February 22, 2021

Mr. Norris Cochran
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Acting Secretary Cochran,

The Electronic Health Record (EHR) Association appreciates the opportunity to provide input to the Information Collection Request on the burden of collecting information for the HHS Teletracking COVID-19 Portal (US Healthcare COVID-19 Portal), ways to enhance the quality, utility, and clarity of the information collected, as well as the means to collect the information.

The EHR Association's nearly 30 member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our focus is on collaborative efforts to accelerate health information and technology adoption, assist member companies with regulatory compliance, advance information exchange between interoperable systems, and improve the quality and efficiency of patient care through the use of technology.

As the COVID operational reporting requirements emerged and evolved, EHRs have been one of the primary sources of data and reports. In our response to the four questions, we will highlight the key challenges we encountered in attempting to minimize organizational burden and streamline reporting, and we will provide more specific feedback on the individual questions raised.

Overall Observations and Recommendations

Clarity of information requirements
Ideally, COVID operational reporting would be entirely automated and flow from documentation already being captured in electronic systems. However, in practice, requested information has been ambiguous and vaguely defined, requiring manual intervention to categorize data for purposes of reporting. While some definitions were refined and made clearer, the same challenges continued as new data elements have been added.

Our recommendations:
We suggest that as new data requirements are being considered, developers of systems that are the source of such data (like EHR developers and other health IT suppliers) are engaged early in the design process. Our early input can not only reduce downstream confusion around data definitions, we can also identify opportunities to collect data electronically rather than manually. The EHR Association has reached out to HHS and established a communication platform to address the many clarifications our clients and our members require. We urge that this existing communication platform be used moving forward, in order to iron out implementation details much earlier in the information definition phase.

Variety of information sources
The operational reporting requirements include non-clinical data, e.g., capacity data, data about supplies, etc., but EHRs are not the sole source for all required information. Bed management, inventory management, laboratory information systems, and other systems are all sources of different information requirements. Today, collating this information into one report is typically a manual process before it is entered into a portal, or pulled together into a spreadsheet.

Our recommendations:
We suggest that data submission be flexible, based on source systems involved. This will minimize collation steps and increase the opportunity for automated submissions. Given the disparate systems that may be involved, we recommend allowing for distinct data submission for each major data type/section of the hospital data submission set, such as submission of a data file for therapeutic use, submission of a data file for supply chain related information (PPE use, ventilators), submission of a data file for bed use and bed capacity, etc. We also suggest that HHS consider managing data consolidation when data is submitted in multiple files, so that hospitals do not have to bear that burden themselves.

Jurisdictional variations
Reporting requirements vary by state, creating substantial challenges to submitting the variety of datasets to the various jurisdictions. Individual jurisdictions too may require additional information, define information differently, or have different requirements for submission frequency and timing. While keeping track of jurisdictional variations is challenging for EHR developers, it also poses difficulties for healthcare organizations that deliver care across multiple states or along state lines.

Our recommendations:
We suggest that HHS work with the states to establish a common dataset to enable providers to collect one dataset consistently, using a common distribution approach to share data as needed across multiple jurisdictions. We believe that a singular submission that is then shared is the most efficient and effective way to minimize duplicate/variant reporting to enable full transparency on the same data, from the local to the national level.

Standardized reporting format
Current reporting methods are manual and cumbersome, requiring data collection in spreadsheets and entering data directly into portals. Considering the speed at which new information requirements

needed to be identified and implemented, we appreciate that adoption of more robust standards and methods at the time was not realistic.

Our recommendations:
We suggest that, moving forward, the dependence on portals and spreadsheets be minimized if not eliminated, particularly where providers have health IT that can generate the reports and submit in an automated flow, thus reducing burden. HHS should work with public health agencies, healthcare providers, and suppliers of the health IT primary data sources to establish a reporting framework that enables automated data-sharing, based upon electronically-available data using common standards for access and exchange. The EHR Association supports efforts such as those by CDC NCEZID, in collaboration with HL7® through the HL7 SANER project, to introduce a standards-based approach towards well-defined, computable measures of interest, reporting formats, and a means to use API-based reporting. The rapid adoption of HL7 FHIR-based APIs in health IT, not just EHRs, will enable a more robust, less error-prone reporting infrastructure than the Teletracking Portal can provide, especially given the numerous data sources and the need to adapt quickly as new information requirements emerge.

