*Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*

[*https://www.healthit.gov/buzz-blog/health-it/strategy-on-reducing-regulatory-and-administrative-burden-relating-to-the-use-of-health-it-and-ehrs-released-for-public-comment*](https://www.healthit.gov/buzz-blog/health-it/strategy-on-reducing-regulatory-and-administrative-burden-relating-to-the-use-of-health-it-and-ehrs-released-for-public-comment)

Comments

PP 7:

Blue Button 2.0 contains four years of Medicare Parts A, B, and D data for 53 million Medicare beneficiaries. Medicare beneficiaries have full control over how their data can be used and by whom, with identity and authorization controlled by MyMedicare.gov. This data reveals a variety of information about a beneficiary’s health, including type of Medicare coverage, drug prescriptions, primary care treatment and cost.

Need to add Medicare Part C, those patients enrolled in Medicare Advantage Plans.

PP 13:

Strategies should be achievable within the near to medium term, roughly 3–5 year window.

Window should be 2-3 years.

PP 14:

For instance, limited appropriate use of the “copy and paste” and auto-populate functions within the EHR can ensure records do not become overloaded with extraneous information.

The issue is more that the record not contain information that is not accurate and information that is misleading. Also the “copy and paste” bring up compliance issues, such as billing supported by information which is not accurate (and known not to be accurate), leading to a potential false claim assertion.

Ultimately, patient safety is at the center of the “copy and paste” scenario, where a clinician could be given inaccurate data about their patient and then making assessments and treatment plans which are based on inaccurate information.

PP 14:

Consistent with HIPAA, HHS could expand on current work to identify common data elements and standardized templates that can be implemented by health IT developers to support more automation around these processes.

Also need to add the notion of NLP: Natural Language Processing, as a means to capture important data and work with templates and with the common data elements.

PP 15:

Testing these new approaches is important, and HHS could engage a wide variety of payers, health care providers, and other third-party intermediaries in working toward robust standards-based automation of these transactions.

Would also bring in the ISA (Interoperability Standards Advisory – [www.healthit.gov/isa](http://www.healthit.gov/isa)) as a resource of standards. The ISA, as a living document, needs to be kept up-to-date, with new, evolving standards.

PP 15:

Implementing these recommendations will require collaboration across a range of stakeholders, including clinicians who best understand how to reduce burden within their own processes, health IT developers and other vendors who must implement these changes within their products, and HHS and other institutional stakeholders who can help to develop and disseminate best practices.

The end-users (e.g. the Physicians and others) need to participate in the “testing” of usability options, and their feedback needs to be considered in the final product.

PP 15:

Finally, EHR developers can improve information presentation and display to minimize information overload for the end user.

Data provenance needs to be in place, where the Physician is able to know the origin of the data, did the data change as it passed from the originating site, and it the data believable? There also needs to be a pivotal notion of data quality and of data integrity. Is the data accurate and is someone making sure that the data is accurate? Is the data in the correct context?

PP 16:

The industry should also consider options to develop and adopt health care-specific GUI design components (such as flowsheet list generation and navigation components suitable to the busy clinical environment) that could better support the clinician's cognitive process and the clinical workflow.

One needs to recognize that more data and more information is not necessarily better. Too many details will slow down the clinician and important information will be hidden “in the weeds”. There needs to be a “drill-down” process, if the clinician needs more information related to a template or to a workflow.

PP 16:

Health IT developers can ensure that the user interface is consistent throughout an entire product, and health care institutions can consider limiting customization that significantly changes this user interface. Finally, a better design of the physical environment can reduce EHR-related burden by making it easier for clinicians to interact with health IT systems in ways that better align with existing clinical workflows.

“consistent throughout an entire product” does not mean anything. The Physician may be entering an order, thus the order entry process needs to be consistent – the rest of the application (e.g. viewing results) is a different scenario. Customization is done because the end-users are trying to make the product better and safer. Thus, customization is necessary, and should not be limited. There is a conflict of interest: the developer/vendor’s goal is to sell product, as their priority. The developer/vendor will not be incented to listen to end-users if sales are up and if the entity is profitable. Most developers/vendors do not care how the end-user customizes the product; the developer/vendor wants the “sale” and wants an executed maintenance agreement.

