Dr. Marilynn Malerba
Chairwoman
Tribal Self-Governance Advisory Committee
 c/o Self-Governance Communication and Education
P.O. Box 1734
McAlester, OK 74501

Dear Chairwoman Malerba:

I am writing to share updates from the March 28-29, 2017, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) meeting. I want to thank the members of the TSGAC for the work you do to assist us in meeting our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS values the TSGAC advice and recommendations related to the IHS Tribal Self-Governance Program and implementation of Title V of the Indian Self-Determination and Education Assistance Act. Enclosed is a document that provides IHS updates from the March meeting. The TSGAC's concerns regarding the IHS Electronic Health Record/Resource and Patient Management System, which were e-mailed to the IHS during the last TSGAC's meeting, are addressed in an addendum to the document.

We look forward to meeting with you on July 18-19, 2017, in Washington, D.C.

Sincerely,

RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director

Enclosures

Indian Health Service (IHS) Headquarters (HQ) Programs, Services, Functions and Activities (PSFA) Manual: The Tribal Self-Governance Advisory Committee (TSGAC) requested discussions regarding updating the IHS HQ PSFA Manual at the Tribal Self-Governance Annual Consultation Conference in April 2017. The TSGAC recommended that the IHS collaborate with the TSGAC Technical Workgroup to update the IHS HQ PSFA Manual.

> *IHS Update*: This activity is in the planning phase. The IHS Office of Tribal Self Governance (OTSG) is the lead for this activity. The OTSG will coordinate with the TSGAC's Technical Workgroup to update the PSFA Manual in a manner consistent with the IHS Tribal Consultation Policy.

Planning and Negotiation Cooperative Agreements: The TSGAC recommended that the OTSG consider changing the timeframes for the due dates (typically in June and July) for the Self-Governance negotiation cooperative agreements, as it conflicts with the negotiation timeline.

> *IHS Update*: The OTSG manages the Self-Governance planning and negotiation cooperative agreements, authorized by Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) 25 U.S.C. § 5383(e). Pending available appropriations in fiscal year (FY) 2018, the OTSG will consider the TSGAC's recommendation.

Agency Lead Negotiators (ALNs): The TSGAC requested that the IHS respond to their recommendations, provided in the February 27 letter, for improving recruitment, oversight, and other processes regarding ALNs.

> *IHS Update*: The IHS appreciates the recommendations provided in the February 27 letter. The IHS will continue to work with the TSGAC to explore sustainable options for filling ALN positions, which includes ALN development, recruitment, and succession planning. The ALNs have delegated authority to represent the IHS, as the designated official, in negotiating the terms and conditions of Self-Governance compacts, funding agreements, and associated amendments, as authorized by Title V of the ISDEAA.

Joint Advisory Meeting: The TSGAC requested that the IHS coordinate a joint meeting with the TSGAC, Direct Service Tribes Advisory Committee (DSTAC), and possibly the Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC) and the National Council of Urban Indian Health (NCUIH) on Monday, October 23, 2017, at the TSGAC's 4th Quarterly Meeting in Washington, DC.

IHS Update: The IHS agrees to coordinate a joint meeting on October 23. The OTSG will work with the TSGAC, the DSTAC and IHS Office of Direct Service and Contracting Tribes (ODSCT) to facilitate the meeting logistics and agenda. At this time, the intended audience for the joint meeting is the TSGAC and DSTAC. We look forward to discussing possible participation and agenda topics that would include the HHS STAC and the NCUIH.

Patient Protection and Affordable Care Act (ACA): The TSGAC requested that the IHS take a proactive position to protect the cost-sharing provisions for American Indians and Alaska Natives in the ACA, (Public Law 111-148).

> *IHS Update*: The IHS shared your concerns with the transition team and the new HHS Administration leadership.

S. Bill 465, IHS "Audit" (introduced by Senator Rounds): The TSGAC requested that the IHS: (1) develop a plan to address deficiencies in the IHS system, including an audit in Areas where all Tribes requested one; (2) report regularly on the plan's progress and audit results to Tribes, and Congress; and (3) provide Tribes with a copy of the Request for Proposals (RFP), with cost estimates, for the proposed IHS audit. The TSGAC also recommended that the IHS be more responsive to Congressional requests for information, and share information with Tribes to ensure consistent communications with Congress.

