

January 27, 2019

Alex M. Azar II

Secretary of Health and Human Services

U.S. Department of Health & Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

Dear Secretary Azar,

Thank you for the opportunity to comment on the *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* Initiative.  I am Zachary Mulkey, the CMIO of UMC Health System and Texas Tech University Health Sciences Center School of Medicine in Lubbock, Texas. I am also the Medical Director of UMC Health Network and UMC Accountable Care.

I would like to provide comment regarding the three main goals of the Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs:

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

We find this initiative well-worded and on point with provider needs across the nation. Electronic health records (EHRs), although helpful and have proven to increase patient safety, have moved provider dissatisfaction to a breaking point. There is increased evidence of physician, as well as nursing, burnout well documented in the literature. Since implementation of EHRs and computerized provider order entry (CPOE), many providers have reported that their face-time with patients has significantly decreased, they have not been able to increase their patient load back to what it was prior to CPOE, and they spend a great majority of their time after work finishing their documentation (NextGen, 2018). There is also skepticism that the potential patient safety goals that EHRs promise have not been realized (Borycki, 2016).

Please see below for additional details and pertinent literature.

Sincerely,

Zachary Mulkey, MD, FACP

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Medical Director, UMC Health Network and Accountable Care

**CLINICAL DOCUMENTATION STRATEGIES**

* **Strategy 1**: Reduce regulatory burden around documentation requirements for patient visits.
* **Strategy 2**: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.
* **Strategy 3**: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

**Comment:**

Regulatory burden has been discussed as being one of the top documentation dissatisfiers amongst our local physician and advanced practice provider (APP) population. They feel it is “administrative” documentation and takes away from provider-patient interaction and practicing quality medicine.

**Regarding Strategy 2:** It has been noted that nationally informatics is moving from “best practice” to “evidence-based” in an effort to support the translation of evidence into practice.

**Regarding Strategy 3:** This is a top priority for vendors and location IT departments in the better use of data within and EHR. The amount of double, even triple documentation is cumbersome for bother providers and nursing staff. Closing the loop on the referral process is also an issue that our institution recognizes and applauds for being included in this initiative. According to the 2017 joint publication with the Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF), delays and even misses in diagnosis, testing, and treatment of a patient causes substantial patient safety issues (IHI, 2017).

We also recommend that in the efforts to decrease physician documentation burden, the load not simply be transferred to another clinician, such as a nurse. The nurse documentation burden is already significant and evidence is pointing to their burnout issues as well revolving around documentation (Harris et al., 2018; Senior, 2018).

Physicians, although undeniably overburdened with documentation, also need to understand ownership of the patient’s record. It is the patient’s record, not the physician. There must be willingness to maintain and up-to-date and accurate problem list. There must be an effort to keep notes to a minimum, only what needs to be included; avoiding “note bloat” and not telling the whole clinical story via check boxes. Not only is there the stress of patient care, but missing or lost documentation also opens physicians to liability issues. This is added burden that no clinician needs.

**HEALTH IT USABILITY STRATEGIES**

* **Strategy 1**: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.
* **Strategy 2**: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.
* **Strategy 3**: Promote harmonization surrounding clinical content contained in health IT to reduce burden.
* **Strategy 4**: Improve health IT usability by promoting the importance of implementation decisions

**Comment:**

**Regarding Strategy 1:** With the next generation of clinical decision support (CDS) in our midst, the use of APIs, AI, CDS Connect, etc., will aid in not only in improved EHR usability, but faster turn-around times for informaticists that work on such things as updating infectious disease evidence-based guidelines within the EHR. As far as aiding in decision making, CDS is a top tool, but overreliance, misuse, and poor construction and usability continues to contribute to provider issues such as alert fatigue.

We recommend increasing educational efforts by both vendors and local IT groups with end-users to maintain a base-performance level that is standardized and consistent. Often, education and one-and-done, without follow-up nor remediation if needed. Physicians frustrated by lack of understanding of what they are seeing/looking for in the EHR is a well-known dissatisfier.

