



Physicians Caring for Texans

July 30, 2021

Richard Landen, Co-Chair
Denise Love, Co-Chair
National Committee on Vital and Health Statistics
Subcommittee on Standards
3311 Toledo Rd.
Hyattsville, MD 20782-2002

Via: NCVHSmal@cdc.gov

RE: Comments NCVHS Standards Subcommittee | [Federal Register Notice](#)

Dear Co-Chairs Landen and Love:

On behalf of the Texas Medical Association (TMA) and our more than 55,000 physician and medical student members, thank you for the opportunity to provide input ahead of your Aug. 25 stakeholder listening session.

TMA offers the following feedback on the questions posed to stakeholders:

1. How can data sharing be improved between patients, providers, payers, public health systems, and other actors in health care? What are the barriers to these improvements?

Improving interoperability: More than a decade after the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act, there are still many significant barriers to true interoperability that meets one of the Office of the National Coordinator's (ONC's) goals of "a learning health system where individuals are at the center of their care and providers have a seamless ability to securely access and use health information from different sources."¹ The following are suggested improvements:

- **Data available for exchange must be focused and clinically relevant to the recipient.** Rather than the intended focused set of data that is useful for clinical care, consolidated clinical document architecture (CCDA) documents frequently are a hodgepodge created to meet government requirements. We have seen examples of these documents missing problem lists, medications, allergies, and other key data as each organization creates its own approach without any feedback from clinical recipients. We also have seen examples of "CCDA bloat" where the problem list and imaging reports, as examples, contain reams of clinically useless data.

¹ HealthIT.gov; www.healthit.gov/topic/interoperability; accessed July 28, 2021.

An example using a typical lab (bilirubin) that is done on virtually all normal newborns might be illustrative. Should every single bilirubin value be reported to the follow-up clinician? Most would answer resoundingly “no” in virtually all cases. Then what is the clinically relevant data? Is it the rate of rise? The most recent bilirubin value and the hour after birth it was obtained? Is it the infant’s risk factors for kernicterus presented clearly and in a standard format? Currently, there is no guidance from professional societies as to what’s important and what’s not, so each hospital creates its own approach to this. Some put the risk factors in notes. Others put the risk factors in the problem list. Others don’t include them at all. The result is that follow-up clinicians are often confused, ill-informed, and frustrated. The simple bilirubin case is just one small example. Follow-up of pediatric and adult diabetics admitted for ketoacidosis are equally challenging in terms of deciphering what was done and what needs to be done. The number of use cases is enormous but not infinite. TMA recommends that NCVHS encourage quality measure development reflective of TMA’s policy²:

Evidence-based quality-of-care measures must be the primary measures used in any program.

1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

Interoperability isn’t just about creating the pipes to move data. It’s also not just programming computers to “read” what is received. It *is*, and perhaps most importantly, the usability of the data received. The approach taken to date is that it’s the recipient’s responsibility to make sense of the flood of data, rather than having standards that focus the flow to what’s needed, relevant, and appropriate at the point of care. TMA strongly supports efforts to foster this approach using Fast Health Interoperability Resources (FHIR). We also recommend support for professional organizations to develop what data should be available for use cases and how these data should be communicated. This isn’t a simple or quick approach, but it’s necessary.

² TMA Policy Compendium; 265.017 Pay-for-Performance Principles and Guidelines; www.texmed.org/Policy; accessed July 28, 2021.

- **Data available for exchange must be ubiquitously available and easy to access.** Unfortunately, competing proprietary electronic health record (EHR) vendors and the patchwork of local health information exchanges (HIEs) have made it difficult for physicians to purchase off-the-shelf tools that quickly connect to the data they need. **In most cases, it is a capital expense in physician budgets to connect to external sources. This causes undue financial burden to physicians who are continuously challenged with increased expenses and often-declining revenues.** In addition to interface fees, physicians must pay ongoing monthly fees to maintain the interface. If we are serious about interoperability, EHRs must come with it preinstalled and working immediately. It should no longer be viewed as an add-on.

This “built-in” data-sharing should require local and national HIEs and EHR vendors to develop and test the needed connections for seamless bidirectional exchange in advance of product general availability so that physicians are not burdened with the expense of “connecting the pipes.” Physicians want to be able to securely, with minimal extra effort, and within their normal workflow, send, receive, and use relevant patient information.

The NCVHS subcommittee on standards should consider the example set by Apriss, the prescription monitoring program (PMP) vendor for more than 42 states. Apriss built the interface with the vendors so that when it is installed and updated, physicians automatically, within their workflow, have access to PMP information on a patient when launching a prescription for that patient. This did not require additional effort or cost by the physicians. In fact, since the state of Texas funded the integration for the state PMP, Texas physicians did not even need to make the request to have access to the PMP. It just appeared one day and worked – to the satisfaction of physicians needing access to the PMP.