> *IHS Update:* The IHS appreciates the input and recommendations. We will provide updates as they become available.

S. Bill 304, "Tribal Veterans Health Care Enhancement Act" (introduced by Senator Thune): The TSGAC expressed concern that S. Bill 304 will require the IHS to pay co-pays to the Veterans Health Administration (VA) for providing health care to Native Veterans. The TSGAC recommended that the IHS and the VA include legislative language in their budget justification(s) exempting Native Veterans from co-pays.

> *IHS Update:* The IHS appreciates the input and recommendations. The IHS FY 2018 Congressional Budget points out that the FY 2017 and FY 2018 requests were developed in collaboration between the IHS and the VA. The IHS and the VA have agreed to continue to monitor actual reimbursements and will update estimates as more data becomes available. The IHS continues to work with the VA to identify the actual number of American Indians and Alaska Natives with VA benefits eligibility and, of those, the number who receive direct care from the IHS. The IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with ongoing support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

Special Diabetes Program for Indians (SDPI): The TSGAC requested that the IHS advocate on behalf of Tribes, for an increase in SDPI funding and provide permanent reauthorization of the SDPI.

> *IHS Update*: The IHS provided testimony before the Senate Committee on Indian Affairs on Agency accomplishments with regard to preventing diabetes among American Indian and Alaska Native (AI/AN) youth, including a SDPI update, on March 29, 2017. The SDPI is currently authorized at $150 million per year through the end of FY 2017. In total, there are currently (301) SDPI community-directed grant programs located in 35 States: 252 are Tribal sites; 20 are IHS sites; and 29 are Urban sites.

Presidential Executive Order (EO) 13781: *a Comprehensive Plan for Reorganizing the Executive Branch*[1]: The TSGAC requested information to clarify whether the current IHS proposed "Realignment" meets the requirements of the "Reorganizing" EO; and requested Tribal Consultation prior to taking action in response to the EO.

> *IHS Update:* In response to a request from the TSGAC, the IHS held a joint TSGAC and DSTAC conference call on May 25 to discuss options for obtaining input from Tribes. The IHS also held a national *All Tribal and Urban Indian Organization Leader* call on June 16 to obtain Tribal and Urban input and recommendations for next steps. On June 30, 2017, the HHS submitted a draft proposal to the Office of Management in Budget (OMB). In accordance with EO 13781, the OMB Director shall publish a notice in the *Federal Register* inviting the public to suggest improvements in the organization and functioning of the executive branch and shall consider the suggestions when formulating the proposed plan. EO 13781 shall be implemented consistent with applicable law and subject to the availability of appropriations. The IHS will share updates as they become available.

Presidential EO on Enforcing the Regulatory Reform Agenda[2]: The TSGAC requested that the IHS: (1) provide information on how IHS plans to respond to this EO; (2) confirm if Tribal Consultation will occur regarding how to implement the EO; and (3) identify an IHS regulatory point of contact.

> *IHS Update*: RADM Kelly Taylor, Acting Chief of Staff, is the designated IHS Regulatory Reform Officer. The IHS looks forward to discussing options for Tribal Consultation on this EO with the TSGAC.

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[1] President Donald Trump (March 13, 2017). Presidential Executive Order on a Comprehensive Plan for Reorganizing the Executive Branch. Retrieved from https://www.whitehouse.gov/the-press-office/2017/03/13/presidential-executive-order-comprehensive-plan-reorganizing-executive

[2] President Donald Trump (February 24, 2017). Presidential Executive Order on Enforcing the Regulatory Reform Agenda. Retrieved from https://www.whitehouse.gov/the-press-office/2017/02/24/presidential-executive-order-enforcing-regulatory-reform-agenda

User Population and Vacancy/Personnel Reports/Statistics: The TSGAC requested that the IHS provide user population information and vacancy/personnel reports/statistics, which should be readily available and posted on the IHS Web site.

> *IHS Update:* As of June 2017, the IHS has approximately 3,400 Federal position vacancies, reflecting a 19 percent vacancy rate. The IHS believes we can make user population data available to Tribes. Additional information will be forthcoming.