PP 16:

“standardizing medication information”

Regarding medication orders, the “reason” or the “indication” for the medication needs to be part of the medication order. The dose of a medication (e.g. beta-blocker) can differ depending on the reason the medication is being administered. The “reason” or the “indication” is not necessarily on the problem list or in the list is diagnoses. Most all Pharmacists would be highly appreciative if the “reason” or the “indication” for the medication was part of the medication order. In our past hospital EMR, the “reason” or “indication” was a required field and the “reason” or “indication” was entered on every medication [Inpatient EMR].

PP 16:

Finally, promoting better implementation decisions in the deployment of health IT systems can improve clinician efficiency and satisfaction and lower burden. Health IT developers and institutions that manage system deployment can increase end user engagement and training to ensure that the product purchased by an organization will meet the needs of its end users and their desired workflows.

Lacking is the above thought, is the need for clinician participation in testing and in workflow design. Testing is critical and needs to be perfumed by the end-user, and there needs to be resources (time and money) to correct issues and errors found during testing, before the application is placed into production.

PP 16:

Greater transparency and thoughtful planning around budgeting for health IT investments can ensure adequate resources are available for critical training and ongoing support.

Regarding the budget, critical part of the EMR should not be omitted (not purchased) by the Provider’s institution, due to budgetary constraints. Important features that improve on usability, increase efficiency of workflow, and increase visualization of data, should not be omitted. Just because the end-user (Physician) does not have offered imported processes that improve efficiency does not mean that these improved processes are not offered by the vendor (and are ready for production).

PP 16:

For instance, in the CY 2019 Physician Fee Schedule final rule, CMS reduced the number of required measures as well as simplified the scoring methodology for the Promoting Interoperability performance category under MIPS by eliminating the base, performance, and bonus scores and established a new scoring methodology focused on clinician performance at the individual measure level.

We need to move from “process” to that of “outcomes”. Being too prescriptive increased Physician burden.

PP 16:

“while continuing to invest in technical assistance for health care providers to improve understanding and overall success”

Yes, there needs to be a program, as there was during the time of Meaningful Use (REC – Regional Extension Centers) to assist providers with advise regarding EMR workflows and training.

PP 17:

Reducing EHR-related burden in these programs will require collaboration between HHS, health IT developers, and other health IT vendors, in order to take advantage of the potential of health IT to improve the technical infrastructure available for reporting. Stakeholders could work together to develop and adopt industry-wide best practices for data mapping that can improve data accuracy and reduce burden when reporting from EHRs, as well as standards that improve the ability to access and extract data from health IT systems.

This will never happen unless incentives (financial) are aligned.

PP 17:

EHR REPORTING STRATEGIES

Needs to have notion that we are trying to improve the health of the population, striving for improve “outcomes”. This is an outcome issue, not a process issue.

PP 18:

The first strategy looks at ways federal stakeholders can work with states to accelerate adoption of EPCS and retrieval of medication history from state PDMPs by promoting improved integration of health IT into health care provider workflows.

Need to also include the Regional and/or state-wide HIE (Heath Information Exchange). The HIE can be a repository for the PDMP, as in the state of Washington (run by the statewide Department of Health).

PP 19:

Clinical Documentation

Need to add the notion of Coding (ICD-10-CM Codes, ICD-10-PCS Codes), Clinical Documentation Improvement (CDI), and reimbursement. ICD-10 Codes, as per the WHO (World Health Organization) are critical to research and bear on the quality of the care provided. Also, need to add NLP-Natural Language Processing and Machine Learning. Artificial Intelligence algorithms can assist the clinician if there are any errors of missing data? Artificial Intelligence can suggest potential treatments? Artificial Intelligence can suggest alternative assessments, which may have been overlooked?

PP 19:

Better align EHR system design with real-world clinical workflow.

“Real-world” does not mean anything. What is pertinent to a clinician can be dependent on their experiences and their familiarity with the patient and with the clinical situation. These experiences vary, and the “world” to one can be vastly different to someone else. One may wish to say “clinically relevant” instead of “real-world”.

