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January 28, 2019

Don Rucker, MD
National Coordinator for Health Information Technology
U.S. Department of Health and Human Resources
330 C St., SW, Floor 7
Washington, DC 20201

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

Dear Dr. Rucker

On behalf of our 39 hospitals in Arizona, California and Nevada, Dignity Health appreciates the opportunity to comment on the draft report from the Office of the National Coordinator (ONC) for Health Information Technology (IT) entitled "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use to of Health IT and EHRs)." The nation's fifth-largest non-profit hospital system, Dignity Health is committed to our mission of providing compassionate, high-quality care to all and strongly supports the use of Health Information Technology (HIT) as the central tool used to transform health care delivery and change the tide from volume to value. Dignity Health's perspective is shared by our faith-based and community hospitals balancing our capital commitments, implementing cutting-edge technology, while providing the highest quality, most cost-effective care with the greatest compassion to the communities we serve.

To achieve the full potential of technology, Dignity Health believes the implementation of technological tools requires a systemic clinical change process strongly grounded on the belief that quality health care is and should primarily be a human enterprise enhanced by electronic tools. As we implement systems across our facilities, Dignity Health applies lessons from each experience and is guided by the recognition that EHR implementation and system updates are much more than the mere installation of computer systems. Fundamentally, it is a people and process effort, requiring a multi-disciplinary approach in execution, providing appropriate adoption by the care giver, resulting in a safer and higher quality delivery of care.

As a system, Dignity Health works to optimize resources to meet requirements while maintaining the highest standards of care. Made up of community hospitals

leveraging limited resources and balancing priorities of upgrading electronic systems and improving patient care while maintaining our commitment to our mission, Dignity Health is proud to have 30 facilities meeting Promoting Interoperability Stage 2, with four more attesting to Stage 3 in calendar year 2018. Dignity Health also supports over 1800 affiliated physicians to meet the Merit-Based Incentive Payment System (MIPS). While Dignity Health's commitment to the Promoting Interoperability program has been steadfast, it met the program's objectives utilizing expensive and labor-intensive upgrades, testing and validation. Instead of improving health care through the organic adoption of technology, Dignity Health – and likely other systems – embarked on a strategy to meet benchmark requirements that has not necessarily improved the provision of health care, but rather has caused a disruption in the health care ecosystem. This approach does not facilitate the best use of the technology. Dignity Health appreciates ONC and CMS's efforts to make the metrics more clinically relevant, the reporting requirements more flexible, and not simply focusing on a certain level of certified EHR technology.

In this report required by the 21st Century Cures Act, ONC recommends actions that the Department of Health and Human Services (HHS) and other stakeholders can take to reduce burden on physicians, other clinical staff, hospitals, and other provider organizations from documenting clinical information in EHRs and meeting regulatory reporting requirements. The report also recommends ways to improve health IT usability and the user experience. **Dignity Health greatly appreciates the attention the ONC has paid to reducing excessive burden and offers the following detailed comments on the recommendations in the draft report.**

## CLINICAL DOCUMENTATION

*Documentation burden.* Dignity Health appreciates the ONC's recognition of the double-edged sword providers encounter in the use of health IT and EHRs. Technology supports care delivery but can also increase the burden of providing and documenting care. Dignity Health supports the ONC in its efforts to reduce EHR-related burden while simultaneously optimizing the usefulness of EHRs for patient care and reducing physician burnout cause by IT tools. The agency focuses particularly on addressing documentation and reporting requirements and EHR functionality that have resulted in excessive documentation or "note bloat." Dignity Health believes these efforts to modernize documentation platforms and requirements are essential to ensuring health IT and EHRs support the advancement of patient care; Dignity Health also believes improving the ability for clinicians to utilize EHR to communicate with one another is vital to high-value patient care. **To that end, Dignity Health encourages the ONC to consider ways to ease provider-to-provider communication.**

Dignity Health agrees reducing overall evaluation and management (E/M) documentation burden could also reduce EHR-related burden. The ONC should work with partner agencies, such as the Centers for Medicare & Medicaid Services (CMS), to continue to explore changes specific to EHR documentation that go beyond high-level changes to E/M documentation, and documentation requirements applicable to provision of care other than E/M visits, including care that is delivered via telehealth.