Patient Health Insurance Data: The TSGAC requested that the IHS coordinate another conference call regarding the TSGAC's request for patient health insurance data. The TSGAC expressed concern that the IHS has set a threshold (to guard IHS patients' PII) of 20,000, whereas the CMS has set a threshold of only 20.

> *IHS Update:* The IHS responded to the TSGAC's request for Patient Health Insurance Data in a May 17- dated letter, which explained that the IHS operates a health plan and a program providing health care. Because of this IHS-specific structure, any publically released data on Active User Insurance status must be de-identified in accordance with HIPAA standards in Title 45 *Code of Federal Regulations* (CFR) § 164.514, including certain geographic identifiers for cell counts smaller than 20,000.

Resource and Patient Management System (RPMS): The TSGAC requested IHS to:

(1) Develop an Information Technology (IT) plan to address Tribal concerns regarding RPMS/Electronic Health Records (EHR), and related issues;

> *IHS Update:* The IHS Information Systems Advisory Committee (ISAC) continues to develop a plan to modernize the Agency's electronic health system. This includes RPMS EHR. By letter dated June 26, the IHS notified Tribal and Urban Indian Organization leaders of listening sessions to seek input and recommendations on how best to modernize and improve our RPMS EHR. The IHS hosted two listening sessions on July 6 and July 10. The deadline for submission of written comments is August 25.

(2) Provide assistance to Tribes who continue using RPMS.

> *IHS Update:* On June 26, IHS sent a letter to Tribal and Urban Indian Organization leaders to announce listening sessions to seek input and recommendations on how best to modernize and improve our RPMS EHR. The listening sessions were held on July 6 and 10. IHS will accept written comments through August 25. Currently, OIT is considering adding additional listening sessions.

(3) Provide better data.

> *IHS Update:* Rather than choosing a one-size-fits-all solution, the ISAC's Modernization Workgroup is examining a number of options, including Commercial-off-the-Shelf (COTS) solutions, RPMS patches to assist Tribes who continue to use RPMS, and a combination of solutions and patches to provide better data.

(4) Meet with Tribes to gain knowledge about Tribal IT and RPMS developments/innovations.

>*IHS Update:* In accordance with IHS policies on Tribal Consultation and Conferring with Urban Indian Organizations, the IHS has taken the first step by soliciting input and recommendations through listening sessions. The deadline for submission of written comments is August 25.

The VA and IHS Memorandum of Understanding, and Reimbursement Agreements: The TSGAC expressed concern about plans for IHS/Tribal reimbursement agreements with the Veteran's Health Administration (VA) being "consolidated" for purchasing care under the Veterans, Access, Choice, and Accountability Act (Choice Act). The TSGAC requested IHS/Tribal reimbursement agreements, at a Tribe's option, remain under the authority of Indian Health Care Improvement Act provisions for VA reimbursement, rather than Choice Act provisions.

>*IHS Update*: The IHS does not have any updates to provide at this time. Updates will be shared with the TSGAC when they become available.

Sanitation Facilities Construction and Joint Venture Program: The TSGAC requested that the IHS:

(1) Provide the Sanitation Facilities Construction (SFC) list information to all Tribes.

>*IHS Update*: The IHS SCF list will be posted to the IHS Web site under the Reports to Congress tab after the annual report is transmitted to Congress.

(2) Open up the Joint Venture Construction Program (JVCP) Projects for more regular competition.

>*IHS Update*: In light of the FY 2018 President's budget request, the IHS will evaluate the potential impact on the JVCP. The IHS anticipates the next JVCP solicitation in 2-3 years, pending availability of appropriations for staffing new facilities already in planning or under construction.

(3) Make available, as public information, the Sanitation Deficiency System (SDS), and the data Tribes enter into the SDS system.

>*IHS Update*: The IHS annually reports the results of the SDS to Congress, as required by the IHCIA at Title 25 U.S.C. § 1632(g). The IHS works collaboratively with Tribes and Tribal Organizations to ensure the data captured during the SDS process accurately reflects the sanitation facility needs of Indian Tribes and communities. The IHS will not provide, as public information, Tribal specific data files.

