**University of Wisconsin Hospitals and Clinics**
**University of Wisconsin Medical Foundation**
**University of Wisconsin School of Medicine and Public Health**
**SwedishAmerican Health System**

**7974 UW Health Court**
**Middleton, WI 53362**

Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
Submitted electronically at http://healthit.gov

Dear Dr. Rucker:

On behalf of the University of Wisconsin Hospitals and Clinics Authority (d/b/a UW Health), we thank you for the opportunity to offer comments on your draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*.

UW Health is comprised of the academic health care entities of the University of Wisconsin-Madison: University of Wisconsin Medical Foundation, University of Wisconsin Hospitals and Clinics and SwedishAmerican Health System. UW Health offers a network of primary and specialty care clinics throughout south-central Wisconsin and beyond and provides access to more than 1,200 primary and specialty care physicians. Our physicians comprise the medical staff of UW Hospitals and Clinics and provide services at other hospitals in the region.

We strongly share the Department's goal in reducing regulatory and administrative burden on providers, especially that imposed by health information technology (IT). We are offering the comments below to help bolster recommendations while augmenting others.

**1. Clinical Documentation**

*a) Revise requirements related to the responsible party for documentation*

In order to more fully reduce the regulatory burden around documentation requirements for providers, we must address the responsible party for the requirement, not simply the requirement itself. At UW Health, providers' frustration is often fueled by the fact that other integral

members of the health care team – including nurses – are not permitted to perform functions within the scope of the electronic health record (EHR) that is well within their scope of practice. We believe that HHS should update the compliance requirements within the EHR, which are often dated, so that these providers are truly operating at the top of their license, and any burden imposed has the minimum impact on delivery of patient care. For example, renewal orders for durable medical equipment (DME) could easily be assessed and ordered by a nurse, who would be familiar with the patient's most recent clinical details. This issue dovetails with the dysfunctional workflow around prior authorization, which could be dramatically improved by leveraging the full care team.

*b) Reduce the burden imposed by non-face-to-face encounters*

In today's health care environment, both the pace of clinical care and the level of patient expectations demands an increasing amount of time spent in non-face-to-face clinical care, including emails, phone calls, and sharing results with patients. We believe that technology could be further leveraged to streamline not only these functions, but any associated documentation of these functions that may be inherently duplicative.

*c) Reduce the frequency of major GUI changes*

The strategy touched on variation in design of Graphical User Interface (GUI) between vendors; however, even within a system, variation can have a negative impact. Many vendors are moving to quarterly software updates, which often include major GUI changes, which can significantly slow provider efficiency to relearn processes and procedures. To reduce burden on providers and increase clinical utility, we recommend that major user interfaces be updated far less frequently, and only following the types of real world usability testing we review in recommendation 2(a) below.

*d) Continue to proactively reduce duplicative or unnecessary federal reporting requirements*

As has been recognized within this report and by the Department at large, many federal programs have overlapping and unnecessarily duplicative reporting requirements, which tie up vital staff resources. Because of undue federal burden, we do not have the flexibility to ask staff to perform

data analytics to better understand critical emerging local issues, leaving us behind the curve to make important clinical and policy decisions for our patients.

**2. Health IT Usability and the User Experience**

*a) Require vendors to increase their usability testing in real world environments*

UW Health strongly supports the recommendations around increasing usability, especially proper integration of the physical environment with EHR use. However, few vendors employ useful usability techniques or testing before a major software release. Vendors should be expected to employ practicing clinicians or experts in human factors engineering that have contemporary knowledge of clinical practice. Testing in manufactured labs or at user group meetings simply does not substitute for real world testing to identify problems and quickly deploy solutions.

*b) Expand clinical content to be harmonized*

We support the recommendation to harmonize clinical content contained in health IT to reduce burden, but recommend adding the problem list and allergies to that content. In addition, we recommend standardization of reconciliation practices and improved technology to support such standardization. The functionality used to bridge information across clinical locations, even within the same EHR, is not ideal, and often draws on outdated information no longer relevant to the patient.

*c) Incentivize regular training for providers on EHRs*

While we support the recommendation to promote understanding of budget requirements for success, in today's challenging financial environment for hospital-based clinicians, we believe further incentives must be provided to fully train providers and maximize the utility of health IT for patients. We suggest building incentives into physicians participating in Alternative Payment Models, as they do at UW Health, or exploring the possibility of a discrete reimbursable code for this type of training.

*d) Prioritize public safety*

Given the enormous priority placed on patient safety throughout our institution, we are concerned by the lack of a public repository to report safety events related to health IT. If an individual provider reports a patient safety event, the process is handled in a one-off fashion, as opposed to organizing a systemic response to identify patterns and quickly deploy solutions. We suggest the establishment of central repository, or a recommended standard set of practices, to report and track health IT safety events. We believe the vendor community could tap into such a system to identify a problematic workflow or design flaw. While HHS currently offers helpful tools and strategies to improve safety, we believe a more detailed reporting system either run or facilitated at the federal level could help reduce these types of errors.

We hope that our suggestions are helpful in the production of your final report. If we can provide any further input or clarification, please contact Shannon Dean, Chief Medical Information Officer, at sdean@uwhealth.org.

Thank you for the opportunity to provide comments on these important issues.

Sincerely,

Alan S. Kaplan

CEO, UW Health

UW Health