**Dignity Health has consistently supported CMS's efforts to free providers from requirements to produce repetitive documentation and enable them to focus documentation on the issues that are most pertinent to patient care.** Dignity Health also supports ONC's strategies to reduce the overall regulatory burden around documentation of patient encounters and reduce re-documentation in clinical notes. These strategies should target both nursing and physician documentation, with the goal of reducing duplication and improving communication.

In an attempt to address the documentation burden, CMS recently finalized a policy to default to level 2 E/M visit documentation requirements in CY 2021 (when the blended payment rate for levels 2 through 4 visits go into effect). This policy will not have a meaningful impact on providers' availability to spend time with patients, and instead will still require providers to document detailed information about resource use and intensity of services to meet other Medicare requirements, the requirements of other payers, and various additional legal requirements, as well as to succeed in certain value-based care programs. Therefore, they are unlikely to relax their documentation practices across patient populations.

**Dignity Health supports the ONC's recommendation to obtain ongoing stakeholder input into updates to documentation requirements and recommends any task force or other mechanism to gather stakeholder input be composed of primarily representatives from the clinical community, including hospitals and health systems, as well as viewpoints from vendors and payers.** In its efforts to promote best practices for clinical documentation, the ONC and partner agencies should evaluate documentation requirements and consider whether certain requirements should be eliminated rather than modified in order to make documentation more efficient for providers. To support this approach, ONC could work with EHR vendors to evaluate the extent to which providers actually access and use existing required documentation for clinical care after entry into the record, as a guide to determine what might be extraneous.

**Any new requirements must be evaluated for their impact on burden to providers.** For example, the new Appropriate Use Criteria requirements for ordering advanced diagnostic imaging tests impose significant burdens on both ordering and furnishing professionals and furnishing facilities, including

documentation that approved AUC tools were consulted. Dignity Health remains opposed to requirements that furnishing professionals and facilities include documentation on their own claims that the ordering professional consulted AUC tools.

*Prior authorization*. **Dignity Health commends the ONC's focus on reducing the administrative burden of prior authorization (PA) and the agency's recognition that the PA process lacks standardization and suffers from limited automation due to lack of an adopted healthcare standard for claims attachments.** Providers see first-hand the burdens that come from these manual and labor-intensive processes, as well as the unnecessary, and sometimes unwise, delays and changes in patient care that can result.

To clarify, there are health care standards for claims attachments and PA already in place:

- The X12 Standard for Electronic Data Interchange (EDI) Health Care Services Review-Request for Review and Response (278) for prior authorization requests has been fully developed and named by HHS as an official administrative transaction standard under the Health Insurance Portability and Accountability Act (HIPAA).
- The X12 Standard for Additional Information to Support a Health Care Services Review (275) has been fully developed as a claims attachment, but has yet to be named by HHS as an official HIPAA standard.

Unfortunately, according to the 2018 CAQH Index Report current industry usage of the X12 278 standard for prior authorization is low, at 12 percent, even though it is the second most costly transaction when completed manually at $7.28 per transaction. In contrast, the health care field has reached 96 percent adoption of the standard for electronic claims submission (X12 837). If we could achieve full adoption of just six of the electronic transactions approved under HIPAA, the health care sector could save more than $9.8 billion in direct administrative costs annually.

**While Dignity Heath supports the ONC's recommendation to adopt standardized templates, data elements, and real-time standards-based electronic transactions to improve automation around these processes, there is concern some of the proposed recommendations could have unintended consequences for adoption of the current standards and the stakeholders that use them.** Specifically, we are concerned about the recommendation to advance new standards without full consideration of the adoption path for the existing standards (X12 278 and X12 837). Indeed, it is unclear whether these standards were even evaluated as a part of these recommendations.

