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January 30, 2015

Karen DeSalvo, MD, MPH, MSc
National Coordinator for Health Information Technology
Acting Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue S.W. Suite 729-D
Washington, D.C. 20201

Re: Draft Version of the Federal Health IT Strategic Plan 2015-2020

Dear Dr. DeSalvo:

On behalf of the American College of Physicians, I am writing to share our comments on Office of the National Coordinator's (ONC) draft version of the Federal Health IT Strategic Plan for 2015-2020. ACP applauds the ONC, and other agencies involved, for their diligence and hard work in developing this draft plan and their willingness to solicit and incorporate public feedback. ACP is the largest physician specialty society and second-largest physician membership organization in the United States. ACP represents 141,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults.

We thank you for the opportunity to provide input on these very important issues. Below we offer our thoughts on specific objectives and strategy goals outlined within the draft plan. We hope that you will find value in our responses. In addition, we hope that there will be regular opportunities for us to be involved in future deliberation as this plan is developed. Should you have any questions, please contact Thomson Kuhn, Sr. Systems Architect, at tkuhn@acponline.org.

Sincerely,

Peter Basch, MD, FACP
Chair, Medical Informatics Committee
American College of Physicians

Federal Health Strategic Plan	ACP Comments
Letter from the National Coordinator Implementation of the prior Plan created a strong foundation for achieving this Plan's goals and objectives. Over 400,000 eligible hospitals and professionals participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. This incredible achievement was not easy. Hospitals and health care providers have invested capital, time, and hard work to digitize their patient medical records. This has created a strong demand for the seamless sharing of information across technology systems, information platforms, location, provider, or other boundaries. There is also a strong interest among providers not participating in the EHR Incentive Programs to collect, share, and use interoperable health information. With this updated Plan, the federal government signals that, while we will continue to work towards more widespread adoption of health IT, efforts will begin to include new sources of information and ways to disseminate knowledge quickly, securely, and efficiently. The first two goals of this Plan prioritize increasing the electronic collection and sharing of health information while protecting individual privacy. The final three goals focus on federal efforts to create an environment where interoperable information is used by health care providers, public health entities, researchers, and individuals to improve health, health care, and reduce costs.	While over 400,000 participants successfully attested for Stage 1 of MU at least once, at least 250,000 failed to continue or start attestation, and the figures for Stage 2 are thus far even less encouraging. The sense of "strong demand" and/or readiness is overstated. Ambulatory physicians are interested in "interoperable health information," to the extent that that information is useful and usable – but are not necessarily interested in information, just because it is interoperable. We are concerned that "increasing the electronic collection…" sends exactly the wrong signal to physicians, as the emphasis is on data gathering and input – more uncompensated work. To state that this will not be burdensome because others might do the work is not credible, as to date; the burden of structured data collection has fallen primarily on physicians.
Vision	There is no reference to what is arguably most

Health information is accessible when and where it is needed to improve and protect people's health and well-being	important…having the right information in the right place at the right time in a usable form. Compare with the "Five Rights" of CDS.
Mission Improve health, health care, and reduce costs through the use of information and technology	We would prefer a statement that clarifies that "reduce costs" means not just reducing costs to payers – as that has been its historical meaning – which has also be tied to increasing costs and burden to providers. Without this clarification, where health IT's mission includes improving the efficiency and effectiveness of healthcare operations - the signal to physicians is more uncompensated work, no efficiency gains, and further micromanagement via health IT.
Overview Improving the secure availability and use of health information Given this range of activities, the federal government is also positioned to improve health, health care, and reduce costs through the secure use of information and technology.	Improving the secure availability and use of <u>accurate and usable</u> health information Given this range of activities, the federal government is also positioned to improve <u>the efficiency of health care operations</u>, and reduce costs <u>and burdens</u> through the secure use of information and technology, which is of course what the promise of IT is to other fields.
Federal Health IT Goals **Collect**	"Collect," by itself, is a troubling word to physicians, particularly in light of the experience to date of EHR adoption under MU regulations. There need to be qualifiers regarding its meaning in this context. For physicians and practices, it just means more work and burden.
Goal 1: Expand Adoption of Health IT	How will this happen without a corresponding change in the payment model? How will this be accomplished? There are plenty of opportunities already for providers to use telehealth, telephone, and other non-visit based care - but not yet a sustainable business case.
Objective 1A: Increase the adoption and	

