

FY22 Comments on White House OSTP RFI

Relevant Links

- [Federal Register](#)

Document Leads

Lead Workgroup: Public Policy Leadership Workgroup

Comment Lead:

Timeline - **now due 3/31**

Action	Duration (days)	Start Date	End Date
Workgroup(s) review & draft comments	8	1/26/22	2/4/22
Workgroup finalizes comments	3	2/7/22	2/9/22
Comms puts comments into document form	2	2/10/22	2/11/22
PPL reviews and approves comments	4	2/14/22	2/17/22
Comms cleans up document for EC review	2	2/18/22	2/21/22
EC reviews and approves comments	3	2/22/22	2/24/22
Final Document Complete	1	2/25/22	2/25/22
Submission Due	1	2/28/22	2/28/22
Post final document on EHRA website	1	2/28/22	2/28/22
Media/Outreach Opportunities	5	2/28/22	3/4/22
Total Business Days	28		

Comments are being transferred to [this google doc](#) for a final EC review. Please do not edit this narrative after 10:45am CT on 3/25/22

March 31, 2022

<address>

The HIMSS Electronic Health Record (EHR) Association member companies serve the vast majority of hospital, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs and other health IT across the United States. Our mission to improve the quality and efficiency of care through the adoption and use of innovative, interoperable health information technology is fully aligned with your efforts to lower barriers for all Americans to accessing quality healthcare and lead healthier lives through the innovative use of digital health technologies.

EHR developers are the lynchpin of any successful digital health technology implementation, including technologies to advance the wellbeing of communities and the social needs of patients. Software developed by our member companies is used across the country and the world to deliver integrated telehealth visits to patients and providers, to store data collected from remote monitoring devices and health trackers, and to exchange complete patient records when needed at the point of care.

The EHR Association supports your focus on community-based health settings and underserved populations. On behalf of our nearly 30 member companies, we appreciate the opportunity to provide input on the role of digital health technologies in transforming community health, individual wellness, and health equity.

Sincerely,

Successful models and promising candidates within and outside the U.S.

To name a few:

- The **ClinicalConnect Health Information Exchange**, in Pittsburgh PA, connects almost 100 organizations, including hospitals, health systems, physician practices, urgent care, pediatrics, senior care, and federally qualified health centers, exchanging information on behalf of millions of patients. CCHIE also connects to other state-based health information exchanges to further interoperability.
- The North Carolina Department of Health and Human Services launched its **Healthy Opportunities Pilot Programs** to test the viability of non-medical interventions to reduce costs and improve outcomes for Medicaid beneficiaries. Services to address housing, food, transportation, and safety issues receive funding through the pilot program. As a part of the program, health plans and providers screen for social determinants of health (SDOH) and refer qualifying patients to community-based organizations (CBOs) that can address those determinants.
- The New York State Department of Health, under its Value-Based Payment program, now requires participating health systems to screen and implement at least one SDOH intervention, and contract with at least one CBO to implement that intervention.
- Finland provides both social welfare and healthcare services through centralized health centers that serve their municipalities. Notably, Apotti administers an electronic social and healthcare record that combines data from health and social care into a single, longitudinal record for over 1.7 million residents in Finland's Uusimaa region.

These models are successful because they take a systematic and standards-based approach to screening, interventions, and interoperability.

More specifically:

- They adopt governance models that act at a system level, allowing for the centralized establishment of policies and procedures guiding the network. Privacy and consent expectations are established for the system, and requirements flow down to individual participants.
- They leverage standards-based approaches to exchanging data, building upon interoperability standards (such as those developed by HL7) that have been used with proven scalability throughout the healthcare industry for years.
- They fund providers and CBOs to take on this extra work of coordinating care and services for their patients. CBOs are given the support they need to adopt technology that allows them to communicate effectively with their healthcare counterparts.

Scaling these models, however, will require:

- A way to identify patients/citizens that allows for a single, longitudinal record of health and community care,
- Reducing state-by-state variations in laws and regulations to allow organizations to more easily coordinate health and social care across state lines,
- A shared governance model that can set a common floor for policies and procedures across multiple health and social networks. The Trusted Exchange Framework, while not yet ready to handle the coordination of social care, will be the best-positioned entity to create and administer this governance model.
- Development and maturation of standards for social determinant domains, screener assessments, and closed-loop referrals between healthcare systems and CBOs. OSTP should support existing efforts in this area, such as HL7's Gravity Project and the Direct 360X Project.
- A more mature and connected technological underpinning for a much wider range of CBOs, not a handful or select few.