**ONC must build on existing work by first thoroughly reviewing the current standards and including these in ongoing discussions so that the agency does**

**not compromise the work done to develop the HIPAA mandated transaction for PA and claims attachment or the stakeholders who use them.**

Dignity Health is also encouraged by the steps the ONC has taken to include key stakeholders in outreach and engagement in this process and agree that HHS must work closely with stakeholders to expand their work and to coordinate efforts to improve the PA process. However, Dignity Health is concerned HHS's recommendation does not include the standard development and data content organizations currently in place to standardize administrative transactions. These include the American National Standards Institute accredited standards development organizations – ASC X12, Health Level 7 and National Council for Prescription Drug Programs, the National Uniform Claim Committee, the National Uniform Billing Committee, and the Dental Content Committee of the American Dental Association. These standards development organizations provide a broad perspective on institutional and professional data reporting and needs and promote the development of uniform electronic administrative transaction standards to and from all third-party payers. These organizations are integral to improving administration transactions and excluding them could inadvertently create duplication of existing efforts.

**While Dignity Health agrees with and supports the need for standardized data and processes, there is concern with the ONC's recommendation to advance new standards to support PA that does not adequately address the issues around broadly applied PA programs and impose significant administrative burdens on all health care providers.** Today, there is significant variation between utilization review of entities' prior authorization criteria and requirements in addition to the extensive use of proprietary forms. This lack of standardization places significant administrative burdens on providers, who must identify and comply with each entity's unique requirements. While there is a need to support more automation around these processes, it will not address the lack of transparency or uniformity around payer requirements for PA.

**Dignity Health strongly recommends HHS expand its work with clinicians, payers, medical product manufacturers, and health IT developers on ordering services and PA processes to include a focus on bringing standardization to both the process and the information required by utilization programs.** All stakeholders also should consider how to reduce the need for PA, particularly as we improve documentation and move to new models of care that put more financial risk on providers.

Both a fundamental transformation that encourages standardization of PA criteria across utilization review entities and standardized electronic communication and transfer of information are needed to promote uniformity and enable timely, transparent, and simplified communication between key stakeholders. Dignity

Health is encouraged the ONC recognizes this needed and stands ready to participate in continued efforts to reduce burden in this area.

**REPORTING REQUIREMENTS**

**Dignity Health greatly appreciates the attention to reducing the burden of reporting under the Promoting Interoperability (PI) program, MIPS, and the Medicare Inpatient Quality Reporting (IQR) program.** The greater flexibility, reduced reporting burden, and better alignment of the PI requirements across hospitals and clinicians were welcome changes. Dignity and looks forward to continued streamlining in the future. Despite some progress, however, the health care ecosystem continues to see differences in clinician requirements across the Medicare and Medicaid PI programs. **Dignity Health urges HHS to take steps to align the Medicaid program with the Medicare requirements.** All providers, and particularly multi-state systems, experience significant burden tracking and complying with varying requirements for reporting across hospitals, clinicians, and states.

**Dignity Health also encourages HHS to make improvements to the usability and performance of reporting systems that clinicians, hospitals and health systems use to report data, such as QualityNet**. The systems can be hard to understand and are often overloaded, slow or even unavailable close to the deadline for reporting. To meet deadlines, Dignity Health has had to divert staff to focus on attestation submissions. Dignity Health has also confronted burdensome systems for enrolling staff and maintaining privileges for accessing systems that include things like the use of wet signatures and monthly password changes for staff who only submit reports annually. Particularly for health systems with centralized reporting structures like Dignity Health, the process to log onto systems designed for single hospital attestation by one end user such as QualityNet, requires staff to regularly update and track multiple login credentials– even when no attestation is being made, using valuable staff time and resources.

*Electronic clinical quality measures (eCQMs).* **Dignity Health applauds CMS for continuing to evaluate the current landscape and future direction of eCQMs and urges the agency to continue to engage those who must report the data in this activity.** Any newly adopted eCQMs should be introduced with a a two-year test period so providers can understand their performance and implement strategies to improve before results are included in public reporting or payment programs. In addition, CMS should only adopt measures that have been tested as electronic measures and received endorsement by the National Quality Forum (NQF). Consistent with CMS's meaningful measures initiative, only a small set of important, valid and feasible measures should be required. Measures should continue to be evaluated for their value and removed if they no longer serve a clear purpose. The variability of reporting requirements across payers also

adds to clinician burden. As a major payer, CMS should to work with providers and other payers to standardize and streamline quality reporting requirements across payers.