PP 19:

Improve clinical decision support usability.

Physicians need to have input into the rules guiding clinical decision support (CDS) rules. How the rules are developed and integrated into the clinical workflow is important. Physicians need to “test” the CDS rules before implementation. There needs to be a plan, how CDS rules are operationalized (a few at a time, what is the schedule?). CDS rules need to be monitored and reports need to be developed. Is the CDS rule capturing important events, or is the user placing incorrect/false data, to obviate the rule?

PP 19:

Harmonize user actions for basic clinical operations across EHRs.

Data from outside sources, needs to be “integrated” into the Physician’s EMR. The Physician does not have the time nor the ability to query outside and secondary systems. The user interface is critical to the viewing and to the consumption of outside data by the clinician. Data provenance and data quality must be ensured.

PP 20:

Promote proper integration of the physical environment with EHR use.

Need to incorporate Social Determinants of Health into the EMR. Such data needs to initiate important assessments and orders for the clinician to review, to assist with the patient’s health status (e.g. community support programs, case management).

PP 20:

Optimize system log-on for end users to reduce burden.

This does not mean anything. The Physician user needs to have undergone a proper process of Identity Proofing, Authentication (OpenID Connect), and Access (OAuth2.0). Biometrics can assist with the Authentication process. Physician want to make sure access is secure. Having PDMP data integrated into Physician’s EMR, (as in the state of Washington), will reduce logging in to an alternative system (the PDMP) – PDMP integration into the Physician’s EMR will clearly reduce Physician Burden!

PP 20:

Data Reporting:

Need to move from reporting processes to that of reporting outcomes (including population measures).

PP 21:

Data Reporting:

Agree with use of APIs.

PP 21:

Federal agencies, in partnership with states, shouldimprove interoperability between EHRs and PDMPsthrough the adoption of common industry standardsconsistent with ONC and CMS policies and the HIPAAPrivacy and Security Rules.\*\*

Need to add: 42 CFR Part 2 Data and how such data is incorporated into the EMR. The burden that the Physician in having to obtain consent from the patient when “Part 2 Data” is shared is huge.

PP 24:

Structured templates within EHRs help ensure that clinicians are capturing all the information required, and clinicians can easily carry forward, or “copy and paste,” prior entries into the record to save time, especially when the same description of a patient’s history has been previously recorded.

The “copy and paste” function in a medical record can be a huge patient safety hazard. The pasting feature allows for the entry of more data in the medical record, making is harder for the clinician to delineate the key and important data from the shear volume of extraneous data, which has been repeated a number of times.

Physicians typically to not realize that the entry of incorrect data, or the entry of data in the incorrect construct, is not only a patient safety issue, but an issue defending one self against a possible accusation of fraud. Knowingly entering (pasting) data in the medical record, which is not accurate, can lead to False Claims Accusations (the FCA-False Claims Act), and to CMP-Civil Monetary Penalties. One cannot bill for an encounter when an event “really” did not happen, or when the patient’s condition [really] was not as indicated in the medical record. Certain data, contained in the Assessment and Treatment, likely should never (nor nearly never) be copies and pasted from one visit to the next day’s visit (inpatient chart).

PP 25:

Furthermore, clinicians assert that they spend a great deal of time complying with these documentation requirements and often are unable to finish all required clinical documentation during clinic hours. Clinicians indicate that this cuts into personal and family time, increasing clinician frustration and, ultimately, physician burnout, which has been noted as a growing problem. CMS has heard from many clinicians that copying and pasting contributes to meaningless data accumulation within the medical record, and in some cases presents program integrity issues.

There is more to documentation centered around E/M coding. For instance, when the patient has Heart Failure, the EMR should require the Physician to select if the Heart Failure is systolic, diastolic, or both – is acute, chronic, or acute on chronic. In other words, stating “heart failure” should not be allowed or possible The severity of the patient’s illness is captured with granular and detailed documentation. [one can also say unknown, is there have been no studies].

