

September 14, 2021

Mickey Tripathi, PhD, MPP
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW, Floor 7
Washington, DC 20201

120 South Riverside Plaza
Suite 2000
Chicago, Illinois 60606-6995
800.877.1600

1120 Connecticut Avenue NW
Suite 460
Washington, D.C. 20036

Reference: Electronic Health Record Reporting Program: Request for Public Feedback on Draft Developer-Reported Measures for the Electronic Health Record Reporting Program

Dear Dr. Tripathi:

The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to submit these comments to the Urban Institute, contracted by the Office of the National Coordinator for Health IT (ONC), relative to the July 14, 2021 request for comment on the *Request for Public Feedback on Draft Developer-Reported Measures for the Electronic Health Record Reporting Program*. Representing more than 107,000 registered dietitian nutritionists (RDNs),¹ nutrition and dietetic technicians, registered (NDTRs), and advanced degree nutritionists, the Academy is the world’s largest association of food and nutrition professionals and is committed to a vision of a world where all people thrive through the transformative power of food and nutrition. The Academy works through its Interoperability and Standards Committee (ISC) to engage national and international standards organizations that develop and harmonize health information technology standards to improve health information sharing and interoperability related to nutrition. We respectfully offer the following feedback on the draft developer measures.

Level of Reporting

The Academy recognizes the potential burdens of reporting measures at a more granular level, but would recommend measures be reported on a client, product, or other level lower than a developer level to account for differences in software implementations. Reporting a level lower than a developer level may also help to show inequalities among specific implementations of Electronic Health Record (EHR) systems, especially where these implementations exist in rural or impoverished areas that cannot afford higher levels of system customization or additional features.

Data Granularity and Distribution of Results

The Academy recommends the measures include sufficient granularity to allow the measures to be stratified by state and county, in addition to other demographic characteristics such as age, income level, race and ethnicity, and by type of clinician. Specialized clinicians, such as RDNs, unfortunately are sometimes excluded from the EHR

¹ The Academy approved the optional use of the credential “registered dietitian nutritionist (RDN)” by “registered dietitians (RDs)” to more accurately convey who they are and what they do as the nation’s food and nutrition experts. The RD and RDN credentials have identical meanings and legal trademark definitions.

development process and have to utilize suboptimal system functionality as a result. Similar to the level of reporting, reporting measures at these lower levels of data granularity may offer valuable insights into the usage and disparities of certified EHRs and could thus help to improve future EHRs to better meet all clinician needs to support quality patient care.

Appropriateness of the Look-Back Period

The Academy respectfully suggests that a look-back period of twelve months is too brief to adequately capture all active patients, including any patients that seek care less frequently. We note that the American Medical Association states, “A look-back period between 18 and 36 months is commonly accepted when assigning patients to a particular physician. A look-back period of 12 months or less runs the risk of missing healthy patients who may only see the physician once a year for preventative purposes, whereas a look-back period greater than 3 years may include patients who are no longer active within the practice.”² Accordingly, a longer look-back period, such as 24 months, would be appropriate.

Measurement Domain: Patient Access

The Academy recommends adding the patient’s condition(s) to the patient characteristics, if possible. Patients with chronic conditions are likely to have a higher number of encounters, thus might access their data more frequently. Additionally, if it can be easily tracked and reported, the Academy suggests identifying what type of data patients are accessing, as this will provide better insight into this requirement of the Cures Act. The nature and value of patient engagement can be better determined by assessing whether patients are accessing clinician notes and labs, for example, or whether patients are using the patient portal or app for less substantive or clinical reasons, such as seeing their upcoming appointments or paying a bill.

When using this measure and data for decision making, the Academy would request ONC and Urban Institute keep in mind that patients need certain technology, such as a cell phone or computer, to access an app or a portal. Patients who live in rural areas or have a lower income adopt technology at lower rates.^{3,4} Total number of encounters as a denominator could skew results if there is no exclusion of those patients do not have access to technology in the denominator.

² Panel Sizes for Primary Care Physicians: Optimize Based on Both Patient and Practice Variables. AMA STEPS Forward™. August 30, 2018. Available at <https://edhub.ama-assn.org/steps-forward/module/2702760#section-247962614>. Accessed September 14, 2021.