Current barriers to digital technology adoption in community health settings, and potential government actions to address them

In many ways, the technological state of CBOs today resembles the landscape of EHR adoption by healthcare providers fifteen years ago: while a few bright spots exist, many CBOs lack the resources or knowledge to adopt technology, and instead subsist on a combination of paper and basic technologies like Excel spreadsheets. OSTP has the opportunity to work with the Office of the National Coordinator, the Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration to explore this parallel in more detail and adapt small, targeted initiatives based on the successes of the HITECH Act, which was largely responsible for the widespread adoption of interoperable EHR technologies.

For example, a successful strategy might:

- Incentivize the adoption of interoperable technology by CBOs, both through direct subsidies or funding and through the inclusion of CBOs in larger value-based care payment models,
- Promulgate standards-oriented guidance specific to technologies that can be useful and efficient in further digitizing CBOs and social services agencies, including exploring ways open APIs can be helpful in making information available,
- Develop and establish vocational programs to produce more available staff with the core competencies needed for a more connected environment,
- Establish regional entities that can help social services agencies understand and choose among technological options and aid in their implementation,

- Finalize the HIPAA Coordinated Care NPRM issued in 2021, to enable increased interoperability among all stakeholders, including more sensitive social care entities,
- Reduce individual state-by-state variation in privacy laws that might impede interoperable exchange,
- Embrace the existing work already done through TEFCA to prioritize future adoption of social care use cases, as standards mature and trading partners come online.

Such an approach would ensure that the country builds upon the existing healthcare technology ecosystem, folding community care into the larger healthcare picture, not as a separate or standalone entity, but as one that can interoperate fully and with ease.

While standards are still being matured through initiatives such as the aforementioned Gravity Project, these policy and funding efforts could begin work now with a possible rollout over the next 3-5 years.

Learning from the COVID-19 pandemic

EHR Association members supported our collective clients across the country from the beginning of the pandemic in a number of ways:

- Clinical decision alerts to optimize care for patients and ensure clinicians were aware of constantly evolving best practices,
- Reporting to a huge variety of public health entities, most requiring different data elements,
- Documentation of SDOH data helpful to decisions during the care process and public health analysis of disease trends.

Further, the dramatically expanded use of telehealth authorized during the pandemic under the Public Health Emergency (PHE) was supported by our member companies, either through direct provision of the technology or connectivity to third-party telehealth providers who interfaced with EHRs for access to clinical data.

The ability to access timely data and continue to support patients' health needs even in the midst of the worst COVID-19 surges helped patients to receive important care as they were ill and continue treatment for numerous conditions. The pandemic provided an opportunity to stress test telemedicine functionality and the provider community's reaction to it at a scale not previously envisioned. There have been numerous studies stemming from the allowances and payment adjustments that made such widespread use feasible. It is clear that telehealth did not increase costs, as had been feared, but in fact proved highly efficient and effective, particularly for certain clinical use cases such as mental health treatment.

While telemedicine/telehealth use increased in important ways over the last two years, it is clear that a fundamental reason is that pay for services was on parity with similar in-person visits. If that is to be

undone at the end of the PHE, the use of the remote technologies will also drop in parallel.

We also note that, for the most part, CBOs and social service agencies working to increase health equity and address SDOH did not benefit in the same way as traditional care environments. The same barriers to a fully connected environment in which healthcare providers and CBOs work seamlessly together with bidirectional information exchange as the norm have affected the inclusion of those organizations in the expansion of telemedicine described above.

Lastly, the pandemic has made health inequity issues abundantly clear over the last two years. One positive result is that recently passed laws have begun to acknowledge the need to modernize technologies used by public health agencies with a greater adoption of standards-based technologies. The burden of reporting on COVID-19 activity amongst our clients - and thus EHRA members, in supporting them - could be significantly lessened if the technologies used to collect data relied on standards-based approaches, as opposed to proprietary softwares with siloed and distinct thinking on the best data to collect and how to collect it.

While the Federal government has done good work to standardize code sets and vocabularies associated with SDOH, those same approaches to consistency are not yet taken by all city, county, state, regional, or specialty-specific public health organizations or data registries. This presents a tremendous opportunity for improvement going forward. The EHR Association strongly encourages the CDC to require that any municipal investment request for funding be accompanied by a plan explaining how they take a standards-based approach to public health information exchange and a commitment to maintaining and modernizing as technologies change in the future.

Ensuring an equitable approach

Any initiative aimed at improving the community-wide care of patients through technology must monitor and measure the impact of the initiative across race, ethnicity, and socioeconomic status. The EHR Associations encourages OSTP to establish key performance metrics and quality measures from the outset and plan to stratify and break down performance on those metrics by citizen demographics. Such reporting should be transparent and accountable.