On the inpatient side, ICD-10-CM codes are paramount to hospital reimbursement. Secondary codes (ICD-10-CM codes) increase the complexity of the DRG and increase reimbursement (CCs and MCCs). If the chart has detailed documentation, there may be a number of secondary diagnoses listed in the DRG sequence. Poorer documentation typically results in fewer secondary diagnosis and a less complex DRG. Being able to capture the Complication and Comorbidity (CC) and/or the Major Complication or Comorbidity (MCC) codes are foundational to clinical documentation integrity and coding.

PP 26:

Non-ambulatory care settings (such as inpatient care) require documentation of other parameters, such as patient status or admission orders, to support payment. Finally, private payers also have varying documentation requirements associated with payment and clinical processes that add complexity to documentation burden, such as patient care plan documentation requirements.

In our previous EMR, we had “required order on admission” which were needed before the EMR would open up for use – the Level of Care Order, which was also mapped to the correct patient Status (inpatient status or outpatient status) was never missed nor omitted. As a required order on admission, this important information was always present.

PP 27:

However, progress towards more effective solutions has been difficult to achieve. Payers and health IT developers have generally addressed prior authorization in an ad hoc manner, implementing unique interfaces to facilitate documentation and sharing of information that reflect their own technology considerations, lines of business, and customer-specific constraints. Utilizing these unique interfaces (for direct data entry) is time consuming for clinicians and often disruptive to their workflows.

The issue of Prior Authorization is difficult because the incentive between the patient/provider and the payer are opposed. If the service is denied by the payer, the payer saves money. The issue is financial and not in the best interest of the patient. The provider spends countless hours trying to get payer authorization approved, and the patient can “blame” their Physician for not trying hard enough to get their test or their equipment approved [by the Payer]. What is needed is “regulation” by CMS, that when one or two key questions are answered (a condition present or not), the service would have to be paid by the payer. Taking the payer to court for breach of contract takes time and money; although usually successful, the payer’s attitude does not change. Having to take the payer to court is not an efficient way to practice medicine.

PP 29:

Another HHS initiative, Electronic Submission of Medical Documentation (esMD), has allowed an increasing number of clinicians to respond to documentation requests from CMS review contractors by submitting records electronically.

Great work with CMS and with the S and I Framework [ONC] in developing esMD. Much time has been saved in forwarding medical records to governmental auditors.

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HEALTH IT USABILITY AND THE USER EXPERIENCE

Unfortunately, I am not convinced that those making up the usability guidelines are those that are on the front-lines using the electronic record with the patient.

PP 31:

In some cases, a health care institution decides to customize an EHR to try to better fit its workflow needs.

The issue is not the workflow. The issue is that the Physician can only think and come up with a conclusion using a finite limited amount of data at one time. When too much is presented on a screen, needing Physician input (especially about critical issues), this becomes burdensome. Being able to breakout information in smaller sizes will yield better results and better patient care.

PP 31:

When a prescriber electronically orders a medication to which a patient has a listed allergy, a pop-up window will appear warning the user about the allergy and suggesting alternative actions for the prescriber. While in theory EHR alerts can help clinicians deliver higher quality care, in practice clinicians are often inundated with pop-up alerts ranging from very minor interactions to truly critical risks. This can lead to “alert fatigue”—a phenomenon where the user, faced with many lower level alerts, starts to ignore all alerts and thereby misses critical alerts that can impact patient health and safety.41

This is not accurate. The Physician is appreciative when an alert appears when a medication is being written, when the patient is allergic to that medication. There is less of a need to have the system suggest alternative medications. The Physician is very upset if the system let them write an order for a medication, without any alerts, when the patient is allergic to that medication.

PP 32:

“a clinician may have to spend time searching through large amounts of information for the piece that is needed to perform a clinical task.”

It would be nice to be able to perform a “search” function, looking for key words. EMRs typically do not have a search function. Being able to find a diagnosis or a medication in a large document, would be time saving.

PP 32:

Thus, a clinician looking for the discharge summary of a hospitalization, typically a few pages of text, may have to search within a 40-page CCD document full of extraneous information about the hospital stay.44

The quality of CCDs can vary. There are applications which score the quality of CCDs. One might wish to encourage the EMR Vendor to monitor and improve on the quality of the CCDs which are published.

