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January 28, 2019

Donald W. Rucker, MD
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW. Office 7009A
Washington, DC 20201

Dear Dr. Rucker:

Thank you for your leadership and the collaborative work of ONC and CMS to provide the *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.* As a key stakeholder to ONC, NAP is appreciative of the opportunities to participate, both in-person and virtually, during the ONC/CMS Listening Sessions, and to provide input into the published strategy.

As a stakeholder health professional society, we believe that NAP can bring a unique perspective to the ONC. NAP consists of 14 distinguished healthcare professions committed to advancing *interprofessional healthcare* by fostering collaboration and advocating for policies in the best interest of individuals and communities. NAP firmly believes that close collaboration and coordination between healthcare professions, aligned with a vision of quality healthcare leveraging health IT, can make significant progress on reducing regulatory and administrative burdens for health professionals. Please find NAP's comments and considerations below that we cover through an *"interprofessional lens".* We are here in partnership to improve our US healthcare system.

Respectfully submitted,

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President, National Academies of Practice (NAP)

Strategy on Reducing Regulatory and Administrative Burden **NAP's Comments & Considerations**

	Strategies	Recommendations	NAP Comments & Considerations
Clinical Documentation	Reduce regulatory burden around documentation requirements for patient visits.	• Continue to reduce overall regulatory burden around documentation of patient encounters. • Leverage data already present in the EHR to reduce re- documentation in the clinical note. • Obtain ongoing stakeholder input about updates to documentation requirements. • Waive documentation requirements as may be necessary for purposes of testing or administering APMs.	• While recognition of the need to reduce regulatory burden in clinical documentation is appreciated, targeted focus on physician documentation is concerning. Although physicians are often the overseers of the patient plan of care, expanding the development of E/M codes could lead to increase regulatory burden to non-physician providers while not improving patient outcome or improving system efficiency. NAP would appreciate serious consideration of the following: • ONC is asked to provide a minimum standard for all electronic health record content. Endorsement of statutory requirements for all healthcare payers to adhere to the standard would be advantageous and would eliminate varying documentation requirements based at the discretion of alternative payment models. • Using the Data Element Library (DEL), establish a core set of essential and standardized elements to be captured in data sets and use this information toward existing quality measurement requirements.

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Clinical Documentation	Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.	● Partner with clinical stakeholders to promote clinical documentation best practices. ● Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.	● Create a stakeholder Interprofessional task force toward standardized regulation and policy development. Consisting of IT developers, a wide spectrum of professional clinicians (i.e. nurses, therapists, social workers, dieticians, pharmacists, etc) and healthcare industry operators, this group could facilitate an interprofessional approach to clinical documentation, decreasing the ONC reported concerns for "Note Bloat" while facilitating the essential health record information needed to meet the requirements of the impending Medicare *Patient Driven Payment Model (PDPM)* and *Patient Driven Grouping Model (*PDGM). ● As an organization devoted to Interprofessional Education and Collaborative Practice, NAP researchers and educators are well positioned to secure and implement best practices for clinical documentation while working in concert with respective professional associations and the ONC. Non-proprietary guidance could be readily established in cooperation with the ONC.
	Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	● Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization. ● Support automation of ordering and prior authorization processes for medical services and equipment through adoption of	● Utilizing the above mentioned stakeholder task force, collaboration with ONC could be used to establish a reasonable and efficient set of clinical documentation elements along with a process to assure a standard for payer approved services, eliminating a repetitive

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Clinical Documentation		standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers and payers. ● Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes. ● Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services. ● Coordinate efforts to advance new standards approaches supporting prior authorization.	and inefficient prior authorization process. ● Consistent with the incentives used to stimulate hospital and physician adoption of EHR, all Medicare providers should be given equitable opportunity to adopt and implement EHR utilization. ● Using demonstration projects and/or pilots as incentives to non-hospital and non-physician providers facilitate a secure and efficient process for communication of service and medication orders that would reduce provider burden while improving the patient experience.
Health IT Usability and the User Experience	Improve usability through better alignment of EHRs with clinical workflow; improve decision-making and documentation tools.	● Better align EHR system design with real-world clinical workflow. ● Improve clinical decision support usability.	● Rarely are patients' cared for by a single health professional. The EHR system-design must support and reflect the contributions of each professional/discipline towards common patient goals. NAP recommends requiring a common workflow to support the professional processes of care followed by all professions (Assessment, Planning, Interventions, and Evaluation) and leveraging the best User-Centered Design (UCD) to integrated into real-world clinical workflow. ● Reduction of clinician burden can be greatly impacted by reducing meaningless clinical