effective use of health IT products, systems, and services. • 3-Year Outcome: Increase the percentage of hospitals and professionals who successfully demonstrate MU • 3-Year Outcome: Increase opportunities for provider and individual use of appropriate telehealth and mobile health technologies and services. • 6-Year Outcome: Increase the number of providers across the care continuum who use interoperable health IT products, systems, and services. <u>Strategies</u> 1. Encourage the use of certified health IT products through federal payment policies, contracts, and public and private programs that fund or provide health care and long-term supports and services 2. Expand the capacity of the workforce to support use of health IT 3. Establish technical guidance and standards, provide technical assistance, and identify and promote proven practices in the development, design, purchase, tailoring, and deployment of health IT 4. Encourage the adoption of telehealth and mobile technologies among providers and individuals, focusing on federal programs funding and/or providing health care, in care and payment innovation model initiatives, and those encouraging	(1st 3yr Outcome) The Meaningful Use program is in deep trouble, and it may not be salvageable at this point. If the adoption and effective use of health IT systems must be tied to MU, then either MU needs to course correct, or this 3-yr outcome is doomed from the start. (2nd 3yr Outcome) How will this be accomplished? There are plenty of opportunities already for providers to use telehealth, telephone, and other non-visit based care - but not yet a sustainable business case. Creating the infrastructure and an expectation of use (or requirement of use) without a modification to the payment model such that non-visit based care is paid for – is a plan to drive providers away from health IT. (6yr Outcome) Increasing the number of providers across the care continuum who use interoperable health IT will occur not by wishful thinking or mandate, but because it makes sense. Creating an infrastructure that adds cost and burden to providers and does not solve problems or create other efficiencies for providers is not a solution. <u>Strategies</u> #1-CMS has already had to back down from this requirement in the Medicare CCM codes, as too few providers are now using 2014 certified technology. That said, if certification and MU were course corrected such that interoperability did not = unnecessary check boxes and result in “interoperababble” – this is potentially a good strategy. #3 – Another potentially good idea. However, if the current federal government’s approach with its MU and EHR certification program is and/or is perceived as a barrier rather than an accelerant to innovation – it may be prudent for a more limited role of government – particularly when it comes to development and design. #4 – A good idea if executed well. Current definitions of telehealth by the federal government are outmoded and anti-innovation. Payment for non-visit based care, with

broadband adoption 5. Expand the ONC HIT Certification Program to certify products useful for providers across the care continuum	improved telehealth definitions and without a requirement for real-time video will create a fertile field for innovation. State laws need to be updated to define and allow for telehealth, as we broadly define it – and not just for Telehealth as it has been traditionally defined. #5 – This may be a good or a terrible idea. If the ONC HIT cert program is and/or is perceived as doing what it was intended to do – which was to encourage the development and purchase of better products that allow health IT to be more than digitized documentation systems, then the cert program should be expanded. However, where the cert program is adding cost and burden, essentially tying health IT functionality to arcane MU regulations, and there is still the risk of decertification of existing systems based on yet to be determined criteria – then the cert program should not be expanded, but either changed, or eliminated.
Objective 1B: Increase user and market confidence in the safety and safe use of health IT products, systems, and services • 3-Year Outcome: Increase the quantity and quality of data and knowledge on the safe use of health IT • 3-Year Outcome: Refine and implement frameworks for health IT safety and innovation • 6-Year Outcome: Increase the ability of health IT to manage information flow and adjust for context, environment, and user preferences. Strategies 1. Support the identification, monitoring, and reporting of complete, precise, and accurate challenges and hazards of health IT design and use 2. Integrate evidence on safe use of health IT into health IT certification 3. Encourage the application of human factors, health literacy, and user-centered	Objectives We also support these objectives, but urge caution in executing on "refine and implement frameworks." This is again a problem with the existing E&M coding requirements and assumptions for visit and non-visit based care. For example, at this point in time ePrescribing has essentially eliminated prescription errors caused by bad handwriting – an appealing solution to an almost non-existent problem. If ePrescribing were to morph to electronic medication management, where safe prescribing was also informed by diagnoses and adherence, the act of prescribing / renewing medication would almost certainly be a more time consuming process. And without a change in E&M codes or the assumption of what % of a particular visit charge was spent on information gathering and medication ordering, implementing a health IT enabled medication safety program could work for patients and consumers – but could undo all progress to date in making primary care more attractive – as PCPs would now have an even bigger and uncompensated burden of medication list management.