(4) Issue supplemental guidance to ensure consistent use of deficiency levels across the Areas.

IHS Update: The IHS issued supplemental/interim guidance on the SDS process in January 2015, January 2016, and March 2017, to ensure consistent use of deficiency levels and improve overall data quality. Data quality has significantly improved. The IHS plans to issue updated SDS Guidelines to consolidate these guidance issuances in September 2017.

(5) Re-examine how projects are defined by the term, "Indian Communities," and remove references describing the term in the draft SFC guidance.

IHS Update: In the proposed September 2017 SDS Guidelines, overarching statements that make assumptions of project deficiency levels based on location (non-Indian versus Indian community) have been removed. The term, "Indian communities" will not be removed from the SDS Guidelines as this concept is included in the Indian Health Care Improvement Act (e.g., many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems), the statute that governs the Sanitation Facilities Construction Program.

(6) Re-examine the Federal template for design that Tribes are required to use for JVCP Projects.

IHS Update: The Federal template for design is required. It provides a standard presentation for health care facilities in the Indian health system. Planning documents are based upon what the Secretary would otherwise provide.

(7) Revisit the staffing package.

IHS Update: The staffing package, as applied to JVCP projects, are applied in the same manner as those projects that are listed on the IHS Healthcare Facilities Construction Priority System list. The IHS welcomes suggestions and changes, noting that they need to apply to both programs equally. Any changes require Tribal Consultation and may require higher levels of approval (i.e., by HHS, OMB, and/or Congress).

(8) Address full implementation of Title V of the ISDEAA, as it pertains to IHS Office of Environmental Health and Engineering (OEHE) funds, at the TSGAC's 3rd Quarterly Meeting. The TSGAC also expressed concern that the IHS OEHE has not distributed funds via a stable based budget.

IHS Update: With the exception of HQ Tribal shares, OEHE funds are negotiated at the Area level. The OEHE is open to working with the Areas and the Tribes in addressing the full implementation of Title V of the ISDEAA and will coordinate with the ALNs to determine the specifics of any Area/Tribal misunderstanding.

Contact Support Costs (CSC): The TSGAC requested that the IHS coordinate an initial conference call with the CSC Workgroup to: (1) discuss CSC estimates for upcoming years; and (2) finalize CSC processes. The TSGAC also requested that the IHS provide education/training to Tribes on the updated IHS CSC policy and information on how to calculate CSC by webinar and by posting the information online.

> *IHS Update*: The IHS CSC Workgroup met via teleconference on May 16 to continue work on the CSC templates. The next CSC Workgroup meeting will be in early September 2017. A meeting notice will be sent out soon. For training, the IHS launched a series of five video training modules for CSC. The training modules cover key aspects of CSC, including a statutory overview, definitions, policy updates, indirect cost, and direct cost. The training is available online at: https://www.ihs.gov/odsct/contract-support-costs/. We welcome any comments on training session content, presentation, and effectiveness.

IHS Returning Funds to Treasury and Audit: The TSGAC requested that the IHS: (1) provide technical assistance to identify ways to improve budgetary flexibility in reprogramming and spending authority to ensure IHS fully utilizes funds; (2) advocate for revising the CSC funding authority to a 2-year appropriation, rather than one year; and, (3) provide Tribes with an itemized amount, and corresponding budget line item(s), of funds returned to the Treasury for the past several years.

> *IHS Update:* The IHS is not returning a significant amount of money to the U.S. Department of the Treasury. In response to several concerns expressed by Tribes and Tribal Organizations, the IHS sent a letter to Tribal and Urban Indian Leaders on March 28 to clarify and explain the perception that the IHS is returning a significant amount of unused money to the U.S. Department of the Treasury each year. In addition, on April 14, the IHS held a national *All Tribes and Urban Indian Organizations Call* and provided a Budget 101 Webinar to provide additional details about the IHS's appropriations and accounts, the availability of IHS appropriations, and reporting and use of funds.

Level of Need Funded: The TSGAC requested that the IHS identify a contact person for TSGAC level of need funded (LNF) requests, who could also be tasked with updating LNF data. The TSGAC also requested that the IHS respond to the TSGAC's request for the IHS to establish a formal LNF workgroup.