³ Pew Research Center. Some digital divides persist between rural, urban and suburban America. <https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/>. Accessed September 12, 2021.

⁴ Pew Research Center. Digital divide persists even as Americans with lower incomes make gains in tech adoption. <https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/>. Accessed September 12, 2021.

Measurement Domain: Clinical Care Information Exchange

The Academy encourages ONC and Urban Institute to take into consideration the fact that fax machines are frequently used to transmit summary-of-care records, especially in long-term care settings. If developers of certified EHRs are to be held accountable, the results of the measure must take into account all forms of summary-of-care records received, not just those that can be parsed and integrated.

The Academy also recommends clinicians be defined by an existing clinician definition or code set, such as Merit-Based Incentive Payment System (MIPS) Eligible Clinician Types⁵ or the Health Care Provider Taxonomy Code Set from X12⁶ as used by the National Plan & Provider Enumeration System.⁷ Using existing taxonomies will allow for consistency across agency definitions.

Measurement Domain: Standards Adoption and Conformance

While the Academy supports the use of Fast Healthcare Interoperability Resources (FHIR) and participates in developing and improving FHIR artifacts, we have concerns that this measure will not show the true progress toward interoperability. Nutrition data does not currently exist in US Core Data for Interoperability (USCDI),⁸ does not have any US Core FHIR profiles,⁹ or any non-core profiles¹⁰ as of yet. Nutrition should be included in interoperability and exchange, because nutrition is an important aspect of patient care given its connection to overall health, disease risk, and management of some chronic diseases.^{11,12} The Academy urges ONC to find opportunities to include vital aspects of healthcare, such as nutrition, in interoperability regulations and standards that enable them to be part of the developer measures and thereby show the true picture of interoperability and exchange.

⁵ U.S Centers for Medicare & Medicaid Services. How MIPS Eligibility is Determined. <https://qpp.cms.gov/mips/how-eligibility-is-determined>. Accessed September 12, 2021.

⁶ X12. Provider Taxonomy Codes. <https://x12.org/codes/provider-taxonomy-codes>. Accessed September 12, 2021.

⁷ National Plan & Provider Enumeration System. Taxonomy Page. <https://nppes.cms.hhs.gov/webhelp/nppeshelp/TAXONOMY%20PAGE.html>. Accessed September 12, 2021.

⁸ The office of the National Coordinator for Health Information Technology. United States Core Data for Interoperability (USCDI). <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2>. Accessed September 12, 2021.

⁹ Health Level 7. US Core Implementation Guide: Profiles and Extensions. <https://www.hl7.org/fhir/us/core/profiles-and-extensions.html>. Accessed September 12, 2021.

¹⁰ Health Level 7. HL7 FHIR Release 4: Profiles defined as part of FHIR. <https://www.hl7.org/fhir/profilelist.html>. Accessed September 12, 2021.

¹¹ Micha R, Peñalvo JL, Cudhea F, Imamura F, Rehm CD, Mozaffarian D. Association Between Dietary Factors and Mortality From Heart Disease, Stroke, and Type 2 Diabetes in the United States. *JAMA*. 2017 Mar 7;317(9):912-924. doi: 10.1001/jama.2017.0947.

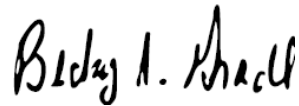
¹² Centers for Disease Control and Prevention. Poor Nutrition. <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm>. Accessed September 12, 2021.

The Academy appreciates your consideration of these comments regarding the *Electronic Health Record Reporting Program: Request for Public Feedback on Draft Developer-Reported Measures for the Electronic Health Record Reporting Program*. Please contact either Jeanne Blankenship at 312-899-1730 or by email at jblankenship@eatright.org or Becky Gradl at 312-899-4835 or by email at bgradl@eatright.org with any questions or requests for additional information.

Sincerely,



Jeanne Blankenship, MS RDN
Vice President, Policy Initiatives and Advocacy
Academy of Nutrition and Dietetics



Becky Gradl, MPH, RD, LDN, CHES®
Informatics Manager and ISC Staff Partner
Academy of Nutrition and Dietetics