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Dr. Donald Rucker
Office of the National Coordinator for Health Information Technology
330 C Street, SW
Washington, DC 20024

Administrator Seema Verma
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Rucker and Administrator Verma:

Thank you for the opportunity to provide feedback on the draft report, *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.*

The American Health Information Management Association (AHIMA) is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to promoting and advocating for best practices and effective standards in health information. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

AHIMA continues to support the intent of Section 4001 of the 21st Century Cures Act to reduce "regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records."[1] We are committed to assisting ONC and CMS in reducing regulatory and/or administrative burdens that hamper the ability of clinicians to provide quality care to their patients while ensuring that health information contained in the electronic health record (EHR) is confidential, complete, accurate, reliable, timely, useful and perhaps most importantly, continues to tell the "patient's story" within the medical record. Along these lines, our detailed comments and recommendations can be found below.

We thank you for the opportunity to submit comments on the draft report, *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.* We look forward to continued collaboration with ONC and CMS to reduce EHR-related burden for clinicians and the subsequent implementation of the recommendations set forth in the draft report. Should you or your staff have any questions or comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org and (202) 839-1218.

Sincerely,

Wylecia Wiggs Harris

Dr. Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer
AHIMA

[1] P.L. 114-255.

Clinical Documentation	
Strategy—Reduce regulatory burden around documentation requirements for patient visits.	
Recommendation	**AHIMA Comment**
Continue to reduce overall regulatory burden around documentation of patient encounters.	AHIMA concurs with the draft report's recommendation to reduce overall regulatory burden around the documentation of patient encounters. A common source of frustration for clinicians and patients is that there are often many documentation requirements but ultimately the documentation does not get to the heart of why the patient is in the clinician's office for a particular visit. The more we can accurately tell the patient's story through improved documentation, the better for patient care. More specifically, AHIMA agrees with the draft report's assessment that the current E/M documentation guidelines are outdated, overly complex, ambiguous, difficult to understand and use, fail to meaningfully distinguish differences among code levels, require documentation that is redundant or unnecessary for clinical purposes, are not aligned with current clinical workflows and the current electronic environment and frequently lead to "note bloat." For that reason, we commend CMS's efforts to undertake a revision of the E/M documentation requirements in the Medicare CY 2019 Physician Fee Schedule (PFS) final rule. We agree, as the report recommends, that other payers should consider a similar approach to reducing EHR-related burden. That said, as CMS begins to implement over the next several years a single payment rate for several levels of office based/outpatient visit codes, we recommend that CMS continue to engage in discussions with stakeholders, including but not limited to AHIMA, the American Medical Association's (AMA) CPT Editorial Panel, and other physician specialty societies to further refine the policies related to the revision of the CPT E/M codes and the associated E/M documentation guidelines set forth under the Medicare CY 2019 PFS final rule.
Leverage data already present in the EHR to reduce re-documentation in the clinical note.	AHIMA agrees with the draft report's recommendation that data already present in the EHR should be leveraged to reduce re-documentation in the clinical note. Along these lines, AHIMA supports CMS's policy finalized in the Medicare CY 2019 PFS final rule that allows clinicians to focus their documentation of history and exam for established patients on what has changed since their last visit or on pertinent items that have not changed instead of requiring re-documentation of a defined list of required elements.

	AHIMA also supports CMS's policy to no longer require clinicians to enter information in the medical record regarding the chief complaint and history if that information has already been entered by ancillary staff or the patient. We believe these changes will help to remove redundancy in E/M visit documentation and reduce subsequent clinician burden within the EHR.
Obtain ongoing stakeholder input about updates to documentation requirements.	AHIMA supports HHS's draft recommendation that it continue to receive broad stakeholder input to inform future documentation guideline modifications. We support the idea of a representative task force as such a task force would provide extensive representation across a diverse group of stakeholders that have a vested interest in the revision of the CPT E/M codes and the associated E/M documentation guidelines.

