

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

**January 16, 2019**

The American Geriatrics Society (AGS) greatly appreciates the opportunity to review and provide feedback on the HHS Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs developed by the Office of the National Coordinator for Health Information Technology (ONC), in collaboration with the Centers for Medicare and Medicaid Services (CMS). The AGS is a not‐for‐profit organization comprised of nearly 6,000 professionals dedicated to improving the health, independence, and quality-of-life of all older adults.

Below are comments that we hope you consider as you work to improve the current requirements and reduce the regulatory and administrative burden relating to the use of Health IT and EHRs.

**GENERAL FEEDBACK**

The AGS is thankful to be offered the opportunity to submit feedback pertaining to these draft recommendations as we take into consideration the specific needs of the geriatrics population and how to best improve Health IT and EHRs in order to provide best quality patient care and ease the burden of our geriatrics care providers.

Overall, we believe that the recommendations presented are necessary to implement if we want to prevent "burnout" especially among primary care providers who are overwhelmed with trying to satisfy numerous EHR documentation requirements, which entails tracking down the clinical information from different sections of the health record and oftentimes requires information only available on paper, all while trying to deliver high quality care. For example, linking payers, manufacturers and providers on the health IT platform with up to date information will decrease provider burden dramatically as it will decrease their time spent on documentation and allow them more time for patient care.

We are, however, concerned about cost. We urge HHS to address how much more money would need to be allocated towards EHRs to fix the issues outlined in this document; if/how it could affect resources for direct patient care (e.g. staffing); and to specify who will be responsible for paying for and making these improvements.

**SPECIFIC FEEDBACK ON CLINICAL DOCUMENTATION RECOMMENDATIONS**

**Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.**

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

The AGS strongly opposes the proposal in the Medicare CY 2019 Physician Fee Schedule (PFS) to create a single-rate payment for almost all Evaluation and Management (E/M) outpatient office visits irrespective of the visit’s length or complexity. In effect, such a change would slash reimbursement for providers who care for older people, offering the same pay for all patients, even those who may need more time and attention from their health professionals because of complex care concerns. We are concerned that these changes could lead to shorter patient visits and visits on separate days, neither of which support coordinated care for people who benefit from time-intensive services and support. The AGS’s full response to the PFS can be accessed [here](https://www.americangeriatrics.org/sites/default/files/inline-files/Letter%20to%20CMS%20on%20CY%202019%20Physician%20Fee%20Schedule%20and%20Quality%20Payment%20Prog.._.pdf). We urge HHS to remove its recommendation suggesting that other payers adopt this approach.

**Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.**

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

The AGS supports this recommendation. Receiving input from and working with care providers/clinicians to design workflow, minimize clicks, and simplify charting is essential as they are the frontline providers utilizing the EHR on a daily basis to treat patients and continuously improve care.

**Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.**

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

The AGS supports this recommendation. Pre-populating information for prior authorization and medical equipment will increase efficiency. For example, if payers linked the covered medications in the EHR, care providers could choose the correct, preferred medication from the start avoiding additional document review and reentering the same information over and over again in an attempt to find the covered medication.

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

The AGS supports this recommendation. Making the process of prior authorization standardized and uniform among payers, manufacturers and EHR vendors is a great suggestion to reduce the current burden and will add a tremendous value for primary care providers, especially geriatricians, and for patients, as it will better facilitate the process and reduce time.

**SPECIFIC FEEDBACK ON HEALTH IT USABILITY AND THE USER EXPERIENCE RECOMMENDATIONS**

***Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.***

Care providers need interoperability to reduce the current extreme burden the lack thereof imposes, and it is crucial for both safe and quality patient care as well as cost savings to have EHRs share information with each other. For example, currently, in one community, three hospital sites utilize the same company for their EHR, however, the EHRs do no communicate with eachother and patient’s medications do not reconcile. Therefore, the burden is on the care providers to spend lengthy amounts of time reading through the various documentations and needing to reconcile and find the pertinent patient information on their own.

For a new patient visit or a medically complex patient with a detailed past medical history, accurately entering the past medical, family, social and procedural history into the EHR can be a laborious task requiring "after clinical hours" effort if it is to be done right. Once the information is entered, it needs to be updated after old records are obtained and when new problems arise or new procedures are completed. Interoperability of structured data would automatically update the latest entries, greatly reducing workload and improving EHR accuracy.