We note that there is currently little consensus among federal agencies as to how race, ethnicity, and preferred language are codified. Moreover, such information is not always consistently or accurately captured due to a lack of organizational incentive and patient reluctance. We encourage OSTP to work together with ONC, who is leading the investigatory effort to address this problem in health systems. A standardized code set and best practices for capturing information can be established in health care and then applied to other settings, including community-based services.

While it is clear that digitization must occur in the community among CBOs and social services agencies, advancing digital health technology adoption in community healthcare depends on the health information technology ecosystem that supports delivering safe, cost-efficient, and citizen-centric services. The EHR Association and our members are well-positioned to offer insight into existing

technologies, strategies, and opportunities. We look forward to continuing to collaborate with you and other federal stakeholders in this important effort.

Raw notes

Overview

Necessary terms

Digital health technologies

The term 'digital health technologies' should be interpreted broadly as any tool or set of tools that improve health or enable better healthcare delivery by connecting people with other people, with data, or with health information. Examples of this include but are not limited to: Telehealth, remote patient monitoring devices, health trackers, mobile devices (*e.g.*, smart phones, tablets), mobile health apps, and technologies for managing health information including electronic health records.

Community health

defined as the collective influence of socioeconomic factors, physical environment, health behaviors, and availability of quality clinical care services,

New! -Guidance for filling out the comment table

- Statement of concern or support - State what our concerns are, or that we support the statements.
- Rationale - Explain why we have a concern or why we support the statement.
- Recommendation / Question / Position Statement - Provide our recommendation, question, and/or position. Wherever possible we need to provide specific recommendations rather than options. We may include what not to do as much as what to do. We should avoid questions for clarification unless we are willing to accept whatever the answer might be. Always try to recommend. If there is no consensus on the recommendation (including no consensus on viable alternatives to pursue), then we should not comment. This should be highlighted for EC awareness where they may be able to facilitate consensus, or agree to not include that in EHRA comments.

C o m m e n t I D	Workgroup(s))	P a g e	Section	Text from Proposal we are commenting on	Statement of concern or support	Rationale	Recommendation / Question / Position statement	Internal Comments
		4 9 3		1. <i>Successful models within the U.S.:</i> Descriptions of innovative examples or models of how community health providers within the United States successfully use digital health technology to deliver healthcare, enable healthier lifestyles, or reduce health disparities.	ClinicalConnect in Pittsburgh, PA - almost 100 connected organizations (hospitals, health systems, physician practices, urgent care, etc.) exchanging information about millions of patients; also successfully connected to region's other HIE (Allegheny Health Network) Los Angeles Maryland - CRISP North Carolina has robust programs (Healthy Opportunities Pilots) to address SDOH (facilitated with help from Community Care North Carolina, Medicaid coverage for SDOH			<i>Suggest we save the individual examples for member companies responses and focus on more generalizations</i>

				interventions through a Section 115 waiver) NY Bureau of Social Determinants of Health - NYS has formally submitted a 1115 Medicaid waiver amendment to CMS (11/27). A component of the waiver seeks approval to create regional Social Determinants of Health Networks (SDHN) to develop a formal network of CBOs that will deliver social determinant of health services San Antonio?			
		493	-	The key features of the organizations and/or the digital health technologies that have been most successful,	Collaborative governance models EHRs using standards-based approaches to connect and collaborate Ingredients list of what makes successful digital health info framework - standards-based		<i>Aligned incentives</i>

				documentation tools / assessments for health equity, funding for community health orgs to access to contribute to digital records, FHIR app availability			
		4 9 3	- what is needed to support the scale up beyond individual organizations,	Patient identification consistency Shared trust frameworks (TEFCA reference) Health equity: funding for CBOs to connect into existing HIE infrastructure Municipal support (financial or convening power) Broadband and free internet availability for individuals - making the most of CARES Act, Recovery Act funds Funding for Community based providers to upgrade to electronic record keeping systems that incorporate 2 way interoperability			<i>Standards, sufficient technology on both sides, networks that connect stakeholders</i>

		4 9 3	- examples of best practices				
		4 9 3	- examples of important user protections to institute (<i>e.g.</i> , privacy best practices)	Robust P&S approach - Federal privacy framework or the UPDPA, but consistency is critical for patients and organizations and doesn't exist now			
		4 9 3	- examples of positive user experiences, metrics or measurement strategies of how community health providers measure outcomes or success,	Health equity: connections between CBOs and health providers SDOH examples that can be easily reported - the simpler the measures, the better (i.e. how often are SDOH-related data elements captured in visits) General connectivity: simple approaches are the easiest to implement, very complicated attempts in the past ended up being unsuccessful			