In contrast, TMA recently heard from practices working to comply with the 21st Century Cures Act by giving patients access to their information immediately upon request. In attempting to put radiology reports on the patient portal, practices are having to concoct an arduous workaround. A radiology report should be easily uploaded to the patient portal. According to the EHR vendor’s technical guidance, practices have to take the EHR vendor’s default .tif file, which cannot be published to the vendor’s portal, and convert it to a .pdf file, which the portal supports. To accomplish this, *for each image*, staff must exit the secure EHR and complete the transformation by printing and scanning. Staff then have to log back into the EHR, upload the .pdf and publish it to the portal. **This task repeated many times over is an enormous undue burden and expense to the practices and is fraught with safety and security issues.** Sadly, the EHR used by these practices is one of the largest ambulatory vendors in the country. EHRs, as part of certification, are required to perform certain functions, but those functions do not have to be performed efficiently. TMA urges the common-sense implementation of requirements that efficiency must be part of certification.

- **Additional regulations and standards need to be evidence-based rather than consensus-driven and should have meaningful post-implementation evaluation.** Technology in most other aspects of life such as banking, travel, and shopping have improved exponentially over the past decade. EHRs are a glaring exception, with many physicians still expressing frustration and experiencing burnout. A recent (2020) survey of TMA physicians indicated that 33% are either

somewhat or very dissatisfied with their EHR.³ Perhaps more important, 58% reported that data entry at the point of care interferes with their diagnostic thought process, and 68% reported that use of the EHR interferes with communication and attentiveness to the patient.

As the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services, and ONC place more regulatory requirements on physicians requiring technology components for interoperability, TMA pleads for thorough development and testing of those new requirements prior to widespread deployment.

2. Are there any new standards or use cases available or under development that should be considered by NCVHS for recommendation to HHS for adoption to support interoperability, burden reduction and administrative simplification? Some examples might include new information sharing in health care, such as data or semantics for social determinants of health, public health case reporting, or All Payer Claims Databases. Please do not limit responses to these examples.

TMA is not aware of any additional technical standards that should be considered. However, as outlined in the answer to the first question, an enormous number of use cases need to be defined and standardized – much like the many different situations that pilots may experience in flight.

In creation of new requirements, TMA strongly urges consideration of data formats that minimize the effects of artifacting, as file types such as .jpg can lead to loss of image quality across multiple file transfers, which may prove detrimental to the long-term preservation and use of an image.

3. How have other industries effectively implemented, tested, and certified standards for data and their exchange that could be considered for health care?

While health care is unique regarding data exchange, privacy, and security, it is not unique in terms of having use cases that need standard data and standard display for appropriate care. Just as aviation has slowly developed use cases and standard data requirements for the large number of situations that can occur in flight, medicine needs to do the same at warp speed to catch up. While aviation is the industry best known to have defined use cases and requirements, many other high-reliability industries have done this.

4. What short term, mid-term and long-term opportunities or solutions do you believe should be priorities for HHS?

Short-term: HHS should reevaluate ONC's implementation of the 21st Century Cures Act as related to information blocking. TMA supports the concepts of making sure patients have access to their health information, but as health care works towards compliance, we find nuances that were not considered. The recent requirement that significantly abnormal test results must be released before they are finalized with a physician review, while noble in intent, is generating underreported problems that are damaging to patients and physicians. As examples, patients in emergency departments (EDS) are now seeing radiology and lab reports before the treating ED physician and coming to their own conclusions,

³Survey of Texas Physicians: Health Information and Technology;
www.texmed.org/uploadedFiles/Current/2016_Practice_Help/Health_Information_Technology/2020%20HIT%20Survey%20Final%20Report.pdf; deployed August 2020.

sometime incorrectly, about whether additional care is needed. There are multiple examples of issues in pediatrics, especially regarding adolescent privacy and newborn records in the case of divorced parents. For example, the newborn chart may contain sensitive health information about the mother that would be available to the father requesting the child's record. These are just a few examples of use cases that need evidence-based professional society guidance as to how they should be handled in a standard way across the country.

Short-term: Greatly increased cyber security support, with a national approach is needed. Expecting each physician practice to have to figure out how to protect against international cyber villains is not feasible.

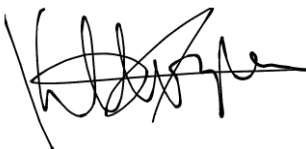
Mid-term: HHS should use policy levers that require certified vendors to develop and test interfaces with HIEs that can easily be deployed to physicians with little effort and at no cost to physicians. HHS should also support professional societies in the creation of the data use cases, tools, and filters to provide clinicians with focused, meaningful information, not tsunamis of data.

Mid-term: It is extremely costly for physicians to convert from one EHR to another. The ability to switch vendors quickly and easily would bring rapid improvements in EHRs. TMA supports the development and enforcement of standards and systems that allow ALL data to be efficiently, accurately, inexpensively, and quickly migrated to a new EHR just as smart phone users can switch data providers and have all applications, contacts, photos, and other data seamlessly and completely moved across platforms. TMA has requested and advocated for this for nearly a decade, and there's little evidence of progress towards this goal.