design in the development and use of health IT products, systems, and services 4.Implement a balanced, transparent, and risk-based approach to health IT oversight 5. Develop, select, promote, and implement health IT standards in transparent ways that promote competition, foster innovation, and minimize barriers to market entry for developers and users 6. Promote data portability and interoperability to encourage competition, foster innovation, improve individuals' and providers' choices, and reduce barriers to change health IT products, systems, and services	When ePrescribing standard messages were being developed – the developers did not sufficiently validate their assumptions with prescribers or clinical pharmacists. This lack of a standard "STOP this med, replace with this med" – has led to many medication errors. Strategies We support these strategies – especially #3 and #4.
Objective 1C: Advance a national communications infrastructure that supports health, safety, and care delivery • 3-Year Outcome: Increase access to broadband connectivity for health IT applications, such as high-resolution imaging, telehealth, and mobile health. • 6-Year Outcome: High-speed networks are broadly available to support rural and other underserved communities. Strategies 1. Use federal authorities and investments to improve access to and choice of broadband and wireless networks 2. Encourage comparable upload and download speeds for consumers and providers in rural and other underserved communities 3. Ensure that the national health IT and telecommunications infrastructure are secure, resilient, and operational during public health emergencies and disasters	(3yr Outcome) We need clarity on what "telehealth" solutions means. The traditional definition of Telehealth is remote care provided in a rural area, where the patient is physically with a PCP, and both PCP and patient are present for a real-time video conference with a remote specialist. To optimize health IT, federal policy must also pay for non-visit based care, where "telemedicine" may be real-time video, asynchronous video, secure messaging, etc. Strategy #2 Does encouraging comparable upload and download speeds serve the needs of most consumers – or will it provide cover for slower download speeds, which is what most consumers need.
Goal 2: Advance Secure and Interoperable Health Information The significant progress in digitizing the collection of health information has	We question the claim that significant progress has been made. We are still in a phase similar to manual punch cards, where providers are suffering from reduced productivity by the burden of manually creating

increased the demand to securely share health information electronically and use it to improve health and health care. The ONC HIT Certification Program serves as a valuable mechanism for promoting the use of common standards for interoperability; however, significant work remains.	structured (digital) information. The collection of digital health information is tedious. Where has there been significant progress in making data collection digital without creating undue burdens on people whose job is care delivery rather than data collection? The certification program has also led to unusable one-size fits no one health IT, and poorly usable health IT that is certified to clunky MU workflows. Further, with decertification of previously certified systems now a possibility, it adds cost and complexity, with a specious sense of certainty.
Objective 2A: Enable individuals, providers, and public health entities to securely send, receive, find, and use electronic health information • 3-Year Outcome: Increase the percentage of individuals, providers, and public health entities that electronically and securely send, receive, find, and use a basic set of essential health information across the health care continuum. • 3-Year Outcome: Trusted entities that exchange health information follow common rules of engagement to ensure information is securely shared through supportive and non-obstructive business practices. • 6-Year Outcome: Increase the percentage of individuals, providers, and public health entities that electronically securely send, receive, find, and use an expanded set of health information across the care continuum. Strategies 1. Establish rules of engagement and a governance mechanism related to	This objective seems appropriate, particularly if the Summary of Care (SoC) and Clinical Summary documents can be done away with, and if federal payers will begin to accept information output from health IT that results in fewer and ultimately no need for redundant forms (prior auth, FMLA, sick leave, etc.) (1st 3yr Outcome) If the so-called "basic set" of information looks anything like the bloated and mind-numbing SoC, this will not be a step in the right direction. If the current SoC requirements are not revised, and thus the "basic set" of health information is not truly useful and appropriate in all clinical situations, then this will probably lead us in the opposite direction – physicians wanting to disconnect. (2nd 3yr Outcome) This is a critical requirement, and the details of the current problems can be subtle. For example, with one leading EHR system, a physician can view records from other hospitals that use the same system, but cannot integrate the med list, problem list, labs, and allergies. Inaccurate med lists, repeat lab and x-ray testing increases cost and risk to patients.