Clinical Documentation	
Strategy—Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.	
Recommendation	**AHIMA Comment & Recommendations**
Partner with clinical stakeholders to promote clinical documentation best practices.	AHIMA agrees with the draft report's recommendation that HHS continue to partner with clinical professional societies to promote an understanding of documentation best practices, recognize best practice industry initiatives and increase awareness of tools and resources that can support implementation of best practices. Along these lines, AHIMA believes that clinical documentation improvement (CDI) can play a critical role in improving documentation by enhancing the accuracy, completeness, and trustworthiness of the data within the medical record. AHIMA has developed a number of resources including its Clinical Documentation Improvement Toolkit and Copy Functionality Toolkit to assist healthcare professionals in ensuring the accuracy, timeliness, and consistency of clinical documentation.

Clinical Documentation	
Strategy—Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	
Recommendation	**AHIMA Comment & Recommendations**
Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.	AHIMA supports the draft report's recommendation that HHS consider ways to engage stakeholders to further address the challenges associated with prior authorization, including but not limited to a discussion of (1) developing and disseminating best practices for optimizing electronic workflows around prior authorization, and (2) health IT-enabled

	processes that leverage existing data within the record to reduce the total volume of prior authorization requests that clinicians must submit. AHIMA and its members are aware of a number of different technologies including AI-assisted products that seek to streamline and automate the prior authorization process. Where appropriate, we recommend that HHS seek to highlight such innovative approaches as part of its development and dissemination of best practices around prior authorization.
Coordinate efforts to advance new standard approaches supporting prior authorization.	AHIMA concurs with HHS's recommendation that it continue to pursue standards that seek to improve the prior authorization ecosystem through multi-stakeholder groups such as the Da Vinci project and the P2 FHIR Task Force. We recognize that both ONC and CMS may be constrained in their agency authority to dictate the use of certain standards and common approaches to all payers. However, the lack of standardized electronic transactions across payers not only continues to burden clinicians but can stand in the way of patient care. HHS's ongoing participation in multi-stakeholder activities will serve to highlight such important efforts and help disseminate such standards across all stakeholders.

Health IT Usability and the User Experience	
Strategy— Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.	
Recommendation	**AHIMA Comment & Recommendations**
Better align EHR system design with real-world clinical workflow.	AHIMA concurs with the draft report's recommendation that health IT developers should work with practicing clinicians, nurses, laboratorians, administrators, and professional organizations who can advise developers as they make decisions and prioritize interactive display features during the development stage to help streamline workflow. End user involvement in the development stage is critical to ensuring that initial EHR system design aligns with clinical workflow and minimizes administrative burden for clinicians.
Improve clinical documentation functionality.	AHIMA strongly agrees with the recommendation that policies regarding copy-and-paste functionality should be put in place at the institutional level for the management of copied text that balances efficacy with safety. The practice of copy and paste can lead to errors such as inaccurate or outdated information, redundant information (including information not relevant to the patient encounter), inability to identify when the documentation was first created, "note bloat," and the propagation of false information. Inappropriate use of copy-and-paste can also raise significant patient safety concerns and create risk for the clinician and/or institution.

	We agree with the draft report that the private sector has led the way in developing best practices for copy and paste functionality and recommend that HHS continue to look to the private sector for solutions that address the appropriate use of copy-and-paste functionality. Along these lines, AHIMA's "Copy Functionality Toolkit" seeks to assist HIM professionals in ensuring that appropriate organization-wide governance policies and procedures are in place to manage copy and paste functionality including but not limited to: model copy and copy function sanction policies, a model copy functionality audit policy, an education policy for use of copy functionality as well as a provider training checklist and organizational and vendor checklists.
Improve presentation of clinical data within EHRs.	AHIMA supports the draft report's recommendation that health IT developers could reduce cognitive load on the end user by working to optimize and improve information display and by using healthcare-specific graphical user interface (GUI) elements. We agree with the report that such optimization may enable clinicians to be presented with a manageable amount of data to inform their clinical decision making. That said, we are concerned about the recommendation in the draft report that "data contained in documents such as scanned reports should be extracted and indexed for better retrieval." We agree that when possible, such information should be extracted and indexed, and that existing technologies enable such data to be extracted and indexed from scanned reports. However, such technologies and processes can be costly, require additional staff resources, and may be difficult for small and/or rural practices and facilities to implement. Additionally, our members have noted that existing technologies may be limited in their ability to extract and index handwritten documentation from scanned reports. AHIMA is hopeful that increased use of natural language processing and related technologies will help to address this current challenge including driving down overall costs associated with data extraction and indexing. However, we recommend that the report acknowledge the challenges associated with extracting and indexing data from scanned reports and suggest that the draft report recommend that HHS highlight and disseminate best practices around the extraction and indexing of data from scanned reports that enhance data retrieval.

