**CLINICAL DOCUMENTATION:**

I applaud the effort to reduce the regulatory burden around clinical documentation and agree that it often forces clinicians to document information not particularly relevant for the episode of care or any subsequent care providers. MISSING from the strategy is the involvement of the person it affects the most, the patient. Specifically, the recommendations do not include the patient as an advocate for improved documentation clarity, relevance, and usability.

**Don’t forget the patient!** I recommend that you include a strategy that encourages health providers to adopt movements like OpenNotes ([www.opennotes.org](http://www.opennotes.org)) in which patients are given digital access to their complete note (not a summary). Patients can act as quality control agents (for free) by ensuring their own medical documentation is accurate, not full of “note bloat” and meaningful for the service and payment provided.

**HEALTH IT AND THE USER EXPERIENCE:**

The fastest growing user base of EHRs and Health IT are… yep, the patients once again. As FHIR apps come on-line and portal use grows, patients are becoming the largest “user” of health IT dwarfing that of physicians and nurses.

There is no mention in your draft proposal that recognizes this rising tide of users who will benefit from a user-experience designed from the patient perspective. We’ve asked patients what they want most from their health care portals and the vast majority respond with “ease of scheduling” and access to care. Why is it most healthcare systems still require their patients to call to schedule a specialty appointment? Why is appointment availability worse for patients scheduling online vs. calling via the phone (look at portal websites and you’ll often see please to “call us”).

 It should be the opposite and ONC can help drive innovation in this area by incentivizing or requiring a threshold of online scheduling as part of the requirements. Healthcare systems spend millions to pay staff to answer phones and manually schedule appointments when other industries have allowed self-service to flourish. Patients scheduling their own appointments are more likely to show up (less no-shows), more likely to be prepared for the visit, and feel more “in control” of their healthcare experience. Oh, and it’ll reduce potentially billions of dollars of cost across the U.S. to avoid the manual scheduling that is today’s current state.

**EHR REPORTING:**

I applaud the efforts to simplify reporting and would emphasize one burden/issue that exists: the reporting requirements change so frequently it introduces cost and confusion among physicians who have to adjust their workflows to account for the new “reporting” requirement that was published with only a small window of notice.

**PUBLIC HEALTH REPORTING:**

It is silly that most county agencies are still accepting paper faxes as the primary means of reporting syndromic data. Establishing clear requirements and exchange standards would be a move in the right direction. Most EMRs can extract the data needed and provide it in whatever format required so flexibility in the beginning might help increase adoption and pave the way for future standards.