PP 33:

Compounding this issue, medications in the United States are typically referred to by both their brand and generic names. The formulation, dosage, and schedule information can also appear differently depending on the EHR system. Each of these issues adds an additional layer of cognitive load on the end user, increasing burden.

This is an issue which is not impossible to solve. We always had both the generic and the trade name of the mediation as part of the order and as part of the list of active orders. Such a display containing both the generic name and the trade name of the medication, along with the indication (the reason) for the medication improves patient safety and improves the workflow of the Pharmacist.

PP 34:

Different EHRs, however, lay out the laboratory results table in different configurations, most notably with regards to chronology. Some systems display the oldest results to the left, others display the newest results to the left, and still other systems allow the end user to configure this as an option. Results screens that a user is not familiar with can increase the likelihood of error.61

The display of “lots of data” has been accomplished for years. Please see the work of [Edward Tufte](https://www.edwardtufte.com/tufte/). Clearly, a very abnormal and critical result, needs to be easily captured by the Physician.

PP 34:

During implementation, a number of decisions are made by the health care organization, in concert with the health IT developer, regarding configurable options of the health IT product. In larger health care systems, these decisions can be complex and plentiful.

Having to “fix” the design, attend to usability issue, and workflow challenges can be lifesaving for the patient. Remember, the EMR vendor’s primary role is to sell product. The usability issues are of secondary importance to the vendor – the responsibility of attendant errors resides on the shoulders of the clinical team. Vendors need to assess how the end-users are re-configurating their system – then when a upgrade is made available, important changes can be, ideally, made available. Small hospitals and smaller providers do not have the IT infrastructure to address usability needs.

PP 34:

At times, this difficulty integrating data from other systems requires data to be entered multiple times.

Integrating data, using IHE Profiles (e.g. XDS.b) can be easily accomplished. Need to have experienced technical staff.

PP 37-38:

Quality Reporting needs to be more outcome based, not process based.

PP 39:

In a 2015 comment letter, the American Medical Association urged CMS to develop new health IT measures that avoid process-based measurement for more goal-oriented measures that focus on patient outcomes.82

I agree, there needs to be a move from process measures to outcome measures.

PP 40:

Although smaller physician practices, for example, face financial hardships in implementing health IT and administrative challenges in program participation, they must meet the same program requirements as larger practices. While MIPS currently excludes participation by eligible clinicians below a certain volume threshold, there are still smaller, resource-challenged practices that continue to struggle to meet program requirements.

Certainly in rural America, resources are low (and where margins are thin), and fine tailoring of the EMR and a deep dive into quality reporting pose significant challenges.

PP 41:

For instance, HIV public health programs receive funding from several federal agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA), each of which imposes different funding requirements on their grantees.83

The 42 CFR Part 2 restriction, requiring patient consent to share treatment information to other providers is now outdated and is a genesis of poor patient safety outcomes. Part 2 data needs to be share with the patient’s healthcare team, so the healthcare team is fully cognizant of the patient’s condition. Marinating key patient data points from the care team, post a patient risk, when the care team is not fully acquainted with key patient data. There should be a relaxing of the 42 CFR Part 2 Rule anytime a patient enrolls in a federally funded program, such as Medicare or Medicaid. Privacy and security measures, found in the HIPAA Privacy Rule and in the HIPAA Security Rule are adequate for patient protection.

PP 42:

Even within one public health jurisdiction, different transport requirements may be required for different public health options. For example, Simple Object Access Protocol (SOAP) web services may be required for immunization reporting while secure File Transfer Protocol (FTP) may be required for syndromic surveillance.

One needs to sunset FTP (File Transfer Protocol) means of transport. Public Health Information Systems need to be updated and be aligned with the ISA (Interoperability Standards Advisory, [www.healthit.gov/isa](http://www.healthit.gov/isa))

PP: 43

EPCS requires two-factor authentication, which can be burdensome for prescribing clinicians to integrate into their workflow. This has slowed adoption of EPCS nationally, with only 24 percent of prescribing clinicians currently having the capability for EPCS.86 While some health IT vendors and health care providers have implemented authentication technology seamlessly into clinician workflow, the ways newer approaches to authentication can be used and fit into health care providers workflow is not well understood.