standards, data policy, and operations, for electronic health information exchange to facilitate security and interoperability across all types of entities and networks that provide exchange services and safeguards for appropriate levels of information access 2. Work with partners to reduce regulatory and business challenges that impact health information exchange 3. Promote the coordination of care for individuals across the care continuum through innovative care and payment models, shared care plans, and value-based purchasing 4. Ensure health IT products and services support the privacy, technical, and vocabulary standards necessary for capturing, finding, exchanging, and using standard health information across the health care and long-term services and supports continuum, and with individuals and public health entities 5. Encourage electronic information sharing between public and private health providers and payers to promote care continuity	Strategy #3 While we support the promotion of coordination of care, as an activity where care suggested or provided by two or more providers is reviewed, reconciled, and made understandable to patients and families – we are concerned that prior ONC and CMS requirements that pertain to care coordination define it quite differently (i.e., care coordination = sending a communication to another provider). We believe that communication does not equal care coordination and thus want to make sure that our support of the technical, workflow, and payment enablers of coordination of care is what we believe it to be – typically a function of the PCP or principal provider.
Objective 2B: Identify, prioritize, and advance technical standards to support secure and interoperable health information • 3-Year Outcome: Increase use of common standards among federal agencies, private industry, and the biomedical research community • 6-Year Outcome: Improve the capability of health IT to manage information from varied sources in both structured and unstructured formats Strategies 1. Encourage consistent standards implementation, reduce implementation variability, and improve modularity in health data standards for terminology and vocabulary, coding, data content and	We support these objectives – but again urge caution with an objective that calls for “increased use of common standards” without necessarily creating a reason to use them. Thus, it is only an increase in burden when standards are required for data input, but there is no requirement for data recipients (such as payers) to accept information collected within those standards. Strategies #1 – This makes good sense, and should also include work on standard semantics, i.e., what is included in a problem list, med list, or allergy list. #4 – We are concerned that without clarification as to

format, transport, and security 2. Require that certified health IT products and services have functions that facilitate users' compliance with requirements related to privacy and security 3. Advance technical and electronic methods to accurately identify, proof, match, and authenticate information across data sources 4. Advance standards that support interoperability between medical devices and certified health IT products and systems, including standards for documentation of medical device use by unique device identifier and methods for adverse event reporting 5. Advance standards for common data elements to enable capture and use for clinical decision support, clinical quality measures, and reporting 6. Encourage the adoption and use of prioritized sets of common standards through health IT certification, federal regulations and programs, and research funding mechanisms	who must document unique device identifiers, that this will fall to the provider upon whom most documentation requirements have fallen, the PCP, who as the person who is least likely to implant a device, is least likely to be able to determine a device identifier. #5-Who will decide what is included in the "common data element" set and what is not? What will be the ongoing governance process by which elements are selected, modified, and deleted? How will decisions be made regarding which codes from which vocabularies, terminologies or data sets will apply to which data elements? What will be the requirements regarding collection and reporting? Will there be a mandate to collect all data elements in all situations? Must all elements be sent in all situations? What will happen when two different public health reports demand different coding for a "common" element? We believe that none of these decisions can be made without the full participation of practicing clinicians who routinely work with each candidate data element. Thus far, it appears that this is an internal HHS project involving only terminology experts and consultants.
Objective 2C: Protect the privacy and security of health information • 3-Year Outcome: Increase the reach of education and training information and tools for health IT privacy, security, and cybersecurity • 3-Year Outcome: Improve providers' and other stakeholders' compliance with federal privacy and security requirements in managing electronic health information • 6-Year Outcome: Establish and implement federal policies and technical solutions related to emerging uses of individual electronic health information Strategies 1. Support the development and	Strategies #3 – This issue, the ability of individual patients to "manage, control, and authorize the disclosure of specific