Health IT Usability and the User Experience	
Strategy— Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	
Recommendation	**AHIMA Comment & Recommendations**
Increase end user engagement and training.	AHIMA concurs with the draft report's recommendation that clinicians should be involved in all phases of the lifecycle of an EHR including acquisition, implementation, optimization, upgrades and additional product and/or application integration. Clinician involvement throughout the lifecycle of the EHR will help ensure that the EHR is meeting the needs of the end user. Initial and ongoing EHR training is also a critical component of helping to ensure that end users can demonstrate a high degree of competency with the EHR, and we are pleased that the draft report includes such a recommendation. That said, smaller and/or rural practices and facilities may face challenges in having the resources necessary to provide such ongoing training. Under such circumstances, we recommend that ONC and CMS leverage existing communication channels to highlight federal resources for such practices and facilities including the *ONC Change Package for Improving EHR Usability.* We also appreciate the draft report's recommendation that healthcare institutions can consider leveraging EHR metadata such as audit logs to help develop insight into workflow and usage patterns. That said, it is worth noting that the ease of use of audit logs can vary by EHR vendor and can often be difficult to use, often requiring extensive resources, including manpower, to process and synthesize the information. Under such circumstances, smaller and more rural practices may be unable to fully take advantage of such resources.
Promote understanding of budget requirements for success.	A frequent challenge that AHIMA members face is educating institutional leaders that the lifespan of EHR implementation is not a one-time investment but one that requires ongoing budget allocation. For that reason, AHIMA believes that if a healthcare institution is not inhibited by resource constraints, it should transition from a fixed budget implementation model to one that incorporates: ongoing technical support for end users, ongoing training of clinical staff, and required technical resources to support upgrades, system maintenance, troubleshooting, system backup, and disaster recovery functionality. We also agree with the report's suggestion that EHR developers assist institutions in their budgetary planning by being transparent with projected costs over the anticipated lifespan of the EHR implementation. Such transparency will enable health IT and HIM departments as well as C-suite leaders to appropriately plan for the lifespan of the EHR implementation.

EHR Reporting	
Strategy—Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	
Recommendation	**AHIMA Comment & Recommendations**
Simplify the scoring model for the Promoting Interoperability performance category.	AHIMA supports CMS's restructuring of program requirements for the Promoting Interoperability performance category and the Medicare Promoting Interoperability program for eligible hospitals and critical access hospitals (CAHs). We believe the performance-based methodology as finalized by CMS in the Medicare CY 2019 PFS final rule and the Medicare CY 2019 IPPS final rule will reduce administrative burden for clinicians and offer additional opportunities to demonstrate success under the Promoting Interoperability performance category under MIPS and the Medicare Promoting Interoperability program. Narrowing the focus of the required measures under the revised scoring model to measures that seek to promote interoperability and improve data exchange, access, and use will enhance coordinated care while enabling patients to access their health information.