Specific Question Responses

The necessity and utility of the proposed information collection for the proper performance of the agency's functions

We appreciate the need for vast, comprehensive, and near real-time information to inform decisions and analyses in response to the pandemic. However, HHS must continue to evaluate the necessity of information going forward, and retire information collection that is no longer necessary. We also recommend HHS work together with data collectors, data holders, and data recorders to understand the burden of data collection, in order to weigh that burden against the data's utility.

The accuracy of the estimated burden

We defer to the provider community to address the accuracy of the estimates of burden provided by HHS. However, we note that burden comes from a variety of sources, and we urge HHS to consider burden broadly when determining the effect of adding new reporting requirements, particularly as the aim should be to enable automation. Burden could come from:

- Normalizing definitions in local systems to align with HHS definitions, once understood. For example, "ventilator" is not defined standardly and the original data requirements did not state whether pediatric ventilators were included, whether anesthesia ventilators should be counted, etc.

  HHS can minimize this burden by working with data stakeholders early in the requirement authoring process to eliminate ambiguities and posting public FAQs after requirements are released in order to pool knowledge.

- Collecting information from multiple systems, or abstracting information from one system into each other. For example, ERP systems may track some aspects of capacity, while EHRs track clinical utilization.

  HHS can minimize this burden by working with data stakeholders to group requirements logically by the most likely system of record, and then, if necessary, establishing independent or staggered reporting schedules for each.

- Attributing data to individual sites or locations, as appropriate, and identifying data as such. For example, NHSN locations are defined differently and may have different identifiers than hospital sites or clinics.

  We recommend HHS partner with other stakeholders to brainstorm what reporting granularity may be needed in the future (department, site, provider, etc) and assess the prevalence and appropriateness of existing identifiers to represent that granularity.

- Entering information into a spreadsheet or portal.

  HHS can minimize this burden first by looking at low-tech models of data submission (comma-delimited files, secure file transfer). In the future, we propose HHS work with standards development bodies to define standard ways of capturing and transmitting data automatically.

Ways to enhance the quality, utility, and clarity of the information to be collected

Emergency preparedness starts well before the emergency occurs and needs to be based on a robust public health infrastructure where ongoing data-sharing already occurs, using consistent data definitions and standard exchange/access formats that utilize data already documented in normal operations. We applaud CDC's efforts to identify how the combination of syndromic surveillance, electronic laboratory reports, and electronic case reporting can minimize the need for additional operational reporting (as operational metrics can be derived from those feeds). When additional operational metrics must be provided, we support the use of HL7 FHIR. We encourage HHS to join collaborations, such as the HL7 SANER project, that are progressing these efforts, and we recommend incentivizing its adoption by state reporting systems, to reduce or eliminate the reliance on more manual data submission processes.

We suggest that HHS expand on the resource provided in the current table, by providing more of a true data dictionary that includes consistent data definitions (as is already suggested) as well as purpose of collection.

The use of automated collection techniques or other forms of information technology to minimize the information collection burden

We strongly support the need to pursue more automated means of accessing and exchanging relevant data. Where the data sources involve EHRs, we offer to closely collaborate between HHS, state, and EHR developers to advance the state of public health reporting.

This is a process that needs to start now. Together, we must identify current and anticipated data of relevance, determine the opportunities to use existing data to reduce documentation burden, and build upon the relevant technologies and standards that are readily available.

We appreciate this opportunity to share our experience and expertise on data collection technology.
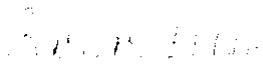
Sincerely,

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