implementation of policies, practices, and education that protect health information from breach, and address cybersecurity risks and developing technologies 2. Continue development, administration, and enforcement of federal privacy and security regulations and standards for HIPAA-covered entities and business associates 3. Support the development of policies, standards, technology, guidance, and solutions to facilitate individuals' ability to manage, control, and authorize the disclosure of specific electronic health information 4. Require and test that certified health IT products incorporate privacy and security safeguards 5. Support, promote, and enhance the establishment of a single health and public health Information Sharing and Analysis Center (ISAC) for bi-directional information sharing about cyber threats and vulnerabilities between the private health care industry and the federal government 6. Continue enforcement of applicable federal privacy and security requirements for entities not covered by HIPAA	electronic health information," has been an ongoing and vexing issue for years. We need clarity from ONC as to exactly what this means. Thus, does it mean that a doctor sending a note (via electronic means) to a colleague may no longer do so, and that a patient has the right and ability to essentially redact the note? Does that right also apply to non-electronic communications – or are those exempt? Or does this mean that the information that might populate a HIE is under the control of patients, whereas direct provider-to-provider communication is also exempt. If the intent of this strategy is to allow a patient to redact/edit a provider note to a colleague, we would be opposed, as the removal of certain key words or findings can not only lead to an incomplete transfer of information, it can lead to redundant effort and even errors of omission and commission. We would not be opposed to patient control of what populates an HIE, as long as the HIE could show to any receiving provider that the information received was subject to patient redaction and thus may be incomplete. #4 - As this affects physicians' time and the real and/or perceived requirements on them to protect the medical record as well as to keep it accurate – there is a need to include practicing physicians and other clinicians in this process. This has not been the case in the majority of ONC deliberations on any health IT topics thus far.
Goal 3: Strengthen Health Care Delivery	
Objective 3A: Improve health care quality, access, and experience through safe, timely, effective, efficient, equitable, and person-centered care • 3-Year Outcome: Increase individuals' access to health care through health IT products and services • 3-Year Outcome: Increase use of electronic quality improvement tools and measurements that support	Efficient care requires that health IT work like IT in other disciplines - meaning the ability to reuse collected information. In healthcare operations we are still burdened by payer requirements that are unique and require duplicative documentation. We will never have the time and focus to increase safety, quality, effectiveness, etc. if we don't begin to address the burdensome nature of health IT-enabled care. What is there in all of the federal health programs that helps to make health IT use lead to operational

provider adherence to evidence-based guidelines and improve outcomes - 6-Year Outcome: Increase use of health IT integrated with primary and specialty care that facilitates informed individual engagement and shared decision-making Strategies 1. Incorporate telehealth and mobile health technologies and services within federal programs funding or providing health care and innovation model initiatives to improve access to and quality of health care services 2. Promote the well-designed incorporation of usable electronic information, clinical quality measurement, safety and adverse event information, and clinical decision support into clinical workflow 3. Develop and encourage the use of automated tools for testing and validating information used in capturing and reporting quality measures 4. Develop health IT solutions that allow federal regulatory agencies to receive and evaluate pharmaceutical, biologic, and medical product risks more efficiently and promote the safe use of these products 5. Encourage health IT use to collect and integrate person-reported outcomes, accommodations, and preferences as part of routine health care and long-term supports and services delivery 6. Address the health literacy issues for different individual and caregiver populations so that the technology matches and improves their health management skills	efficiencies? (1st 3yr Outcome) How does ONC intend to increase individuals' access to health care via health IT, unless there is appropriate payment for non-visit based care? Does ONC intend to require uncompensated e-Care? (2nd 3yr Outcome) What quality improvement tools are being referred to? To have an objective of quality improvement, ONC needs to do more that increase use of existing quality measures, many of which are a poor fit for e-Measures and do not reflect existing evidence. (6-yr Outcome) We support the 6-yr outcome, but again caution that health IT is being utilized to support work that is now not typically being done (informed individual engagement and shared decision making). Having this as an objective without appreciating the added work of the provider will lead to more of the same concerns that providers are expressing now – that EHRs are adding work. Note that while that may be the case some of the time – here we are just adding new work to EHR users that is not necessarily there for providers using paper records. Strategies #1-We agree, but only if "telehealth" means more than it means now; specifically that it also includes non-visit based care provided by a single provider, and that it also include such services, even without the use of real-time video. #2 – We agree, but it must be well designed and not include duplicative documentation requirements. #3 – What does encourage the use of automated tools mean? We would simply say "good idea," but with the current history of MU mandated busy work – we are concerned that encourage will mean "require," and automated will mean "manual duplicative entry." #4 – Similar to #3, we support the intent, but wonder where the burden will lie. If the past is suggestive of this future, we are concerned that these health IT solutions will be dependent on provider manual data entry of new