> *IHS Update*: The request and recommendation is under IHS review. An update will be provided when information is available.

IHS HQs and Area Assessments: The TSGAC requested that the IHS: (1) apply assessments uniformly across all IHS Areas; (2) provide information regarding how much Tribes are being charged in assessments; what costs are included; how it is being addressed in different Area Offices; and (3) adjust the assessments monthly in order to account for the Intergovernmental Personnel Act (IPAs)/Memorandum of Agreements (MOAs).

> *IHS Update:* The IHS is reviewing the request at this time. An update will be provided when the review is complete.

Catastrophic Health Emergency Fund (CHEF) Final Rule: The TSGAC requested that the IHS not finalize a rule until the pending case (Redding Rancheria case) has been decided to avoid any conflict.

> *IHS Update*: The IHS has temporarily suspended finalizing the CHEF Final Rule.

IHS Loan Repayment Program (LRP): The TSGAC recommended that the IHS Loan Repayment Program (LRP) expand eligibility to allow other health care professionals (i.e., administrative), not just clinical professionals, participate in the program.

> *IHS Update:* This recommendation requires legislative changes. The IHS faces significant recruitment challenges due to the remote, rural locations of our health care facilities and Area offices. The IHS implements various strategies to increase recruitment and retention through the IHS Scholarship and Loan Repayment Program. In addition, the IHS continues to partner with the National Health Service Corps (NHSC). Use of the NHSC allows IHS facilities to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. As of April 2017, 472 NHSC recipients are currently part of our workforce serving in IHS, Tribal, and Urban facilities.

Addendum:
Tribal Self-Governance Advisory Committee Health Questions/Concerns regarding the Indian Health Service Resource and Patient Management System/ Electronic Health Record

1. **Question**: Some Tribal sites received hardship exemptions for 2014 and 2015 Tribal Meaningful Use (MU) stage 2 years, due to not being able to participate in the Resource and Patient Management System (RPMS) Network, which contains the Indian Health Service (IHS) Health Information Exchange (HIE), Master Patient Index (MPI), Personal Health Record (PHR) or Patient Portal, and Direct Messaging.

    a. Some Tribes are still working on resolving issues with the Multi-Purpose Agreement (MPA) so it can be signed.

    b. Even with the MPA the RPMS Network HIE would not include data from private health systems that Tribes deal with on a daily basis.

       IHS Response: If private providers are using certified Electronic Health Record (EHR) technology, and participating in a Health Information Exchange, they can send a Consolidated Clinical Document Architecture (CCDA) (i.e. summary of care documentation) with/to the patient, who can provide it to their IHS/Tribal/Urban (I/T/U) provider via PHR and Direct Messaging.

    c. Tribes have implemented solutions for meeting requirements through State HIE's, etc.

       IHS Response: The IHS Office of Information Technology (OIT) would like to request more information from the Tribal Self-Governance Advisory Committee (TSGAC) to address the issue or concern. The RPMS Network is almost 100 percent deployed for those who signed up to participate.

2. **Question**: (Please note the following question was revised after OIT staff spoke with OTSG representative, Ms. Melissa Gower, on April 20): What is the status of RPMS EHR in supporting Meaningful Use (MU) and Quality Payment Program (QPP) - Medicare Access and CHIP Reauthorization Act (MACRA).

       IHS Response: Currently, RPMS is certified for the 2014 Edition standards also known as 2014 Certified EHR Technology (CEHRT) and supports Modified Stage 2 of MU. To support MU Stage 3, RPMS needs to be updated and certified for the 2015 Edition standards. In January 2017, the IHS awarded a contract for software engineering and development to support RPMS. This includes supporting the move from a 2014 Edition CEHRT to the 2015 Edition CEHRT. To address QPP - MACRA for calendar year 2017, an EHR certified for either the 2014 or 2015 standards may be used (e.g., 2014 Edition or 2015 Edition). The current version of the RPMS EHR is certified for the 2014 Edition and can be used.

3. **Concern**: Patient engagement tools, such as appointment reminder notifications and lab result notifications to the patient are not available.

