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Alex M. Azar II
Secretary of Health and Human Services
U.S. Department of Health & Human Services
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Ms. Seema Verma
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Dear Secretary Azar, Dr. Rucker and Ms. Verma:

On behalf of the American Nursing Informatics Association (ANIA), we are pleased to provide written comments on the *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* Initiative. ANIA's 3,200+ members are the registered nurses working to design, build, implement, maintain, and optimize technologies which impact patient care delivery and outcomes including all the various electronic health record (EHR) applications.

In most clinical settings, it is registered nurses who provide most of the hands-on care and therefore bear a large amount of the documentation burden. We recommend these strategies specifically prioritize nursing's needs. This burden is illustrated by the length of a basic hospital admission assessment which 40 years ago could be completed in approximately 15 minutes but now takes a minimum of 45 minutes due to documentation requirements.

We believe it is critical to educate the public so they understand and can advocate for themselves. An avenue to consider is soliciting patient/consumer input on ways to improve integrating electronic patient health records at the point of care so they are part of the process. For example: how willing would patients/consumers be to have some of the documentation

requirements transferred to their control? This could increase patient/consumer engagement and accountability.

Transparent communication surrounding the financial responsibility for these strategies is needed. Each stakeholder must have a clear understanding of the objectives, how to use any funding, and a plan for ongoing compliance.

We support the strategies outlined in the draft with the following recommendations and suggestions outlined below.

Clinical Documentation Strategies

As healthcare moves to evidence-based practice, we recommend the second strategy be reworded to: “Continue to partner with clinical stakeholders to encourage adoption of best evidence-based practices related to documentation requirements.” There are several organizations such as ECRI Institute working on clinical documentation guidelines and/or models addressing the clinical documentation burden.

We recommend focusing on documentation from cradle to grave including provider practices, acute care settings, long-term care, dental, optical, and home health for a complete picture of the patient.

We would propose that HHS promote consistency in design and key functions within – and between vendors. For example, it does not matter what kind of vehicle one buys; there is significant consistency in icons for different warnings, how to start it, the location and functionality of shift lever, lights, and wipers. While they are not exact matches, they are similar enough that one can get into almost any vehicle and safely operate with no additional instruction.

Vendors do not even have internal consistency with color schemes for high alerts which is critical for patient safety. The inconsistency of functions and icons makes it very difficult to have a similar navigation experience which leads to frustration and potential errors.

We are concerned there was no mention the importance of Human-Computer Interface (HCI) principles unless the reader was to assume these were part of the optimization goal: "Promote user interface optimization in health IT that will improve the efficiency, experience, and end-user satisfaction." Perhaps the intent is to be vague about how to promote user interface optimization, we would recommend more clarity such as: “Promote user interface optimization in health IT using HCI and usability principles that will improve the efficiency, experience, and end-user satisfaction.”

The burden should not be on the user to log in 3 separate times but rather on the vendor to create the seamless "behind the scene" experience that is necessary for efficient, safe, timely care. For example: The barcoding medication process could be in a completely different system than the electronic documentation record. In this situation, nurses must go into one system for meds, another for documentation, and so forth.

There is a need to identify the areas of redundancy in clinical documentation between various clinical professionals. For example: If a pharmacist documents current medications in the patient's EHR, then physicians and nurses should not be required to document them again.

We strongly support the need to reduce the regulatory documentation burden of all clinicians while not shifting documentation from one clinical profession to another.

Further streamlining information access within the EHR is needed. An example of this is Meaningful Use Stage II, Menu Set 3/6 which required imaging results must be accessible through Certified EHR Technology (CEHRT). This requirement reduced the burden of the clinician having to log into/access another system to access images.

EHR Reporting Strategies

All standardized data definitions and metadata concepts need to reflect nursing documentation as well as provider documentation.

We suggest increased focus on rural areas which have not adopted EHR technologies thus increasing the paperwork burden and risk of comprise to patient care especially when transferring patients from rural to urban facilities. We support the narrowing of the gaps between urban and rural healthcare.

Consider certified EHR specifications that outline the EHR must be able to data mine from various data entry points in the EHR versus only one point of data entry.

Health systems EHRs should include robust patient portals incorporating patient education and interoperability with physician EHR systems.

Ensure reporting submission portals set forth by the Centers for Medicare and Medicaid Services are tested and working prior to clinician required submission deadlines. For example: PQRS/Quality Initiatives having data submission issues.

Public Health Reporting Strategies

It is our understanding PDMP participation is at the state level so additional strategies may be required to achieve desired standardization. Consider requiring CEHRT to integration access to prescription drug monitoring program (PDMP) anytime a narcotic prescription is electronically generated in the EHR. This would flag the provider within the EHR reducing the time burden of having to go outside the EHR to access another database.

Our organization is committed to supporting innovations in technology to transform health and healthcare by improving quality and care, enhancing the patient and clinician experience, containing cost, and improving access to care.

We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Dr. Carolyn Harmon or Dr. Cheryl D. Parker via email with questions or for more information. Thank you for your consideration.

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