	fields – making EHR enabled care even more onerous than it is today. #5-We agree, but we remain concerned about any mention of data collection without context. Up to this point, "data collection" has meant increased burden and clunky workflows for physicians and other clinicians. #6-As with #5 above, to physicians this sounds like a few more mandated fields to populate. It appears that the only option ONC offers for anyone interested in a disease, condition, or problem is to mandate collection of a few more structured data fields by people whose primary job is not data collection.
Objective 3B: Support the delivery of high-value health care • 3-Year Outcome: Identify and increase administrative efficiencies that reduce cost and improve provider and patient experiences • 3-Year Outcome: Increase the number of providers receiving technical assistance for using electronic health information as part of practice design and management of their patient population • 6-Year Outcome: Standardize and expand regional multi-payer claims and clinical data infrastructure to facilitate clinical performance reporting and feedback to providers <u>Strategies</u> 1. Leverage health IT to improve the accuracy and <u>consistency of documentation</u> and coding 2. Use health IT to simplify participation and reporting requirements across programs for quality and claims information 3. Improve the capacity of electronic information sources to support providers' ability to accurately and efficiently report and receive feedback on health care quality	While we support this objective, we are concerned that no strategies are offered that are specifically focused on the real daily problems. Formularies are not accurate or useful. Payment rules are not transparent. We recommend starting with Medicare Part D payers - who are the current worst offenders when it comes to formulary inaccuracy and unjustifiable prior authorization requirements. Specifically, providers do not need technical assistance where the information is inaccurate and misleading, and the process for operational efficiency is either nonexistent or poorly designed. This paper offers concrete suggestions. We recommend that ONC put some of this into action. Dedicate resources to caring about healthcare operational efficiency. Wikler, E, Basch, P, Cutler, D. Paper cuts: Reducing healthcare administrative costs. *Center for American Progress*; June 2012. http://cdn.americanprogress.org/wp-content/uploads/issues/2012/06/pdf/papercuts_final.pdf <u>Strategies</u> #1-Consistency of documentation would be seen as a red flag by the Office of the Inspector General (OIG). The OIG has indicated that too much consistency may be evidence of possible fraud. This needs to be addressed if ONC is to

measures for public and private programs 4. Provide health IT implementation and usability support to health care and long-term supports and services providers to help them succeed in innovation models and use IT solutions to evaluate and manage cost, complexity, and outcomes to aid their organizational and clinical processes and practices 5. Advance multi-source data integration, innovative data use agreements, open data sources, and reliable connectivity and computational power to connect care across time, geography, and appropriate users of health information	achieve this objective. Also, we are concerned with the possible risks of tying the program to coding accuracy without additional context. We also take exception to the need for providers to accurately code to billing standards. There is a valid argument that accurate documentation using SNOMED-CT is sufficient, and that the introduction of billing system coding requirements only results in pseudo-accuracy. #3 – We support this strategy, but also remind ONC that to make this work will in some instances require improving or removing some existing measures, as they are a poor fit for EHRs and clinical workflow; and in other instances change the measure, as the measures no longer reflect best evidence. #4 – If this strategy is, as it sounds, a departure from the existing one-size-fits-all care model; and instead is signaling a role for ONC that recognizes that health IT optimization is specialty specific, we strongly support this strategy.
Objective 3C: Improve clinical and community services and population Health 3-Year Outcome: Increase use of health IT systems to provide evidence-based guidance on appropriate use of screening and prevention services 6-Year Outcome: Identify innovative uses of health IT to connect individuals and providers to community resources, social services, and health education programs. Strategies 1. Promote data collection, clinical decision support, and analytic capabilities to allow for precision medicine and to identify individuals and communities that are underserved or at risk to target timely health interventions 2. Facilitate the interoperable exchange of common data elements and quality	Strategies #1-What does that mean? Who will now have to collect what additional data? Specifically, with recent history as our guide, we are concerned about any new calls for "data collection," as in the absence of clear direction to the contrary, we expect this will fall upon the shoulders of physicians and other health care professionals. #4 Before digging into brand new areas of development we urge ONC to take this approach with all the