Mid- to long-term: HHS must reconsider patient portals. Currently patients under the care of multiple physicians have multiple portals with separate log-ins, passwords, and platforms. While this works for banking, it doesn't work for health care to have a patient's health history spread across multiple computer systems. Clinical decision support and artificial intelligence tools have to be made enormously more complex when the data is in multiple places, with the potential for data conflicts. Patients' portals must be combined into one easily accessible portal containing all necessary health information for the patient. This should be combined with a "patients should share responsibility for their own medical records" awareness program.

TMA appreciates the opportunity to provide this important feedback to NCVHS. Any questions may be directed to Shannon Vogel at TMA by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,

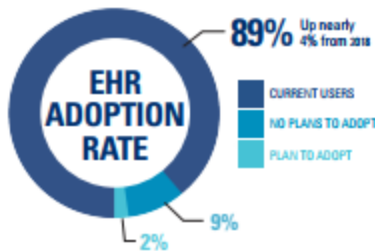


Ogechika Alozie, MD, MPH
Chair, Committee on Health Information Technology
Texas Medical Association

Attachment: Infographic | The State of EHRs in Texas 2020

THE STATE OF EHRs IN TEXAS ★ 2020

A TMA SURVEY OF TEXAS PHYSICIANS



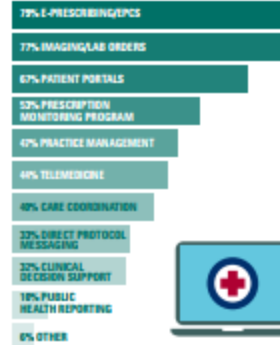
PATIENT PORTAL ISSUES



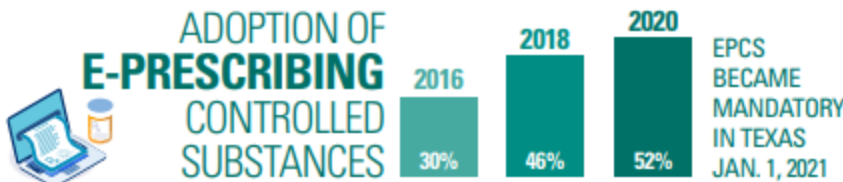
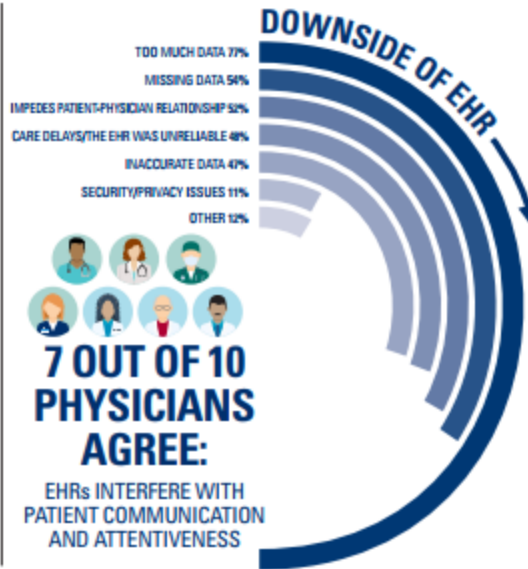
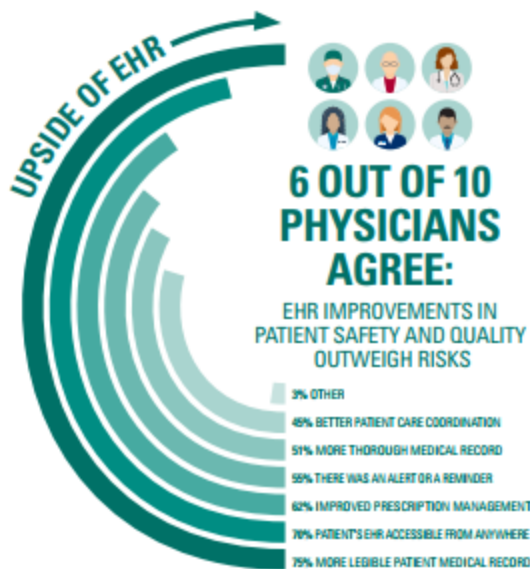
53% HAVE DIFFICULTY GETTING PATIENTS TO USE

41% HAVE PATIENTS WITHOUT A COMPUTER OR INTERNET ACCESS

EHR FUNCTIONS USED



PHYSICIANS' OVERALL SATISFACTION WITH EHR



This infographic is based on the final results (from 1,303 respondents) of TMA's August 2020 email survey of 36,889 Texas physicians. Full survey at: texmed.org/StateofEHRs2020



Questions about your EHR?

Contact TMA at HIT@texmed.org or (800) 880-5720

texmed.org/EHR