American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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Don Rucker, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street, SW
Floor 7
Washington, DC, 20201

Dear Dr. Rucker:

The American Academy of Pediatrics (AAP), an organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to comment on the draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.*

The AAP is committed to the meaningful adoption of health information technology (HIT) for improving the quality of care for children, and commends the comprehensive approach being taken by the Office of the National Coordinator for Health Information Technology (ONC) to identify the essential elements that should be examined when considering nationwide interoperability. We also appreciate the fact that ONC recognizes that "providers of health care in the United States have identified regulatory and administrative burden as a key contributor to a number of challenges facing the health care delivery system." Pediatricians have been early and ambitious adopters of HIT. Despite that fact, however, data from ONC has revealed that pediatricians' participation rates in the Medicaid Electronic Health Records (EHR) Incentive Program is quite low compared to other physicians.

One of the larger barriers to pediatrician adoption of EHRs, according to a Pediatric Survey conducted in 2016, is the time spent on documentation. According to the survey, pediatricians reported spending a mean time of 3.4 hours per day (median 3 hours) on clinical documentation on a typical day when seeing patients, with 36% of respondents spending 2 hours or less, 42% spending 3 or 4 hours, and 22% spending 5 hours or more. The finding in this survey is consistent with previous research, as direct-observation time-use studies of ambulatory practice physicians have found that nearly half of the time during office hours is spent on EHR and desk work activities. The substantial amount of documentation time may be a function of poor EHR design, usability, workflow, or may be secondary to outdated CMS documentation requirements, which were last updated in 1997 before an extensive number of providers used EHRs. The CMS rules were

designed and implemented before a substantial portion of pediatricians used EHRs. Currently, 94% of pediatric providers in office settings use an EHR, which has changed work flow and documentation substantially.

The draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*, required by the *21st Century Cures Act*, addresses specific sources of clinician burden that will require coordinated action on the part of a variety of stakeholders across the health care system, including federal, state, local, territorial, and tribal government entities, commercial payers, clinical societies, electronic health record (EHR) developers, various health care provider institutions, and other service providers.

The AAP appreciates the work that was put in by the U.S. Department of Health and Human Services (HHS) and the ONC to prepare this draft report and begin the effort to reduce the regulatory and administrative burden on health care providers. In that spirit, we appreciate the opportunity to submit the following comments on the draft report.

Burden Reduction Goals

The draft report outlines three primary goals informed by extensive stakeholder outreach and engagement for reducing health care provider burden:

(1) Reduce the effort and time required to record information in EHRs for health care providers during care delivery.
(2) Reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and health care organizations.
(3) Improve the functionality and intuitiveness (ease of use) of EHRs.

The Academy agrees that these goals are laudable. We hope that these goals stay in the forefront as HHS and ONC work to reduce the documentation burden on providers but acknowledge that it will probably be hard to implement each goal as written. The Academy stands ready to work with HHS and ONC in any capacity possible to help achieve these goals.

Issues and Challenges

<u>Clinical Documentation</u>

The AAP appreciates that the draft report notes that "stakeholders have often identified the evaluation and management (E/M) visit documentation guidelines that are used by CMS and other payers as being clinically outdated and a source of EHR-related burden."

The Academy has previously raised similar points regarding E/M documentation guidelines. For example, the 1995 and 1997 CMS guidelines for E/M documentation state that ancillary staff may record the Review of System (ROS) and/or Past, Family, and/or Social History. However, the History of Present Illness (HPI) is not included in what ancillary staff may record, implying that only the provider can enter the HPI. While it is critical that the provider review and validate the HPI details to make safe and effective medical decisions, many times this information is

captured by ancillary staff—receptionists, medical assistants and nurses—as they are the first to encounter the patient, often play a triage role, and frequently are the first team members to inquire about and document the current illness. Forcing the provider to re-enter HPI to support an appropriate coding level results in double documentation and wastes resources. [1]

We are glad that the draft report noted that the result of this excessive documentation, sometimes referred to as "note bloat," can contribute to an "unwieldy patient record that may satisfy billing requirements, but is clinically outdated and fails to convey effectively the most relevant patient information and to document evidence-based decisions related to actual patient care—the very information that is critical to improving health care quality and outcomes."

While these burdens are important to note, the Academy would encourage ONC and HHS to consider adding a recommendation exploring the possibility of delinking documentation and billing. In other words, there may be more meaningful progress in reducing documentation when it is decoupled from billing. Delinking documentation and billing could be a massive undertaking, but we feel it is worth exploring.

In addition, we realize it may not be an easy task to make dramatic changes to the E/M documentation guidelines and any attempts to do so would take several years to fully address. In the meantime, we would encourage ONC and HHS to consult with pediatricians regarding any proposed changes, as pediatric providers have unique challenges that can differ from physicians who treat adults.

We would also like to note that current EHRs are designed to upcode. There is good evidence that implementing an EHR might increase costs, but not necessarily the quality of care. Many current EHRs are poorly designed because they are built to maximize monetary returns from following the current E/M guidelines even if the information added to the EHR is not helpful to the care of a patient. We encourage ONC and CMS to investigate this issue by providing research incentives that might highlight the role of vendors and health care institutions in the documentation burden.