improvement documents and tools 3. Encourage and partner with communities to find ways for using health IT to streamline eligibility requirements and expedite enrollment processes to facilitate individuals' access to preventive and social services 4. Encourage and partner with communities to explore ways for using health IT to facilitate coordination and implementation of complementary health strategies among clinical, behavioral, preventive services and social services 5. Encourage collaboration between public and private providers and payers to facilitate comprehensive care delivery	burdensome prior authorizations and other forms that waste almost an hour per FTE provider per day.
Goal 4: Advance the Health and Well-Being of Individuals and Communities	
Objective 4A: Empower individual, family, and caregiver health management and engagement • 3-Year Outcome: Increase individuals' access to their electronic health information, and improve their ability to share and authorize its use, or incorporate this information into their health IT tools • 6-Year Outcome: Expand ability for individuals to safely contribute relevant and usable electronic health information to their clinicians for engaging in shared decision making on their care and wellness goals • 6-Year Outcome: Increase the number of federal care delivery systems and programs incorporating the use of innovative technologies (Sensors, medical devices, assistive technologies) to improve the health of the populations they serve	We fully support patient empowerment. The difficult question is, "How?" Engagement and collaborative management change the dynamic with physicians and other clinicians, which may lengthen visits and non-visit encounters. How do we improve the experience for one patient without reducing access for other patients? (3yr outcome) We need to figure out how to accomplish this. Many medical offices already have a person managing information requests from insurance companies and other record releases. What is the time estimate per FTE provider for providing this to patients? (1st 6yr outcome) The existing limitation is less technologic and more that the required work is a poor fit with our existing payment model. Contributed information has to be viewed and reacted to. We agree that shared decision making is the way to go; however it cannot be treated as a casual opportunity. It deserves planning and time and attention. Payment model reforms to accommodate the implications of this approach are necessary. <u>Strategies</u>

Strategies 1. Advance individuals' ability to securely access, control, amend, and make other choices regarding the use and disclosure of their electronic individually identifiable health information and their self-generated health information in formats they can use and reuse 2. Disseminate health IT tools and educational resources for individuals that are designed to enable them to understand their health information, costs, and care options, and to become advocates for their own health 3. Support health IT policies that enable products that integrate self-generated health information, self-reported outcomes, and genomic information into an individual's longitudinal care records and self-care and wellness technologies 4. Work with partners to support providers' and individuals' understanding of risks and responsibilities of care options that lead to informed shared decision-making 5. Promote health IT that incorporates the provision of evidence-based health information resources, logistical support, decision aids, and risk calculators to providers	#3-How will we carve out the necessary time to address this self-reported information? Do federal payers currently support unrestricted genomic testing? #4- We agree, and this means more time for many office visits, particularly for chronic care. #5 Excellent!
Objective 4B: Protect and promote public health and healthy, resilient Communities • 3-Year Outcome: Increase public health entities' ability to use, benefit from, and manage advances in real-time electronic health information for public health surveillance and targeted alerting • 6-Year Outcome: Increase use of health IT systems to assist national, state, and community efforts to support the early detection and mediation of emerging hazards	(3-Yr Outcome) We agree with the concept, but are again concerned with the implicit and assumed uncompensated increased burden on providers re: data input and responding to targeted alerting. (1st 6yr Outcome) Without a more detailed explanation, this objective appears to mean more manual data entry requirements for healthcare professionals.

• 6-Year outcome: Increase use of health IT in enhancing public health situational awareness by incorporating environmental, psychosocial, and other non-medical information into providers' workflow and health care records Strategies 1. Support the use of health IT that can help communities conduct needs assessments and protect high-risk individuals 2. Expand the capacity for health IT and predictive analytics to assist communities in managing and preventing chronic health conditions, health care-associated infections, urgent threats, and other nationally notifiable diseases, and to promote community well-being and resilience 3. Use health IT and integrated platforms to support resilience and mitigation of emerging hazards and public health threats 4. Prepare public health systems and leverage health IT, communications, and integrated platforms to inform decision making to ensure continuity of appropriate care during disasters and health emergencies 5. Enhance or, if necessary, develop and maintain standards for the unique health IT needs associated with emergency care, public health emergencies, and disasters to include rapid transfers of care, unidentified individuals, and individual movement	(2nd 6yr Outcome) This outcome seems desirable, but how can it be implemented? Should health IT redefine the current concept of medical history, which has time and payment implications for physicians and other healthcare professionals? For example, if a 99213 visit assumes 15 minutes of a physician's time with x minutes dedicated to history, how much longer will it take to read and incorporate environmental, psychosocial, and other non-medical information into the physician's workflow and the healthcare records?
Goal 5: Advance Research, Scientific Knowledge, and Innovation	
Objective 5A: Increase access to and usability of high-quality electronic health information and services • 3-Year Outcome: Increase the number, timeliness, quality, and usability of federal health and other relevant data sets available for public use while	(6-yr Outcome) While we support this in principle, we favor a modification to the statement, which includes an analysis of the implications to current EHR workflow that