> **IHS Response**: Patient lab results are available through the CCDA via the PHR. The patient has the ability to e-mail a provider directly and obtain lab results from their provider as well. The appointment reminder functionality is currently in the backlog for RPMS development.

4. **Concern**: EHR has no mobile capabilities.

> **IHS Response**: The request for RPMS EHR mobile capabilities is noted in the backlog. There are many security requirements that need to be addressed before mobile functionality is tested and implemented.

5. **Concern**: Notification or alerts cannot be processed from a phone or mobile device.

> **IHS Response**: The request for RPMS EHR mobile capabilities is noted in the backlog. There are many security requirements that need to be addressed before mobile functionality is tested and implemented.

6. **Concern**: EHR is not easy to integrate with other systems. Some Tribes have integrated certain pieces of RPMS with other systems (e.g., CARESTREAM). However, each integration requires programming.

> **IHS Response**: Integration is a challenge for the health information technology industry, and recognized nationally as a concern. Interoperability with other systems requires development and programing for each software application. Interfacing standards continue to be defined and developed by national standard agencies, committees, and states (e.g., HL7, ONC, and State specific rules).

7. **Concern**: Provider workflow is not intuitive, it can be cumbersome, and has required creative workarounds. Examples include: SNOMED workflows; multidisciplinary care plans are not available in EHR; intakes and outputs are not available in EHR; and Clinical Decision Support functionality is limited in EHR.

> **IHS Response**: The IHS recognizes the need to support usability of the EHR and its workflows to promote efficiency and quality care. Workflow standardization requires multidisciplinary input and collaboration, as the development is an iterative process. Sponsors to address and define requirements for these enhancement requests would be needed, as well as resources allocated to support the development.

8. **Concern:** Holistic view of the patient is not easy to see. While the data is there, it is fragmented and difficult to piece together. Also, the patient functionality mechanism does not work.

> **IHS Response:** The ability to extract data to develop quality reporting is available. For specific report development, it would be necessary to define the measures needed to present what their area identifies as a holistic view. Ideally, this would be developed through an IHS-wide collaborative effort, so resources could be focused on creating the best possible view, vs. divided for creating different views and reports for each site.

9. **Concern:** EHR/RPMS is not focused toward Revenue Cycle management. Examples include: Reports are lacking; ability to have patient photo IDs easily visible at registration is not available; and Medical Support Technicians (MSTs) do not utilize the Registration functionality within Practice Management Application Suite (PMAS) due to some missing functionality and HL7 interfaces for our insurance eligibility checks, among a few other things.

> **IHS Response:** One of our goals is to use health information technology to improve patient care and support population health of the American Indian and Alaska Native (AI/AN) population. The revenue cycle is addressed, but limited resources postponed the release of revenue cycle enhancements. However, those enhancements will be forthcoming. We encourage sites to enter enhancement requests through their local workgroup representative.

10. **Concern:** The infrastructure behind EHR is an older technology, however, with innovations, EHR could still have modern functionality. Per IHS recommendations, EHR is confined to run on Windows 32-bit machines, with Office 2010. VistA Imaging users have been expressly banned from utilizing VistA on any Windows 10 computers. EHR/VistA is not keeping up with advancing technology, and there are growing difficulties, as well as some security concerns with not bringing these applications up to run on the latest versions of Windows.

> **IHS Response:** The enhancement/upgrade to the infrastructure is a priority. For calendar years 2017 and 2018, the IHS plans on updating RPMS applications to operate on Windows 10 client and Windows 2012 servers.

11. **Concern**: EHR is a very thick client, and has virtually no tolerance for network latency, meaning the data required to be passed back and forth from the server to the client PC is large and is very sensitive to any network packet loss, therefore not stable to be connected over a wireless network, even if working off a mobile laptop.

    a. Even over a hard-wired connection, any network loss can cause disconnected sessions, and lost data for providers. The disconnected sessions can also cause issues for the EHR servers, as disconnected sessions, though disconnected at the desktop, are still active on the server. As users continue to re-connect, the EHR server can get overwhelmed with EHR sessions.

       IHS Response: The IHS acknowledges the thickness of the EHR client as an issue. Funds are being requested to analyze the EHR framework and database architecture to optimize usage and the user experience.