EHR Reporting	
Strategy—Improving the value and usability of electronic clinical quality measures while decreasing healthcare provider burden.	
Recommendation	**AHIMA Comment & Recommendations**
Continue to evaluate the current landscape and future direction of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project.	AHIMA members continue to cite clinician challenges in utilizing their EHRs to report quality performance data as such reporting often requires manual extraction and reporting. AHIMA is supportive of efforts to transition to electronic measurement and reporting provided the quality measures align with clinical workflow and do not create additional administrative burden on clinicians. Additionally, we believe that as CMS works to revise existing eCQMs and develop new eCQMs, it should continue to engage with provider groups including specialties and subspecialties to ensure that the quality measures are meaningful and relevant to the provider communities.

Public Health Reporting	
Strategy—Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMPs through improved integration of health IT into provider workflow.	
Recommendation	**AHIMA Comment & Recommendations**
Federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules, to improve timely access to medication histories in PDMPs. States should also leverage funding sources, including but not limited to 100 percent federal Medicaid financing under the SUPPORT for Patients and Communities Act, to facilitates EHR integration with PDMPs using existing standards.	AHIMA supports the draft report's recommendation that federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules. A concern for AHIMA members is that not all EHRs are currently fully integrated with a state's PDMP. As a result, clinicians must often abandon their workflow and log-in separately to a PDMP and manually enter the data to document completion of the query. Because separate sign-in to a non-integrated PDMP requires hand entry of demographics to search for a specific patient, this in turn, increases the probability of erroneously matching a patient to another individual's health information—raising patient safety and privacy concerns. The adoption of common industry standards by federal funding agencies could help to further accelerate PDMP and health IT integration thereby improving workflows and reducing administrative burden on clinicians.

Public Health Reporting	
Strategy—Inventory reporting requirements for federal healthcare 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 providers.	
Recommendation	**AHIMA Comment & Recommendations**
HHS should convene key stakeholders, including state public health departments and community health centers to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.	AHIMA supports the draft report's recommendation that HHS should convene stakeholders, including state public health departments and community health centers to inventory reporting requirements from federally funded public health programs that rely on EHR data. AHIMA members note that clinicians are often bound by a patchwork of local, state, and federal public health reporting requirements that result in the reporting of the same data sets to several authorities via multiple methodologies which in turn contribute to clinician burden. For that reason, we recommend that HHS adopt an approach similar to its establishment of the HHS Measurement Policy Council in 2012 which sought to align clinical quality measures across national programs and supported state and private-sector efforts to adopt core measure sets to advance further harmonization across the healthcare ecosystem.

HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from providers to streamline the reporting process across state and federal agencies using common standards.	AHIMA supports efforts to harmonize reporting requirements across federally funded public health and healthcare programs. To avoid duplication, we recommend that ONC review and consider existing work by HIT trailblazer states that have previously worked to streamline the reporting process across state and federal programs.
HHS should provide additional guidance about HIPAA privacy requirements 42 CFR Part 2 in order to better facilitate electronic exchange of health information for patient care.	AHIMA supports the provision of additional guidance about the federal confidentiality of alcohol and drug abuse patient records regulation also known as 42 CFR Part 2. However, we are concerned that additional guidance may not fully alleviate the current challenges associated with 42 CFR Part 2. The Part 2 regulation currently presents operational challenges for HIM professionals working in designated Part 2 programs. HIM professionals working in such programs are often forced to work with paper records. In instances where a Part 2 program may have an EHR, data segmentation functionality is often not available. Lacking such functionality, HIM professionals must keep a patient's addiction records separate from the rest of the patient's medical record—resulting in the creation of two separate medical records. Because such information is kept separate, providers are often unaware of the risks to their patient from multiple drug interactions and co-existing medical problems even though substance use disorders can have a cascading effect on an individual's health and must be carefully managed and coordinated. We recommend that HHS, through SAMHSA, consider using its agency authority to align 42 CFR Part 2 with HIPAA for purposes of treatment, payment, and healthcare operations. Such alignment with HIPAA will not only provide clarity to all stakeholders about when substance use disorder information may be shared but will also help ensure that providers have the information necessary to provide safe, effective, high-quality treatment and care to individuals living with a substance use disorder.