				Critical that efforts are not duplicated across various govt agencies - need alignment and harmonization of reporting requirements AIMS template is a good example to look to to reduce reporting burden and allow centralized data analysis plus access by regional or state entities, researchers - report once, benefit many			
		4 9 3	- creative ideas or models that may be in nascent stages	North Carolina - used 115 waiver to put Medicaid dollars toward evidence-based interventions (called the Healthy Opportunities Pilots program); follows prior restructuring to shift Medicaid to a value-based care model, which is better suited to pay for social needs (including direct Medicaid payments to CBOs), case management, etc. Also includes NCCARE360, a statewide resource			

				database and referral platform that connects healthcare providers with community-based organizations and social service agencies NY is conducting Research and evaluation on housing programs to demonstrate the positive health outcomes, and cost effectiveness of supportive housing as a intervention			
		4 9 3	2.	Specific descriptions of the current barriers faced by individuals or organizations to the use of digital health technologies in community-based settings. Funding for technology connectivity (one-time or payment models) Funding for hardware and software in community based organization to participate in digital health efforts Governance - TECCA may help address in the future? Provides framework for adding on SDOH in the future, bringing in CBOs Getting patients involved and at the table in health			

				equity initiatives			
				General: variation in state and federal laws related to privacy and data exchange (PDMP, behavioral health, general consent laws, pediatrics)			
		493	- Technical (including broadband access),	Health equity: Lack of investment in CBOs - most don't have any type of software that could help with connectivity Broadband, access to digital technology in the home			Broadband access
		493	- training	National effort to promote patient engagement and to educate CBO how to use digital health opportunities			
		493	- costs, reimbursement/policies	Value-based care has not gained all of the traction that was expected - this was supposed to be a key part of the business case for providers to care about information exchange and care coordination As CBO says, cost driven by aging population and			Expand here

				new technologies OSTP should collaborate with health IT companies and innovators because we can do a lot more but are left out of early strategy and process conversations - more collaborative			
		493	- buy-in across organization or community				<i>Need for networks and shared agreements</i>
		493	- user education/comfort (privacy, security, discrimination, the effectiveness of the technology, etc)	Some level of consistency across states on privacy rules and modernization of HIPAA to be reflective of current technologies and the integration or create a symbiotic relationship with 42 cfr part 2			<i>HIPAA modernization?</i>

		4 3 9	3. <i>Trends from the pandemic:</i> Impressions or data reflecting how the use of digital health technologies (including the use of telemedicine) has changed over the course of the pandemic by individuals, community-based organizations, and in community-based health settings. This includes impressions of what is likely to continue, or not, after the end of the public health emergency or COVID-19 pandemic	EHR Association members supported our collective clients across the country from the beginning of the pandemic in a number of ways: - clinical decision alerts to optimize care for patients and ensure clinicians were aware of constantly evolving best practices - Reporting to huge variety of public health entities, most requiring different data elements - Documentation of SDOH data helpful to decisions during the care process and public health analysis of			Telehealth volumes?
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4. *User experience:*
Descriptions of how technology developers, community-based healthcare providers, or other community-based stakeholders consider and/or assess the patient and client experience in the use of health technologies.

		4 3 9		- descriptions of how digital health technologies could be better designed with the user experience (<i>e.g.</i> , community health workers, healthcare providers, or patients) in mind				CX wg?
		4 9 3		- as aspects of the user experience that could be changed to help remove barriers due to willingness to use (<i>e.g.</i> , privacy protections)				
		4 3 9		5. <i>Tool and training needs:</i> Information about the current technological tools, equipment, and infrastructure needs of community health workers and other community-based health providers.				Whatever structure is used it should be informational and not a sales site. Federally vetted site that is informational and not marketing
		4 9		- Descriptions about what is needed to train	Clear and easily accessible training			

		3	and/or certify community health organizations and workers on the use of digital health technologies	materials as well as a continuously updated FAQ location			
		4 3 9	6. <i>Proposed government actions:</i> Opportunities for the Federal Government to support the transformation of community health settings through the uptake of innovative digital health technologies and telemedicine at the community level. Please specify whether these opportunities could take place in the immediate future (<i>i.e.</i> , 0-2 years), in the next 5 years, in the next 10 years or beyond.				Essentially summarize here. Continuation of Telehealth and many of the loosened regulations such as cross state line authority
		4 9	7. <i>Health Equity:</i> Information about how				Previous statements re standardizing collection of race, ethnicity, and

[illegible]