The draft report also highlights that Medicare fee-for-service has begun developing a Documentation Requirement Lookup Service that will use the HL7 Fast Healthcare Interoperability Resources (FHIR) standard for Coverage Requirement Discovery. The draft notes that the ONC, to support these and other efforts, has established the Payer-Provider (P2) FHIR taskforce to "help pilot, test, and spread FHIR solutions nationwide." We would encourage ONC to reach out to pediatricians and include them in these efforts, as Medicare is geared towards adults and does not normally include pediatric perspectives as they move forward. With the chance that any particularly innovative Medicare initiatives may eventually be adopted by Medicaid, it is important that pediatricians are at the table when new methodologies are being developed.

Two other areas that we would encourage HHS to focus on in the clinical documentation section are assistive technology and the utilization of graphics or videos for communication. The AAP

[1] Lehmann CU, Kressly SJ. A call to modernize CMS evaluation and management coding requirements http://www.aappublications.org/news/2017/05/23/Commentary052317

would suggest possibly adding a recommendation supporting the utilization of assistive technology to extract key clinical problems and other information to populate problem lists, diagnostic lists, equipment lists, supply lists, and so on, and to display them in variable ways that are meaningful to the subsequent user's role. There could also possibly be a recommendation to support the development of graphic and video information displays, like patient problem timelines, or problems presented by shape, size and color, rather than a list, or equipment lists displayed as pictures rather than text, and video documenting seizures, for example.

Health IT Usability and the User Experience

The AAP appreciates that the draft report highlights the problem of "alert fatigue" and correctly notes the "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." The draft report goes on to highlight how poor clinical decision support (CDS) tools like pop-up alerts exacerbate alert fatigue. To improve CDS tools and alleviate alert fatigue, the draft recommends implementing a robust CDS framework and highlights the National Academy of Medicine's recent publication *Optimizing Strategies for Clinical Decision Support*, which encourages the "development and adoption of technical standards; tools to measure efficacy of CDS; collaboration surrounding a common repository for CDS tools; a legal framework for CDS; and research into the safety, quality, productivity, and outcomes of successful CDS implementation that will help drive the business case for future CDS adoption." While the Academy agrees with this recommendation, we would further suggest that the draft report specifically call for increased funding for research to bolster CDS tools. The academy further recognizes that developing and implementing of decision support is costly and time consuming and requires extensive expertise. Thus, the Academy encourages ONC to look for means of allowing CDS sharing among providers and institution through APIs or web services.

EHR Reporting

There is significant discussion in the draft about the Medicare Access and CHIP Reauthorization Act (MACRA) passed in 2015 that restructured programs focused on quality and value for physicians paid under Medicare Part B. As the draft report states:

> Through the new MIPS, MACRA combined for physicians, in a single framework, the existing Medicare EHR Incentive Program, Physician Quality Reporting System (PQRS), and Physician Value-based Modifier programs. It also added a new component around completing "improvement activities" which contribute to higher quality care and better outcomes for beneficiaries. Performance scores across the MIPS categories contribute to a single score.

While MIPS and MACRA may be a positive development for physicians who are paid under Medicare Part B, this largely leaves out pediatricians, as few children are covered by Medicare. As such, as MIPS is rolled-out, it focuses on the adult population, leaving the needs of the pediatric population behind when developing improved quality reporting requirements and

standards. It is essential that the needs of pediatricians and the children they serve are included in these important programs going forward, as pediatricians could see increased reporting requirements if Medicaid payment systems eventually begin to adopt MIPS-type payment systems, and pediatricians must comply with quality reporting measurements that do not align with the pediatric population.

Strategies and Recommendations

While the Academy is mostly supportive of the strategies listed in this section of the report, we would like to suggest that the draft report make clearer who is supposed to implement the strategies and how they will be incentivized to do so. For example, for Health IT Usability and the User Experience Strategy 1—improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools—we would encourage ONC to spell out who should be involved in better aligning the workflow. If the ONC would like vendors of EHRs to be included, then we would encourage them to make this explicit and build in certification requirements for vendors to ensure they will comply.

In addition, while many of the recommendations suggest standardization of EHRs across best practices, the draft report does not make clear how EHR vendors would be incentivized to accede to the recommended standardization.

As for specific recommendations, we would suggest that EHR Reporting Strategy 2, Recommendation 3—implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products—should include incentives built in for vendors to open their EHRs to outsider organizations and reviewers.

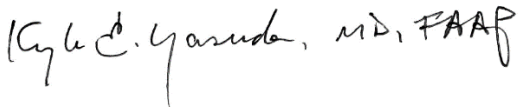
The Academy also believes that Clinical Documentation Strategy 1, Recommendation 2—leverage data already present in the EHR to reduce re-documentation in the clinical note—is positive and is much needed, as it allows the use of existing data instead of data re-entry as is currently required.

While we appreciate the focus of EHR Reporting Strategy 1, Recommendation 4—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—we worry about pediatricians, as well as vendors, having to comply with 56 different rules and procedures for promoting interoperability in Medicaid health care providers. We realize that each state and territory administer their own Medicaid programs, but it would be much easier to improve interoperability if there was uniformity between the states in efforts to promote health IT systems.

The AAP appreciates the opportunity to provide comments on draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.* The AAP is committed to the meaningful adoption of HIT for improving the quality of care for children and appreciate the acknowledgement from HHS and ONC that there is a need to reduce the documentation burden currently in place for health care providers. The Academy is willing and ready to work with HHS and ONC on any of the issues raised in the draft report. If you have any

questions on our comments, please contact Patrick Johnson in our Washington, DC office at 202/347-8600 or pjohnson@aap.org.

Sincerely,



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