EHRA
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April 11, 2023

Bob Sivinski
Chair, Interagency Technical Working Group on Race and Ethnicity Standards
Executive Office of the President
Office of Management and Budget
1650 17th St., NW
Washington, DC 20500

Dear Mr. Sivinski,

On behalf of our nearly 30 member companies, the HIMSS Electronic Health Record (EHR) Association is pleased to offer comments on the initial proposals from the Federal Interagency Technical Working Group on Race and Ethnicity Standards (Working Group) for revising OMB's 1997 Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15).

As a national trade association of EHR developers, 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. Together, we work to improve the quality and efficiency of care through the adoption and use of innovative, interoperable, and secure health information technology. The EHR Association supports OMB's effort to improve the quality and usefulness of Federal race and ethnicity data. As such, a standard means of capturing and communicating this information is crucial for health IT developers to properly support it in our software. Changes to SPD 15 will carry a significant impact on our systems as:

- Organizations rely on EHRs to collect information about the race and ethnicity of patients (directly from patients or from other staff)
- EHRs store race and ethnicity as a core part of patient demographics
- EHRs must communicate race and ethnicity to
    - Federal programs
    - State and local programs
    - Payers
    - Other healthcare delivery organizations
    - Other stakeholders

- As certified EHR technologies, our software is required to support USCDIv1 (currently), which requires it to follow USCDIv1 standards
- In addition to communicating patient-level information, organizations may be required to report compiled statistics related to race and ethnicity that they use their EHRs to compile.

We appreciate the opportunity to provide industry insights to the OMB and the Working Group on this matter. Our detailed responses follow.

Sincerely,

David J. Bucciferro
Chair, EHR Association
Foothold Technology

William J. Hayes, M.D., M.B.A.
Vice Chair, EHR Association
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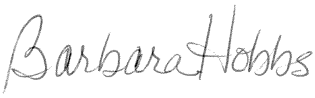
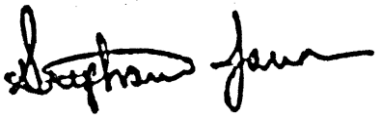
Leigh Burchell
Altera Digital Health

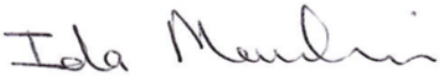


Barbara Hobbs
MEDITECH, Inc.

Cherie Holmes-Henry
NextGen Healthcare



Stephanie Jamison
Greenway Health



Ida Mantashi
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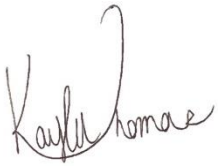

Kayla Thomas
Oracle Cerner

1c. If a combined race and ethnicity question is implemented, what suggestions do you have for addressing challenges for data collection, processing, analysis, and reporting of data?

We support the single-question format so long as adequate time and guidance are given to transition systems to the new format. The EHR Association recommends that OMB provide guidance that explains how systems exchanging data might communicate if one captures race and ethnicity in the older format while the other supports the new format. For example, guidance might explain how the single question might be tagged as a different data element, and systems could exchange all three for a grace period.

1d. What other challenges should we be aware of that respondents or agencies might face in converting their surveys and forms to a one-question format from the current two-question format?

Converting surveys and forms is relatively straightforward, but converting data storage on file could be significantly more challenging. An EHR might contain millions of patients, and it is irrational to assume that all stored data will be converted to the new format in bulk. To avoid performance concerns, EHR software might convert data as it is accessed or reported, resulting in scenarios in which not all data has been converted.

The EHR Association suggests that OMB should offer guidance to agencies or other stakeholders who require aggregate statistical reporting about this concern and how their requirements might accommodate it, perhaps by introducing a grace period for reporting compiled statistics in either format.

In general, we encourage the Working Group to consider not just the implications of capturing data on a paper form but also how the data is stored and how it is communicated.

2c. Would this proposed definition allow the generation of statistics necessary to track the experience and well-being of the MENA population?

In order to address this need, many healthcare delivery organizations may have already extended the category list by which they capture race. While we support this addition, we point out that such additional information may not be converted into the new category list.