The PDMP data needs to be integrated into the Physician’s EMR. Once the Physician is authenticated in the EMR, the Physician should not need to re-authenticate in the PDMP. Having the Physician to access two different systems (the EMR and the PDMP) is burdensome and time consuming. Please look at the Department of Public Health, State of Washington to note that PDMP Data can be integrated into a provider’s EMR; and that one can also leverage the state-wide HIE, as a repository of the PDMP.

PP 44:

Substance Use Disorder Patient Records, known as 42 CFR Part 2 or Part 2. The disclosure of SUD records has the potential to lead to a host of negative consequences, including: loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.

42 CFR Part 2 restrictions were implemented to protect the privacy of the patient being treated for a substance use disorder. However, the restrictions [42 CFR Part 2] , in today’s world of where systems are to be interoperable, and where data is expected to be shared (leaving the silos behind), are now posing a patient safety issue where key information is not received, at the point of care, by a care provider. Patient safety issues are growing due to this restriction. HIPAA offers the necessary privacy and security protections.

PP 44:

For example, technical standards exist for electronically tagging health information to indicate privacy considerations, including legal requirements, within a patient record or summary of care document within the EHR, and SAMHSA supports ONC’s Data Segmentation for Privacy initiative92 to support clinicians sharing of health information in accordance with patient choices.

Although DS4P (Data Segmentation for Privacy) [ONC] is great, at least in theory, important patient data needs to be at the point of care for the provider.

PP 44:

Generally, stakeholders agree that significant burden would be reduced by improving health care providers’ understanding of Part 2 and developing tools to facilitate consent and disclosure processes.

One solution would be that the patient gives “consent” to have their Part 2 Information shared as part of the enrollment process in a federally funded program, such as Medicare and/or Medicaid.

PP 46:

**Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.**

Stakeholders frequently identify the documentation guidelines for patient visits as a source of EHR-related burden. Using the EHR to satisfy documentation requirements for E/M codes should generate greater efficiencies.

E/M Codes are not the only important codes. ICD-10-CM (for diagnosis) and ICD-10-PCS (for inpatient procedures) are key to the coding, key to the billing, and key to the reimbursement, as found in the medical record. The medical record needs to portray the severity of illness of the patient and the risk of mortality of the patient. Clinical documentation needs to be of high quality and key information should not be absent (e.g. Heart Failure: systolic, diastolic, or both, or unknown; acute, chronic, acute on chronic, or unknown).

PP 46:

**Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.**

Many EHRs simply translate a paper-based documentation workflow, meeting the 1995 and 1997 E/M documentation guidelines, into an electronic one, while retaining a paper chart design paradigm and clinically outdated aspects of documentation especially regarding history and exam.

Need to implement tools such as NLP (natural language processing), AI (artificial intelligence), and ML (machine learning). These tools will assist in alerting the Physician about key data elements. As we transition to ICD-11, such tools will be needed.

PP 47:

Clinical specialty societies could continue to provide input to define proper clinical standards for documentation and establish what is required for high quality patient care. Payers could continue to provide input about the information necessary for claims payment. Health IT developers could continue to advise the agency about what technology solutions would best support the agreed-upon guideline revisions.

Agree that specialty societies should become more involved and they can be a “spokesperson” for the Physicians caring for patients with special conditions. Regarding input from payers, when a diagnosis is clearly documented in the chart, the payer should be prohibited from denying that the diagnosis exists, in order to have the chart re-codes with a less complex DRG and deleting important secondary diagnosis. Making the provider submit a “false claim” is not right and the payer’s aggressiveness to deny diagnosis which exist should not be tolerated by HHS. Unfortunately, this practice is growing as payers increase the number of denials imposed on Providers/Hospitals.

PP 48:

**Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.**

Best practices for clinical documentation in EHRs are being developed in many settings. Progress in this area, along with new policies to reduce documentation burden associated with E/M guidelines, will help to reduce duplicative documentation among care teams and template-driven “note bloat.”

Rarely, is there a need to be repetitive (many times) in a clinical note. The copy and paste feature in an electronic record needs better management, especially in the assessment and treatment sections. The medical records needs to be an accurate record of the patients’ condition at the time of the recording of the note. Pasting information in a recent note, with data from an old note, increases the risk of inaccuracies and opens up the door for an alleged false claim, and for CMP (civil monetary penalties).

