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January 25, 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

Submitted electronically at: https://www.healthit.gov

RE: Request for Comment: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Secretary Azar:

On behalf of UT Health Austin (UTHA), the clinical practice of the Dell Medical School at the University of Texas at Austin, we are pleased to provide comments to Health and Human Services (HHS) in response to the Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. UTHA appreciates the opportunity to leverage our team members' expertise in offering feedback on this strategy.

As a not-for-profit clinical practice, UTHA clinicians and team members reflect the thinking of hundreds of experienced medical and administrative professionals dedicated to the health and well-being of our patients. Our clinicians and team members are creating change in health innovation, diagnostic and treatment strategies, public health initiatives, payment models, research and education all focused on giving our patients the outcomes that matter to them. Since we began caring for patients in October 2017, UTHA has grown to include over 370 clinicians and staff members practicing in 19 specialties in the newly created Health District in downtown Austin, TX. Our affiliation with the University of Texas at Austin allows us to leverage the research, innovation and technology of this world-class university in our day-to-day work.

We appreciate the considerable effort that HHS has put into creating this draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. The report correctly identifies the issues and challenges that lead to the burden related to use

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of health information technology (IT) and electronic health records (EHR). However, the strategies and recommendations discussed in the report are too general and lack specificity. We feel that no strategy is complete without listing specific actions that need to be taken to meet an end goal. Although clinicians and other healthcare providers are the end-users of health IT, ultimately its purpose is to enable health improvement of patients. The draft should emphasize this point and place a focus on improvement in health as a measurement of success of health IT implementations. Additionally, the draft fails to address poor patient experience with accessing and transferring medical records due to EHRs that are not designed with patients' perspectives in mind.

Although creation of additional standards for usability will ensure that user interfaces of different EHRs are aligned so that they provide similar user experience for reviewing and documenting clinical notes, in our opinion such a strategy will fail because of the burden of keeping the standardization current. Many issues related to discordant user interfaces of various EHRs can be addressed by only having a single EHR. However, we realize that this may not be feasible as a policy.

In the comments below, we offer general observations and provide our comments on the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.

Clinical Documentation

We agree with the challenges inherent in existing documentation requirements that are discussed in the report. Extensive use of templates, copying/pasting, and checkboxes are required to meet the billing requirements. This leads to "note bloat", which results in making important information from clinical documentation hard to find. EHRs are typically based on paper records and are designed to meet billing needs. They should first be designed to efficiently document and review clinical documentation, and second to meeting billing requirements. The encounter-based nature of EHRs has made it difficult to follow a longitudinal history of the patient.

Photographs e.g. pre/post-surgery photos; video and audio recordings e.g. gait lab and speech therapy results; and hand drawings are a vital part of a patient's health record. The strategy should also address the importance of creating standards for this non-written information so that it can be stored and shared between all EHRs. We applaud the efforts put forth by the Center for Medicare and Medicaid Services (CMS) to help reduce documentation burden. Having a single payment rate for E/M codes for level 2 through level 4 is a welcome

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change, but if the compensation is too low the clinicians will be encouraged to still add more documentation to meet the requirements for time-based add-ons.

Ideally, the EHR should serve as an interface between the patient, clinicians, and family members. The need to give patients more control over their medical records needs to be emphasized. Technology should enable the patients to view their medical records and send them to any provider by the push of a button through the patient portal. The blue button initiative by CMS is an excellent example of one such effort in the right direction. Giving patients control over sharing their own medical records will help reduce burden on physician offices.

Health IT Usability and the User Experience

The problem with poor EHR design and unfriendly user interfaces is well known. Well-designed EHRs would be intuitive to use and would require minimal training. We agree that EHRs need to be designed using user-centered design principles. The current EHR certification requirement only mandates that the EHR vendor attest to using user-centered design principles. Based on user-centered design research, the Office of the National Coordinator (ONC) should create standards for graphical user interfaces (GUI) and require that vendors use these principles in the design of their product. This will reduce the cognitive load clinicians experience when working across multiple organizations with varying interfaces for different EHRs.

ONC's Health IT Certification Program was a laudable effort to ensure that EHRs meet some basic requirements. However, we believe that this program can be improved further. Requirements should be made more robust and thorough so that vendors don't just attest to using some design principles but are instead required to use specific design principles and test the usability of their products. The ONC should use this program to enforce standard design among all EHRs. We support a complete redesign of the EHR which optimizes clinical workflows from the perspective of clinicians as the end-users.

We agree that institutional management teams need to budget for ongoing investment in health IT projects and not treat them as discrete events. We propose that HHS fund specific research to find out if outcomes of care have improved based on the investment in IT resources. Findings from such research would help management teams prepare and justify the budgets for investments in health IT projects. Additionally, HHS should fund research that times standard clinical practice without EHRs and benchmark any change against this performance metric. Voice recognition and natural language processing remain more efficient than most

alternative data entry mechanisms. Greater effort should be made to make voice recognition and natural language processing a standard for data entry into EHRs.

EHR and Public Health Reporting

Electronic clinical quality measures (eCQMs) currently available through HHS are not universally relevant for all providers. Furthermore, the reporting requirements for federal programs are complex and cumbersome. HHS should work on creating eCQMs that are clinically relevant for all providers and simplify their reporting requirements.

At UT Health Austin we place importance on patient reported outcomes (PRO) and employ them throughout our organization in all our integrated practice units. We strongly propose the use and public reporting of PRO data. Such data should be made available through websites like Physician Compare and Hospital Compare so that patients are empowered to make informed choices. Because data standards do not exist for PROs, HHS should commission a task force to create standards so that PRO data can be reported to payers and can be exchanged seamlessly between EHRs.

Most states require prescribers to query state Prescription Drug Monitoring Programs (PDMP). Clinicians have to log into separate systems to access this information. Integration of PDMPs with EHRs will significantly reduce the time clinicians have to spend to look up this information. Such an integration should become a standard for EHRs and become part of one of the requirements for EHR certification. Because of the burden imposed by a lack of electronic harmonization across the systems and processes for reporting for numerous federal programs, we support the HHS's recommendation to harmonize reporting requirements, systems, and processes across all federally-funded programs.

Sincerely,

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