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Health IT Usability and the User Experience		● Improve clinical documentation functionality. ● Improve presentation of clinical data within EHRs.	decision support (CDS) alerts and "alert fatigue". Suggest moving to requirements for synchronous, workflow triggered CDS calls returning information and suggestions relevant to the clinical situation at hand (e.g., CDS Hooks). ● Utilizing the above mentioned interprofessional stakeholder task force and the input to improve documentation elements, the same task force could make suggestions on clinical documentation functionality to further improve advanced CDS in the clinical workflow. NAP also recognizes the importance of the patient's voice in care decisions and advocates for shared decision making (SDM) to also be captured in improved clinical documentation functionality. ● Utilizing the above mentioned stakeholder task force; collaboration with ONC could be used to establish a reasonable and consistent set of data to view patient data.
	Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	● Harmonize user actions for basic clinical operations across EHRs. ● Promote and improve user interface design standards specific to health care delivery. ● Improve internal consistency within health IT products.	● Providing consistency of design and user-experience (independent of the EHR vendor) would help reduce clinician burden and advance interoperability. It is imperative to have interprofessional stakeholders for creating the best standard and user interface design.

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		• Promote proper integration of the physical environment with EHR use.	
Health IT Usability and the User Experience	Promote harmonization surrounding clinical content contained in health IT to reduce burden.	• Standardize medication information within health IT. • Standardize order entry content within health IT. • Standardize results display conventions within health IT.	• NAP recommends that standardization be based on the principles of Evidence-Based Practice (EBP) to assure clinical content is based on the latest evidence.
	Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	• Increase end user engagement and training. • Promote understanding of budget requirements for success. • Optimize system log-on for end users to reduce burden. • Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.	• Encouraging a strategy to engage end users in the design, implementation and evaluation is critical to improve health IT usability (all professions). Recommend the "training" is equally focused on the interprofessional practice workflow as on the technology functionality. Over-focus on the technology functionality leads to clinician burden and moral distress of end-users.

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EHR Reporting	Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	• Simplify the scoring model for the Promoting Interoperability performance category. • Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians. • Reduce burden of health IT measurement by continuing to improve current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow. • To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers. • Revise program feedback reports to better support clinician needs and improve care.	• Utilize Data Element Library (DEL) and Standardized Assessment Elements to facilitate a seamless documentation and transitions of care communication. This would facilitate standardized data collection while increasing accuracy of reported information. • Although hospitals and physicians have had opportunity to participate in incentive programs to initiate the use of HIT and EHR, non-physician Medicare providers and Post-acute settings (SNF, OPT, HHA, etc have not been provided any support or incentive to embrace HIT and EHR. This makes it difficult to standardize processes and/or assure timely accuracy of information submitted to meet compliance to assorted initiatives. • This is not reasonable nor will it be feasible without equitable incentives and standardized requirements. • Use of established QM and the standardized assessment information as noted above would facilitate this.

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EHR Reporting	Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.	• Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting. • Adopt additional data standards that makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals. • Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.	• Inter-professional best practices beyond those of physicians need to be determined before this is feasible. • A first step would be to identify the alignment between CDS and DEL content to create a standard set of clinical definitions all providers must use. It is not advisable for a new set of data standards and terminology to be created. • Only feasible with financial and technical support for ALL Providers. Otherwise, providers not included in the incentive will continue to use their established and less expensive systems.
	Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.	• Consider the feasibility of adopting a first-year test reporting approach for the newly developed electronic clinical quality measures. • Continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project. • Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.	• Good idea if handled like a Demonstration project where certain CMS requirements/policies are waived. This would allow the provider to have the incentive needed to be receptive to the new process. • To assure accuracy, efficiency and compliance, all CMS QMs should be established as eCQMs. Again, this can only happen when providers are given standards and support to facilitate seamless communication, submission and report review.

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Public Health Reporting	Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.	• Federal agencies, in partnership with states, should improve interoperability between EHRs and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules.**	• We agree with this strategic approach. CMS has indicated it will adopt the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard v2017071 in January 2020, which provides many technical solutions for bidirectional communication of medication prescribing and dispensing. Leverage the technology and logic in electronic Medication Prior Authorization to enable electronic prior authorization when ordering clinical services. (Clinical Documentation Strategy 3.) • Consider using existing State health data exchanges to achieve rapid successes while full interoperability efforts continue.
		• HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.	• We agree with the recommendation and offer the following comments. • The SUPPORT for Patients and Communities Act only mandates electronic prescribing of controlled substances for Medicare programs. HHS should advocate for mandatory e prescribing of all medications, scheduled and non-scheduled, and independent of insurance payer. • Medication prescribing of controlled substances must align with the four Clinical Documentation Usability Strategies in this draft document.