protecting privacy - 6-Year Outcome: Expand the capacity and design of health IT infrastructure to support coordinated person-centered outcomes research development and findings dissemination Strategies 1. Support additional, expanded open data releases of federal and federally-funded data that relates to health, consistent with HIPAA and the Privacy Act 2. Collaborate with private and academic research activities on strategic dataset releases, appropriate data dissemination, data discovery and location mechanisms, and education to support innovative data use 3. Fund collaborative research data networks and infrastructure so researchers can generate and disseminate person-centered outcomes and health services research 4. Enable and validate the electronic sharing and use of relevant EHR data in clinical trials 5. Encourage electronic access to clinical trial data from domestic and international sources to expand person-centered outcomes 6. Promote innovation in clinical trials through strategic leveraging of health data and health IT systems in trial design and execution	would likely occur should there be an expansion of capacity and design of health IT infrastructure to support research. Our concern is that current design of research-qualified EHRs differs from patient-care EHRs, as there is an added layered of documentation – and that making this a part of all EHRs could make EHRs even more cumbersome in routine care delivery and documentation. Strategies #1 We are concerned that such a broad release program could reduce the ability of patients to provide informed consent to the previously un-consented use of their data. While it is possible for a data release to conform to the specifications for deidentification, we all know that more data availability means increased likelihood of re-identification.
Objective 5B: Accelerate the development and commercialization of innovative technologies and solutions - 3-Year Outcome: Advance science and knowledge in creating and using sensors, mobile technology, medical devices, and assistive technologies that enable users to quantify and use personal health information while protecting their privacy	We fully support accelerating the development and commercialization of innovative information technologies in healthcare, but we are concerned that existing MU-driven certification requirements are impeding this development. (3yr Outcome) We see troubling implications for expanding the existing concept of taking a medical history that adds more time to even simple visits.

- 6-Year Outcome: Advance science in using health IT for precision medicine and patient-centered care - 6-Year Outcome: Advance science in using health IT to support distributed analytics and evidence sharing. Strategies 1. Fund organizational learning and research, and promote innovation for new health IT products and solutions, including mobile applications, that incorporate privacy protections, wearable technologies, advances in big data, computation and analytic methods, and other scientific discoveries that use health IT securely to help resolve challenging health problems 2. Identify methods to integrate health information securely into mobile health technologies and related social networking platforms to more effectively reach health care professionals, individuals and families while protecting the privacy of the information 3. Develop solutions and guides for incorporating precision medicine and predictive modeling into care delivery 4. Promote transparency in communication about what information devices are collecting and how it is being used, shared, or retained 5. Invest in methods and approaches that support distributed analytics and evidence sharing while protecting personal health information	Strategy #2 – We believe that this strategy should be modified to state, "Determine if integration of PHI into social networking platforms is an appropriate way to reach health care professionals, individuals and families; and if so, identify methods to best do so, while protecting the privacy of information." We are concerned that social networking and health care privacy may not be compatible.
Objective 5C: Invest, disseminate, and translate research on how health IT can improve health and care delivery - 3-Year Outcome: Increase evidence and tools available on proven practices of using health IT - 6-Year Outcome: Translate evidence into clinical practice more quickly and	

effectively through health IT technologies and infrastructure • 6-Yea Outcome: Improve adherence to evidence-based medicine by increasing implementation of supportive health IT technologies and applications	
Strategies 1. Collect, analyze, and interpret data to assess the impact of health IT use and valuebased purchasing incentives on improving health outcomes 2. Collect, analyze, and interpret data to assess the impact of health IT use to reduce disparities in the quality, accessibility, and safety of health care and long-term supports and services	Strategies #1 and #2 – Again, we are concerned where there is a call to "collect" data, as unless it is specifically mentioned otherwise, we assume this will be yet another unfunded mandate on providers.
3. Fund health services research to identify the most effective ways health IT can support organization, management, and delivery of health care and long-term supports and services 4. Fund research to provide evidence and proven practices on use of health IT to improve the quality, safety, and value of care in care settings, among populations, and among human services organizations 5. Promote rapid translation of evidence from health services research and organizational learning into health IT products and practice transformation efforts	Strategies #3, #4, and #5 – It is conventional wisdom that health IT by itself is enabling infrastructure, and without concomitant workflow and a supportive payment environment, modifications to health IT alone are unlikely to result in change, as the business case to support that change does not exist. We thus encourage modification of strategies #3-#5 to include research and analysis of workflow and payment model transformation.