we applaud the fact that developers who are reporting results of their usability testing process have employed typically one of two NIST standards for EHR usability testing, we cannot emphasize strongly enough the need for EHR usability testing to employ a standard minimum number of physicians. We lack the data to provide an evidence-based recommendation for what minimum number of physicians the NIST standards should specify. However, clearly the lack of involvement of a standard number of physicians, from various practice types and settings, is having significant negative impact on the usability of CEHRT by physicians. The AAFP urges ONC to:

- Require usability testing of CEHRT by EHR vendors to include a minimum number of physicians, including those from solo and small practices.
- Publish usability testing data which is helpful. To ensure this, usability testing reports should clearly specify whether the “provider” who participated in usability testing was a physician versus other provider, and specify the specialty of physician, practice demographics and practice setting.

The AAFP emphasizes these recommendations are crucial, as the currently available information in CHPL simply does not provide helpful information for all practices – especially small ones.

What developer-reported criteria are particularly relevant, or not relevant, to health IT users and acquisition decision makers in the ambulatory and small practice settings?

Usability and interoperability criteria are important for all physicians and other providers to inform the best purchase decisions, but this is even more critical for those in small independent practice settings. For these family physicians, switching CEHRT due to even significant usability or performance concerns is often cost prohibitive. All practices, but most especially small practices, also require transparent insights into the conditions or context under which automated measure calculation (170.314(g)(2)) is enabled via the CEHRT. Transparent communication regarding the conditions under which automated measure calculation is possible should note whether such is possible regardless of the brand of practice management (PM) system used versus only possible if using a PM system from the same developer, or if possible only if using specific versions of the developer’s PM system. Developer-reported capability to electronically submit clinical quality measures (170.314(c)(3)) should also include clear and transparent communication about the extent and cost of customization required to do so.

What types of criteria might introduce bias (e.g., unfair advantage) in favor of larger, established developers or in favor of small or new developers?

Requiring developer reporting via new reporting standards (such as Clinical Quality Language or CQL), or including new criteria within escalated timeframes, has the potential to introduce significant unfair competitive advantage favoring larger CEHRT developers. In addition to disadvantaging smaller developers, this in turn can also significantly disadvantage the users of CEHRT because smaller developers disproportionately serve solo and small independent practices. In addition, smaller developers are more likely to incur consulting development costs in order to meet especially challenging implementation deadlines. These costs are then often transferred to users as product point release or version update costs. While requiring developer use of CQL and/or inclusion of new criteria may offer some immediate benefit to physicians and providers, punctuated timeframes for developer compliance translate to increased costs for users. Practices able to afford the associated compliance costs will benefit at the expense of smaller, independent practices.

Categories for the EHR Reporting Program

What categories of reporting criteria are end users most interested in (e.g., security, usability and user-centered design, interoperability, conformance to certification testing)? Please list by priority.

Physicians and small practices have most interest in usability, followed by a need for criteria to help evaluate interoperability and security.

Security

Describe other useful security and privacy features or functions that a certified health IT product may offer beyond those required by HIPAA and the ONC Health IT Certification Program, such as functions related to requirements under 42 CFR part 2. What information about a certified health IT product's security and privacy capabilities and performance have acquisition decision makers used to inform decisions about acquisitions, upgrades, or use to best support end users' needs?

Physicians and other providers often seek information regarding whether CEHRT enables secure Direct messaging to patients or other providers from within its various screens or modules. The capability to securely direct message patients or care providers when reviewing lab data or population health reports enables efficient action to close identified gaps in care or coordinate care without taking the provider out of the workflow.

In addition, whether a CEHRT product supports efficient integration of data received from external care providers while clearly maintaining data provenance is useful in informing purchasing decisions. Family physicians who want to purchase CEHRT deserve clear communication from developers regarding data provenance capabilities. Ideally, CEHRT should foster the exchange of data so that the information can then be useful and actionable, as opposed to keeping the data sequestered following exchange.

What other information would be useful in comparing certified health IT products on security and privacy (e.g., compatibility with newer security technologies such as biometrics)?

Family physicians would benefit from a discussion of the CEHRT developer's mitigation strategy for cybersecurity threats. This discussion should include communication about any tools made available by the developer to support a users' understanding of recommended initial action in the event of security breach. While this would be useful to all users, those in small practices without IT support infrastructures would benefit significantly.

Usability and User-Centered Design

How can the usability results currently available in the CHPL best be used to assist in comparisons between certified health IT products?

A large number of developers merely attest to having completed usability testing. Attestation that testing is completed is less valuable when comparing products to inform purchasing decisions.

Interoperability

How helpful would CMS program data (e.g., Quality Payment Program MIPS Promoting Interoperability Category, Inpatient Hospital Promoting Interoperability Program, Medicaid Promoting Interoperability Programs) related to exchange and interoperability be for comparative purposes?

Such data would be most helpful if it is provided as distributions of users based on MIPS metrics and eQMs for each CEHRT. A distribution would allow potential customers and users of a product to see (1) achievable outcomes and (2) the likelihood of achieving a particular level. While distributions would vary based on demographics, a smaller standard deviation versus a larger one would help inform potential customers that the CEHRT could help achieve improved outcomes. Additionally, the percentages of CEHRT users that have selected interoperability sensitivity eQMs should be disclosed.

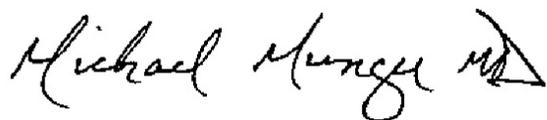
Other Categories for Consideration

How should the above [possible] categories be prioritized for inclusion/exclusion in the EHR Reporting Program, and why?

The list provided could be segmented into task-specific usability and entity-specific interoperability. Given the extreme heterogeneity of physician and other clinician tasks, which also vary by specialty and practice setting and style, there is limited value to generic task-specific usability reporting. A user review methodology may be more appropriate. This would entail users being able to populate profiles to describe their specialty, practice setting and style. We believe that entity-specific interoperability should be prioritized above task-specific usability criteria. We also recommend focusing on national or specialty-wide entities first when prioritizing among entities with which CEHRT is interoperable. An extensive list should not create additional burden for CEHRT developers as they would only need to report the entities with which they interoperate and the degree to which they do so.

We appreciate the opportunity to provide these comments. Please contact Steven E. Waldren, MD, MS, Vice President and Chief Medical Informatics Officer, at 913-906-6000 ext. 4100 or swaldren@aafp.org with any questions or concerns.

Sincerely,



Michael L. Munger, MD, FAAFP
Board Chair