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Donald W. Rucker, MD
National Coordinator for Health Information Technology
Via www.healthit.gov

Re: Comments on the draft "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs"

Dear Dr. Rucker:

Thank you for the opportunity to comment on your overview of the challenges and solutions for America's HIT current and future structure and goals. We appreciate your focus on both efficiency and ease for physicians. Here in the Heartland, we continue to believe the clinician's judgement is the most valuable and *the* central tool in the delivery of care. Anything that causes a disruption for the physician likely adds inefficiency, cost and possibly poorer quality care for patients. We commend you and your team for the development of a strategy that recognizes and addresses this.

Before making specific comments on the draft, we have an overarching comment and a practical suggestion:

A.   To ensure that we foster innovation while adhering to delivery models that are truly patient-centered, it is critical that the nation's HIT strategy is *not exclusively hospital-centric*. We encourage your team members and other policy-makers to travel to non-hospital-based sites and look at the models and opportunities which are tried-and-true, as well as emerging. Too often, the efficiencies that have been achieved outside of hospital systems are dismissed, overlooked and/or not understood. Additionally, achieved efficiencies are lost when regulations are put into place which are designed to work in a hospital model, with no thought to other, community-focused models. We welcome a visit, virtual or otherwise, to one of our 120 free-standing imaging centers, which are connected by an electronic platform. We are happy to also provide other suggestions of successful, electronically linked models, which are not dependent on supporting a consolidated grouping of bricks-and-mortar.

B.   While our country may not be ready to implement a universal HIT identifier for each patient, a requirement that all patients use their *full, legal name* on all health-related documents, would eliminate many of the match-up challenges we currently encounter with our master patient index. Unfortunately, many health systems still are acting on their own business interests instead of patient choice by refusing to share records or refer outside the system, even when the top community expert is not within the health system. There is much to be done to foster interoperability on behalf of patients.

Here are our general comments:

1. The definition of interoperability must explicitly require bi-directional interoperability (e.g., orders out/results in) to achieve our collective goals of patient choice, patient safety and cost savings for all parties. Our company has an "A" security rating, including 625 interfaces with other providers. Bi-directional interoperability is achievable; the barriers to doing so are mainly those manufactured by health systems hoping to electronically "fence-in" patients.

2. Any alerts within an electronic platform should have formal medical review to ensure the information is appropriate/useful.

3. The duplicity in reporting "measures" to government entities, at all levels, is shockingly costly and not necessarily useful for measuring comparative quality, access or savings. Allow us to propose a grand summit of government entities: federal (especially MIPS-related), state, county (including public health agencies) and state-only initiatives (e.g., MN Community Measurement; WA Health Care Authority). The request could be to develop one or two top priorities for the nation. Possibly another one or two could be chosen individually or regionally that are community-based. This would allow electronic platform vendors to: a) design software changes and b) work with the providers to more efficiently pull data that meets integrity standards and is comparatively useful.

4. At Center for Diagnostic Imaging (CDI), we are ardent advocates of tools that provide efficiencies for physicians *and* we are believers in the promise of clinical decision support (CDS) tools, when designed well. CDS tools can make the treating clinicians' workflow easier when the tool is not "cookie cutter" or "cookbook medicine" as is often feared. To avoid this, the model used by CMS with its Appropriate Use Criteria program for imaging could be duplicated and continually refined to assure user-friendliness. This program allows for competition and innovation with electronic platforms and algorithms but also requires qualification and transparency. Those CDS tools which are not user-friendly will be discarded in favor of other options. Many of the commercial, electronic, prior authorization programs lack outside qualification or transparency and are loaded with those disruptive "pop-ups". These commercial products have led to resentment and delivery workarounds, neither of which is healthy for our delivery system.

5. In order for the government to avoid further contributing to the recent, massive consolidation – which is documented to lead to higher costs and less physician engagement – a standard for a secure "single sign on" would be helpful. Using dual or multi-authentication, the industry (possibly prompted by your office) could set a security standard that would allow for physicians to manage a single sign-on process even if the physician is using more than one EHR. This would be a helpful simplification step.

6. Through the CDI Quality Institute, CDI's network of radiologist partners participate in robust continuous quality improvement (CQI) activities. The Quality Payment Program (QPP) has not contributed to higher quality within our network of 400 radiologists. It has, however, contributed significantly to overhead and produced data that is useless for internal CQI. Rather than relying on non-practitioners at the Medicare Agency, specialty societies could be assigned to convene panels to design comparable measures that are meaningful; these could be considered along with other submissions by practicing clinicians. The key is to have them designed by those clinicians who want to use them to continuously improve.

Specific comments are as follows:

7. On page 15 of your document, the Usability strategies are laudable but, again, when referring to "interface optimization", they do not acknowledge specific interfaces between EHRs that need to be bi-directional. Without bi-direction, these strategies will not be effective (see #1 above).

8. On page 19, the idea of working with all stakeholders on standardized electronic ordering of services is terrific. Allow us again to emphasize this cannot be another method to electronically fence patients into a certain health system, especially when there is more expertise or access elsewhere.

9. On page 21, we welcome the opportunity to participate in a pilot program to design and report meaningful and comparable quality measures.

10. On page 25, we wholly support your goals; please allow for innovation that is virtual rather than a bricks-and-mortar care delivery system.

11. On page 27, we believe the development of even more robust CDS tools will eventually (and gladly) eliminate the need for prior authorization. The backend tracking of utilization and adherence to evidence-based medicine is more constructive than the "Captain, may I?" approach, which often leads to inefficient delivery workarounds and no continuous improvement in adhering to best practices. Physicians respond to comparative data, based on evidence.

12. On page 28 – we welcome efforts towards interoperability, including FHIR usage. As experts in large files sizes, we believe it appropriate to caution the policy makers to consider the electronic file sizes that are shared. For example, a 3D mammography study can range from 450 megabytes to as large as three gigabytes.

13. On page 33 and Recommendation 2 of Strategy 3 – referring back to "orders out" bi-directional interoperability, Congressional aides have tagged the omission on a "pull down" list of a provider who is outside of a fenced health system as "white listing". If all orders are electronic, there must be a way to refer to the patient's choice of provider, whether that be because of easier access, health plan network, cost, etc.

Again, we commend you and your team for your awareness of the challenges and opportunities facing our nation's health care system and for raising awareness with any and all who review your draft strategy.

On behalf of the patients we serve and the physicians and hospitals with whom we partner, we stand ready and willing to help you as you proceed.

Sincerely yours,

Thomas J. Gilbert, MD, MPP
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