DRAFT: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, November 2018

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**Strategies and Recommendations**

**Clinical Documentation**

1. Reduce regulatory burden around documentation requirements for patient visits.
	* Agree with proposed strategy.
	* Regarding Recommendation 3, please subject the Appropriate Use Criteria requirement to this recommendation to obtain ongoing stakeholder input, since this is increasing burden on the ordering provider to document.
2. Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements
	* Need standardization of expectations for transitions of care, such as from hospital to skilled nursing facility
3. Leverage health IT to standardize data and processes around ordering services and related prior authorization processes
	* Strongly agree that all four recommendations are high priority, and currently have difficult authorization requirements for Physical Therapy, Surgical Case requests, dependence on fax and telephone workflows and need to clarify CPT codes.

**Health IT Usability and the User Experience**

1. Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools
	* Recommendation 1: Since no standard for “real-world clinical workflow”, seems to keep burden on end users to try and influence their EHR vendor, which is not working. “Real world clinical workflow” also needs to include patients as the ultimate end user of patient portals. Need equivalent of measurement of health literacy level, applied to user interface literacy level.
	* Recommendation 2: Particularly in reference to Appropriate Use Criteria software, which is decision support poorly designed for “real world clinical workflow: and poorly usable. Please also focus on patient portals as being channels of clinical decision support to patients. Expand integration of Blue Button into EHR designs.
2. Promote and improve user interface design standards specific to health care delivery experience, and end user satisfaction
	* Strongly agree, especially for Clinical Information Reconciliation across multiple EHRs. Consider sponsoring an Open Ideo type of design challenge
3. Promote harmonization surrounding clinical content contained in health IT to reduce burden
	* Standardize medication information within health IT: this requires ONC including within scope the electronic messaging via e-prescribing and e-prior authorization the Retail Pharmacy, Pharmacy Benefit Manages, and the anticipated NCPDP 201701 Script standard.
	* For recommendations 2 & 3, include standardization of how results display to patients on patient portals.
4. Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden
	* Optimize system log-on for end users to reduce burden -- Agree and pivot away from frequent password changes
	* Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden – Agree and push for national patient identifier

**EHR Reporting**

1. Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians
* Agree strongly with all recommendations. Please note that Appropriate Use Criteria fail all Recommendation 3 criteria: ‘(1) being evidence-based and relevant to clinical care and a health care provider’s individual specialty; (2) promoting higher-value functionality, such as wide-spread interoperability or clinical support tools; and (3) aligning measurement with clinical workflow, so that data collection for each measure does not contribute extra or unnecessary steps to the use of health IT in patient care. Therefore I urge CMS to remove the requirement to use AUC in 2019.
1. Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs
	* 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: Excellent recent discussion in

“Data Enclaves for Sharing Information Derived From Clinical and Administrative Data”, Richard Platt, Tracy Lieu accessed in <https://jamanetwork.com/journals/jama/fullarticle/2696616>

* + Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products
		- In particular, the NPPES system, to help us standardize provider names, especially name changes
1. Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden
	* Urge standardization driven by a nationally prioritized set of quality metrics, not one driven by need for each specialty to have its metric. ONC should align with approach espoused in **Vital Signs: Core Metrics for Health and Health Care Progress** National Academy of Medicine
	* <http://nationalacademies.org/hmd/reports/2015/vital-signs-core-metrics.aspx>

**Public Health Reporting**

1. 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
	* This is ideal case for data sanctuary at national level, with a federal technical standard that is uniform across all 50 states. It is proving very onerous to meet unique state requirements, such as California CURES IEWS requirement to provide a message received reply, which is not part of the NCPDP Medication History standard.
2. 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
	* Urge standardization driven by a nationally prioritized set of quality metrics, not one driven by need for each specialty to have its metric. ONC should align with approach espoused in **Vital Signs: Core Metrics for Health and Health Care Progress** National Academy of Medicine
	* <http://nationalacademies.org/hmd/reports/2015/vital-signs-core-metrics.aspx>
	* 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

Strongly agree that HHS coordinate HIPAA with 42 CFR Part 2. The Data Segmentation for Privacy design has poor scalability. Model designed around HIE data repositories rather than around EHRs as data repositories directly exchanging data with other EHRs.