**Regarding Strategy 2:** We would recommend adding mention of the Human-Computer Interface (HCI) principles considering how important they are in the current healthcare environment. The increased use of mobile devices, dictation applications, and patient portals add to the complexity of keeping user-interface simple and easy to utilize.

**ELECTRONIC HEALTH RECORD REPORTING STRATEGIES**

* **Strategy 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.
* **Strategy 2**: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.
* **Strategy 3**: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

**Comment:**

**Regarding Strategy 1:** Physicians are often quoted as saying, “we are treating the computer, not the patient.” To a certain extent, this has become true. Data is not always reliable in an EHR, nor is it always locatable in the same place (data lives in more than on location). The physician is not only responsible for laying hands on the patient, but also acknowledging an over-abundance of CDS alerts, and responsible for remembering numerous regulatory documentation needs each and every patient visit.

Incentivizing is a great start, but it does not replace lost hours with family or decreased quality of patient care and face-time.

**Regarding Strategy 2:** This is certainly an area where scribes and administrative staff could come into play and take up the slack. Clinicians, including residents, are reporting over one-third of their daily activity is taken up with documentation. Scribe implementation, although costly, has proven to be a satisfier to most that have implemented them. They are currently increasing in use for not only faculty physicians, but nurses and residents as well (Jones et al., 2018).

**Regarding Strategy 3:** All data and metadata should be standardized throughout clinician users (i.e., physicians, nursing, coders).

Electronic clinical quality measures (eCQMs), indeed, all clinical quality measures seek to define the quality of health care services provided to patients and populations. It is appropriate to use EHRs to track this information but the lack of clinically relevant measures only adds to the sense of documentation burden and busy-work among clinicians. An example of this is the eCQM NQF0101, Falls: Screening for Future Fall Risk. The American College of Physicians (ACP) has rated this measure poorly due to the lack of evidence that implementation leads to clinically meaningful outcomes. Measuring outcomes poses many problems as well. An example is the eCQM NQF0018 Controlling High Blood Pressure. It is tempting to look at outcomes as a measure of technical quality. Did the patient meet the goal or not? This measure is too blunt and current guidelines do not support one goal for all patients aged 18-85 years of age. We often measure quality based on technical details; if a patient lives or dies or develops cancer or not. It is more meaningful to look at process measures that are very tightly linked to those outcomes we desire to achieve. The ACP rated this measure as “Uncertain Validity: Do Not Support” (ACP, n.d.).

**PUBLIC HEALTH REPORTING STRATEGIES**

* **Strategy 1**: Increase adoption of electronic prescribing of controlled substances (EPCS) and retrieval of medication history from state PDMP through improved integration of health IT into provider workflow.
* **Strategy 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.

**Comment:**

**Regarding Strategy 1:** PDMP participation is often seen at the state level rather than federal/national. This may need to be addressed when considering standardization. Overall, this strategy is currently a very “hot topic” with the recent opioid crisis issues.

**Regarding Strategy 2:** Real-time integration/interfaces of EHRs into state and federal reporting systems.

**Final Comment:**

Our organization is committed to supporting all aspect of the quadruple aim, including making strong efforts in decreasing documentation burden for our physicians. Advances in technology continue to improve patient safety and the quality of healthcare. No one can deny that EHRs have been instrumental in transformation the way physicians interact and care for their patients. We wish to recommend that when all recommendations are tallied, that it is recognized that we are not looking to just reroute the documentation to nursing staff or increase stress-reduction training for physicians, but truly find ways to correct these issues. The physicians sense of powerlessness with EHR usage and design, regulatory requirements, etc., are all areas vendors, IT departments, administrations, as well as physicians themselves need to work together to solve.

We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Dr. Zachary Mulkey or Stephanie Hoelscher with questions or for more information. Thank you for your consideration.



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