**Dignity Health also urges the ONC to improve its certification requirements for eCQMs to be more robust, resulting in systems that generate meaningful data with less effort, and require EHR vendors to certify against all defined eCQMs, not just those of the vendors choice.** Otherwise, providers cannot themselves choose what measures to report without paying additional fees.

*Public health reporting*. The agency identifies a real challenge to public health reporting: variation across jurisdictions in ability to receive data. **To address this issue, Dignity Health urges HHS to support states in growing their capability to receive data and adhere to the technical standards included in certified EHRs. This standardization should be extended to all categories of public health reporting, including immunizations, syndromic surveillance reporting, etc. Dignity Health also urges HHS to recognize the need to better standardize and connect prescription drug monitoring programs across state lines.** Dignity Health strongly supports the intent to use the health IT infrastructure to provide insight on Schedule II opioid prescribing practices. However, in addition to variation across states, PDMPs are generally not easily integrated into EHRs, and access fees can be high. Dignity Health urges ONC to work with PDMPs to improve integration into EHRs and sharing of data across states. ONC should consider the use of an open, standard API by PDMPs to enable a provider's EHR to access the Schedule II opioid prescription drug history of a patient.

## HEALTH IT USABILITY AND THE USER EXPERIENCE

**Dignity Health appreciates ONC's focus on improving the usability of health IT and the user experience.** Clinical teams – including physicians, nurses, and other clinicians – routinely experience lack of usability. For example, many report changing their clinical workflows to accommodate the EHR, rather than having EHRs that support their optimal clinical workflow. More attention to usability, deployment of quality design principles, and user-centered design is needed.

**Dignity Health disagrees, however, with the recommendation that health care providers increase their budgets for ongoing training.** While training is clearly essential, and must be funded, usable systems developed according to user-centered design principles should be intuitive and facilitate both rapid onboarding and ease acculturation to changes in the software. In addition to considerations specific to the technology, there is also interaction between reporting and documentation requirements, certification requirements and usability. Excessive regulatory requirements can result in design choices that are

less usable than they might otherwise be. Furthermore, the move to value means that health care providers will need more than clinical data to engage in population health and other activities. **Therefore**, **usable systems will need to connect to information on social determinants, behavioral health, pharmacy benefit data, durable medical equipment, claims history, and other relevant data.**

*Interoperability.* **Lack of interoperability is a factor in poor usability.** Dignity Health urges ONC to continue moving forward to build capacity to share information efficiently and effectively. This will also require addressing how shared information can be managed and parsed to find the relevant information. At the moment, hospitals are routinely sharing care summaries, and physicians and other clinicians increasingly do so. However, as the ones receiving the data, clinicians indicate that the summaries are not easy to use, and pertinent data, such as results of a colonoscopy, must be incorporated into the EHR manually. In addition, redundant information is often contained in the multiple summaries received, leading to even greater "note bloat" and challenges finding relevant information. Other technologies, such as machine learning, natural language processing, and artificial intelligence show promise and should be explored as ways to address these challenges and improve usability overall. EHR vendors need more time to develop interoperability between disparate systems. Dignity Health is spending significant time and resources debugging issues with bringing in outside data into our EHR. The workflow and usability for clinicians reconciling data from outside sources is burdensome and timely. **Overall, the speed of change required by ONC of vendors creates significant challenges to their healthcare clients' ability to keep up with all of the implementations, adoption, workflow, and required training.**

## MEASUREMENT

**Dignity Health recommends the ONC and partner agencies develop metrics to monitor the impact of their strategies to reduce clinician burden.** These could include use of data from vendors, metrics on the volume or difficulty of reporting requirements, or other approaches to understanding the impact of specific strategies. Some of this reporting could be included in the forthcoming EHR Reporting program that ONC is developing under the 21st Century Cures Act.

## CONCLUSION

Dignity Health appreciates and congratulates the ONC on its work to reduce the burden of health IT for providers and stand ready to work with the agency moving

forward. If you have any questions, please contact Clara Evans, Director of Public Policy & Fiscal Advocacy at Clara.Evans@DignityHealth.org or at 916.851.2007.

Sincerely,

Sandy Summers

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