3c. Some Federal information collections are able to use open-ended write-in fields to collect detailed racial and ethnic responses, while some collections must use a residual closed-ended category (e.g., "Another Asian Group"). What are the impacts of using a closed-ended category without collecting further detail through open-ended written responses?

We do not support a closed-ended category, as individuals may not know which category to place themselves in when attempting to self-identify. The Working Group's proposal seems to assume a paper-based collection approach, in which all available race categories must be listed on a single page.

The EHR Association recommends the Working Group consider an approach in which an individual is asked to self-identify from a much more detailed master list (e.g., the CDC's PHIN-VADS Race Value Set) with the ability to select multiple responses. An individual should also be able to self-identify via a free text option, but this option would roll up to a single "Some Other Race" value, in contrast to this proposal which envisions multiple "Other" categories (Another Asian Group, Another White Group, etc.).

We further suggest that the OMB should provide a mapping of values from the PHIN-VADS Race Value Set to SPD-15 (in its expanded form as specified in this proposal, including Hispanic and Middle Eastern / North African). This will allow organizations to back-populate values when communicating with systems that do not support the expanded codeset.

3d. What should agencies consider when weighing the benefits and burdens of collecting or providing more granular data than the minimum categories?

Capturing more detailed information is not burdensome so long as clear guidance is provided on the value set expected to represent this information and how those values map to broader categories, such as the existing OMB 1997 SPD-15 categories.

3f. What guidance should be included in SPD 15 or elsewhere to help agencies identify different collection and tabulation options for more disaggregated data than the minimum categories? Should the standards establish a preferred approach to collecting additional detail within the minimum categories, or encourage agencies to collect additional information while granting flexibility as to the kind of information and level of detail?

The EHR Association strongly recommends that OMB be prescriptive in the value set used to represent detailed race and ethnicity information, but flexible and non-prescriptive in the design of how this information is collected. OMB should establish a detailed "master list" that adequately enumerates the races for which they want to collect data, ideally using CDC's PHIN-VADS Race Value Set instead of creating a new value set, and provide a mapping between those values and SPD-15 (including the Hispanic and MENA categories proposed by the Working Group).

5a. For data providers who collect race and ethnicity data that is then sent to a Federal agency, are there additional guidance needs that have not been addressed in the initial proposals?

While we support the Working Group's proposal to collect multiple values for race, we anticipate situations in which stakeholders may request or require a single response. The EHR Association requests that OMB issue explicit guidance that systems should always accept multiple values for race, and provide implementation guidance for how those systems deal with multiple responses in statistical reporting or other situations in which a single value might be needed. Without this guidance, secondary-use entities may collapse values differently, leading to confusion.

5b. With the proposals to use a combined race and ethnicity question and to add MENA as a minimum category, what specific bridging concerns do Federal data users have? Please submit any research on bridging techniques that may be helpful to the Working Group. Bridging refers to making data collected using one set of categories (e.g., two questions without MENA), consistent with data collected using a different set of categories (e.g., one question with MENA).

We are concerned about the misalignment that will result as programs adopt the new format at different times, while still needing to exchange individual and compiled data about race and ethnicity.

5c. What guidance on bridging should be provided for agencies to implement potential revisions to SPD 15?

The EHR Association suggests that OMB should provide guidance in the form of a detailed step-up/step-down transformation guide. Systems that report this information should be guided to report it as a new field, instead of (or in addition to) the existing two fields for ethnicity and race. Similarly, systems that require race and ethnicity to be reported to them should accept the more detailed, single-question format as a new data element, not extending existing data elements.

Additional Comments

The EHR Association is generally supportive of the Working Group's recommended changes, but we point out that an adequate runway will be crucial to the success of this effort. As a guideline, we recommend a minimum of 18 months – and more ideally, 24 – to allow development, testing, and deployment of the necessary functionality. Any requirements for new standards within a shorter timeline would cause significant expense and burden to health IT developers and users.

Additionally, as the CDC has issued proposed new code sets for detailed races and ethnicities with a different implementation timeline, we are concerned that mappings from one to the other are unnecessarily subject to multiple changes. The EHR Association suggests that OMB and CDC align the rollout of the updated categories and detailed codes, including updated mappings, on the same timeline, minimizing the impact on users and on health IT developers who support the collection and use of these categories and codes.