Public Health Reporting			Medication ordering clinical workflow is an integrated process – not segregated into prescribing of controlled and non-controlled medications. Having an isolated medication history of only controlled substances is not consistent with the prescription process and undermines patient safety. Segregated medication lists/histories could affect Clinical Decision Support warnings – Controlled substance medications interact with non-controlled substance medications and vice versa in addition to non-prescription medications and supplements. ● Clinical Decision Support Alerts should be designed for drug interactions in the active medication list while hospitalized as well as against home medications and supplements, frequently discontinued during hospitalization but restarted at discharge. ● Leverage the work accomplished such as automated query via e-prescribing software to multiple states' PDMPs with results integrated into the patient's medication history. These functions include automatic query of PDMP data and populating the EHR upon appointment scheduling, patient check-in or presentation at an emergency department and

Public Health Reporting			calculating patient opioid equivalents and risk score. ● States can schedule medications as Controlled Substances that are not scheduled drugs at the Federal level. System designs must accommodate State requirements to reclassify medications in software design and filter out unique State additions for multistate prescribers. ● Several states have standing orders for naloxone that may be dispensed at a pharmacy. This portion of the medication history, opioid antidote, may be clinically important information and part of a well-designed PDMP. The design will be challenged since the antidote for the patient may not be dispensed directly to the patient; a caregiver /concerned health advocate rather than the patient may obtain it. ● Consider "tagging" naloxone as a controlled substance so it populates PDMP databases. (Naloxone is not a scheduled medication.) ● Well-designed clinical workflow for prescribing controlled substances should integrate Substance Use Disorder Plans of Care. Details are described in the comments for Public Health Strategy 2, Recommendation 3.

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Public Health Reporting	Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.	• HHS should convene key stakeholders to inventory reporting requirements, and work together to identify commonly reported data for state and federal programs.**	• We support the recommendation. Use of the Data Elements Library may enable this approach. • Consider the same strategy for quality data reporting to ease documentation burden. • Consider adopting the already successful strategy of "Meaning Use" Stage 1 in a phased approach - Capture and share data with focus on the most critical data to share in order to focus activity on the highest value reporting.
		• HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.	• We strongly support this recommendation and offer suggestions to advance this recommendation. • Again, consider adopting the already successful Meaningful Use Approach. In a Stage 1 - Capture and share data, strictly "one way" reporting may be achieved with existing HL7's Clinical Document Architecture (CDA) structure and support clinical data exchange rather than strict "interoperability". Federal Programs that specify data reporting could be required to identify CDA standards for all data elements for both vendors and providers. Receiving entities would be required to "accept" data sent in standardized CDA format. • Prioritize the most valuable data reporting for public health and or individual patient care coordination.

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Public Health Reporting			(E.g. Infectious disease control of outbreaks/hot spotting diseases like influenza or hepatitis A.) ● "Meaningful Use-like" Stages such as - Advance clinical processes and Improve clinical outcomes require care coordination design efforts beyond our current conceptualization of "health care system" and therefore EHR design specifications. Bidirectional sharing Social Determinants of Health intermediate strategy using Clinical Document Architecture (CDA) structure to design Continuity of Care Documents (CCD) containing the data identified in the "capture and share" work above could achieve the purpose of data-reporting; the creation of a shared plan of care. ● HHS could add an agenda item, "Design a Shared Care Plan", to the convention of stakeholders that identify the common data reporting needs as identified in Strategy 2 Recommendation 1 above.
		● 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 guidance and is positioned do more than provide guidance to facilitate electronic exchange of substance use disorder health information. HHS could leverage efforts from the AHRQ Academy; *Develop a Shared Care Plan*, to connect behavioral health and Primary Care. Use

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Public Health Reporting		the design for protecting confidentiality of behavior health information, which already considers SUD care plans, while seamlessly integrating behavior and medical care records. ● Leveraging this existing effort of AHRQ may enable: · Presentation of Substance Use Disorder Care Plans (SUDCP) at appropriate touch-points in the health care system similar to the auto-query of PDMP described above. · Linking PDMP, prescription writing, and SUDCP processes. · Secure alerts for any provider, including pharmacists, to notify the provider/overseer of the SUDCP of potential variations/disruptions in the plan of care. ● EHR vendors' technology support individualized patient care plans that alert providers that a patient has an individual care plan. Using security matrix logic provides appropriate provider access and maintains confidentiality.

** = Recommendation shortened from report