PP 48:

**Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.**

CMS should incorporate best practices for reducing documentation burden into technical assistance provided as part of CMS practice transformation initiatives such as the Transforming Clinical Practice Initiative (TCPI), MACRA Technical Assistance (QPP-SURS), Innovation Center model learning and diffusion activities, and Quality Improvement Organizations (QIOs).

Would bring in the expertise from AHIMA (American Health Information Management Association – [www.AHIMA.org](http://www.AHIMA.org)) This professional organization are at the cutting edge of documentation quality and documentation integrity.

PP 49:

**Recommendation 1: Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.**

The prior authorization ecosystem is currently challenging for clinicians, frustrating for patients, and increasingly burdensome.

Clinical decision support tool can be built around the ordering process. When key elements are present, then the pre-authorization process should be automatic, and not pose an issue for the ordering Physician and the payer should not be in refute.

PP 49:

**Recommendation 2: Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers.**

Completing the clinical documentation required for justifying medical necessity when ordering certain services and/or obtaining prior authorization for services imposes significant burdens on clinicians and other staff.

Medical Necessity and the reason for an order or for a test should be clearing in the medical record and the reason should be also part of the order.

PP 49:

**Recommendation 4: Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.**

Maturing the templates and suggested clinical data elements described above to drive wider adoption across health IT developers, the medical product industry, regulatory agencies, and payers will require a robust piloting effort across different stakeholders. HHS should actively engage with efforts to pilot these…

CMS should observe and manage controls around the prior-authorization process, with authority to reign-in overly aggressive payers.

PP 50:

**Recommendation 5: Coordinate efforts to advance new standard approaches supporting prior authorization.**

HHS should continue to pursue standards that aim to improve the prior-authorization ecosystem through multi-stakeholder groups (e.g., clinicians, health care information technology vendors, and payers), such as but not limited to the Da Vinci project and P2 FHIR Task Force. HHS can help build awareness for these efforts and promote complementary activities. Once new standards are mature, HHS should pursue consensus through the National Committee on Vital and Health Statistics (NCVHS) in order to adopt standards that support multi-payer, real-time, prior authorization and reduce provider burden.

Great work on behalf of NCVHS and the ONC.

PP 51:

Health IT developers can take the lead by working with practicing clinicians, nurses, laboratorians, administrators, and professional organizations, who can advise developers as they make decisions and prioritize interactive display features during the development stage that will help streamline workflow.

One suggestion would be for the EMR Developer to spend an entire day in the ICU, watching how Physicians, Nurses, Respiratory Therapists, and Medical Students, Dieticians, etc. communicate. Have the vendor assess how critical information is communicated and how the patient’s condition is documented. Clearly, a “picture is worth a thousand words” and the EMR Developers would gain a better understanding of the challenges. The EMR Developers need to “gown-up” and put on gloves to watch how patients are cared for. Workflows could be dissected, assessed, and improved.

PP 51:

The sheer volume and complexity of scientific knowledge is greater than ever before, and constantly expanding.99 Tools to help the health care team navigate this knowledge are essential. The appropriate application of data standards and applications that associate critical clinical information data elements is essential to providing high-quality health care.

The Physician needs to be involved with the development, with the implementation and with the management of the CDS Tools.

PP 52L

**Recommendation 4: Improve presentation of clinical data within EHRs.**

EHRs contain vast quantities of clinical data and are capable of sending and receiving incredible amounts of patient information with a keystroke. This can present a challenge for the end user trying to locate one critical piece of information; a needle in the proverbial haystack.1

Data visualization has been accomplished in other industries. Important and critical data should not be “hidden” from view, of the treating Physician. Data which needs the closest attention needs to be easily viewed and acted upon. A large, disorganized “data dump” is not helpful.

PP 53:

**Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.**

Clinicians often serve at different clinical locations and often need to become proficient in the use of multiple EHRs. EHRs currently have widely divergent GUIs and workflow steps required to complete clinical tasks.

There is a risk, having a single graphical or clinical interface, as opposed to having this accomplished differently in differing EMRs. One EMR may do somethings well and other less well. The other EMR may do things in a fine manner, what the first EMR is doing poorly. EMRs for Public Health will function differently that for the acute hospital. The EMR for industrial medicine, will function and be different for the acute hospital or for a busy internal medicine/family practice office. The EMR for a Urologist, will have different constraints and needs as to what data is important. Please remember, “one size does not fit all”.

PP 55:

**Recommendation 1: Standardize medication information within health IT.**

Prescription drug information in EHRs should be displayed in a standardized format to avoid confusion, increase patient safety, and reduce burden.114

The reason/indication for all medications needs to be part of the medication order, as a required data element.

PP 56:

**Recommendation 1: Increase end user engagement and training.**

EHR end user involvement is critical to the success of an EHR implementation in terms of both safety and usability.121 Clinical users should be involved from the very beginning of the acquisition process to ensure that the product purchased by an organization will meet the needs of its end users and their desired workflows.

Training is essential. Consider a mandatory test, with a passing score, for access to the new EMR application. Physician burden will escalate, if the Physician has not been properly trained.

PP 57:

**Recommendation 3: Optimize system log-on for end users to reduce burden.**

The implementation and configuration decisions made by health care institutions can have significant impacts on clinician and end user efficiency and burden reduction.128

sers should never share their password with others. There needs to be a password management system, where passwords are “strong” and change over a finite period of time.

PP 58:

**Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.**

In the 2019 rulemaking cycle, CMS finalized the restructure of program requirements for both the Promoting Interoperability performance category in MIPS and the Medicare Promoting Interoperability Program for eligible hospitals and CAHs.

Need to move from a process construct to one of outcomes. If the outcomes are stellar, the process may be moot?

PP 59:

This could include taking part in ONC’s recently proposed Trusted Exchange Framework with an appropriate Health Information Network (HIN). Finally, HHS should look at innovative uses of health IT that can reduce the reporting burden itself by making it easier for federal agencies to pull data directly from health IT to facilitate reporting.

The Health Information Exchange should be leveraged as a source of data and a tool to which one needs to contribute. The Health Information Exchange can service as a life-time clinical record for patients, accessible anywhere the patient travels, independent of health system.

PP 61:

Similarly, ONC recently proposed the Draft US Core Data for Interoperability (USCDI), which aims to specify a common set of data classes required for interoperable exchange and identify a predictable, transparent, and collaborative process for expanding the USCDI’s scope. The data referenced in the USCDI is currently proposed for use within the Trusted Exchange Framework; however, ONC should explore the potential for use of the USCDI beyond the Trusted Exchange Framework in order to expand the availability of predictable, transparent, and…

Need to reconcile the USCDI, the ISA, and the HHS (CMS) Data Set.

PP 64: Similarly, artificial intelligence and machine learning present opportunities to assess quality performance and improvement in wholly new ways that can yield more detailed feedback. HHS should explore the feasibility of programs that can help develop and evaluate future approaches to quality measurement that will be less burdensome, more accurate, and more impactful in assessing the quality of care provided to patients.

Agree. Need to include Data Mining.

PP 65:

The SUPPORT for Patients and Communities Act now allows states to receive 100 percent Federal Medicaid matching funds in 2019-2020 for qualified PDMPs that integrate into a provider’s workflow and their health IT application for EPCS.

This is good news!

PP 67:

**Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.**

HHS should provide additional guidance about the federal confidentiality of alcohol and drug abuse patient records regulation (42 CFR Part 2),131 which requires the protection of the confidentiality of certain SUD-related information, and the privacy requirements of the HIPAA Privacy and Security Rules,132 which governs privacy and security of patient health information maintained by or for most providers, and applicable state law requirements.

HIPAA, the HIPAA Privacy Rule, the HIPAA Security Rule, and the HIPAA Breach Notification Rule are working fine, regarding the protection of patient data. The [consent] constraints posed by 42 CFR Part 2 are out-molded, pose a significant patient safety issue, as the treating physician, on the frontlines with the patient may not have access to pertinent and essential data to properly care for their patient.

Thank you.

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