January 28, 2019

Comments from Wolters Kluwer on the Draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*

Below are comments from Wolters Kluwer on the recently released draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* (*Strategy*) issued by the Office of the National Coordinator for Health Information Technology (ONC). We appreciate the opportunity to comment.

As way of background, Wolters Kluwer is a leading global provider of information, business intelligence and point-of-care solutions for the healthcare industry. Key solutions include UpToDate®, Medi-Span®, Lexicomp®, Facts & Comparisons®, Pharmacy OneSource®, Health Language®, Emmi Solutions®, POC Advisor® and Medicom (China). Wolters Kluwer had annual revenues in 2017 of €4.4 billion.

Our comments address the proposed strategies for adding higher-value functionality to the MIPS and Hospital *Promoting Interoperability* programs, rewarding innovative uses of health technology, promoting more wide-spread adoption of the FHIR standards, standardizing data to improve the user experience, and improving the usability of clinical decision support software.

Adding Higher-Value Functionality to the MIPS and Hospital PI Programs

We strongly agree with the recommendations contained in the draft *Strategy* that call for the creation of new HIT measures that promote the use of "higher-value functionality, such as…clinical support tools" in both the Merit-based Incentive Payment (MIPS) program's Promoting Interoperability performance category and the Hospital *Promoting Interoperability* program. Clinical support tools such as clinical decision support (CDS) software can reduce clinician burden and provide value by helping avoid overuse of services that show little evidence of efficacy or potentially threaten patient safety. Decision support can also direct a clinician to prescribe an alternative drug therapy that has demonstrated better outcomes or is more cost effective than the patient's current treatment. Holistic CDS solutions can optimize overall quality of care across the full range of conditions, co-morbidities and disease states, many of which are not adequately addressed by discrete quality measures.

We note that incorporating CDS functionality in the MIPS and Hospital *Promoting Interoperability* programs aligns with recommendations in the National Academy of Medicine's recent report entitled *Optimizing Strategies for Clinical Decision Support*, which ONC's draft *Strategy* cites in support of its CDS usability recommendations.

Rewarding Innovative Uses of Health Technology

We strongly support rewards for clinicians and hospitals for innovative use of health technology, including the provision of bonus scoring and expansion of provider compliance beyond a single

performance category or program. For example, CMS has recently moved on from the "all-or-nothing" scoring methodology used to measure compliance with the Hospital *Promoting Interoperability* program. Under the new scoring methodology, bonus points could be awarded to hospitals using CDS and Clinical Surveillance technology to address high cost health conditions such as congestive heart failure (CHF) or sepsis.

Innovative uses of technology should also help facilitate compliance with multiple performance categories in the MIPS program. For example, in the 2019 rulemaking cycle, CMS added a new MIPS Improvement Activity for using CDS to access CDC opioid prescribing guidelines. In future rulemaking, MIPS-eligible clinicians who access CDC guidelines via CDS could receive credit for both the MIPS Improvement Activity and MIPS Promoting Interoperability performance categories.

CMS could also create bonus scoring opportunities for innovative uses of technology across hospital value-based reimbursement programs. For example, Medicare's Hospital Readmission Reduction Program (HRRP) already tracks readmissions for patients suffering from congestive heart failure (CHF). Hospitals that have struggled with reducing readmissions could be rewarded in their HRRP scoring in the year they deploy a new CDS solution dedicated to reducing readmissions for CHF patients. Similar bonus opportunities could be used for hospitals deploying clinical surveillance software to reduce cases of CLABSI, CAUTI, MRSA Bacteremia and Sepsis in Medicare's Hospital-Acquired Condition Reduction Program.

In all the above example, CDS should be defined broadly, giving clinicians and hospitals flexibility to choose all manner of "push" and "pull" technologies as well as installed and cloud-based solutions that help them achieve their clinical and program compliance objectives.

<u>Adoption of HL7's Fast Healthcare Interoperability Resources (FHIR) Standard</u>

We agree with the recommendation to adopt additional data standards to make access, extraction, integration and analysis of data easier and less costly for clinicians and hospitals. The draft *Strategy* cites HL7's Fast Healthcare Interoperability Resource (FHIR®) standard as an example. We agree and wholeheartedly support new government policies that promote the adoption of FHIR to facilitate exchange of health data, clinical decision support and patient data segmentation and analysis.

<u>Standardizing Data to Improve the User Experience</u>

We generally support the various recommendations aimed at improving the user experience through greater standardization of data. Standardizing data displays and orders processes is best accomplished when data elements are codified and mapped to the appropriate standards and terminologies. This is critical if we are to move to an environment that allows for more open and effective data exchange and semantic interoperability.

One barrier to achieving such an environment is the vast amount of unstructured data in electronic records. Though these data are difficult to extract and less likely to get codified and parsed, it is important clinicians be able to document the patient encounter using various methodologies beyond point-and-click templates. As such, we support ongoing research and funding in the areas of advanced technologies such as Machine Learning, Artificial Intelligence and Natural Language Processing to enhance effective sharing of information across the care continuum. We also recommend continued

support for standards-based content and mappings, and centralized reference data management solutions to ensure sound data governance processes are in place.

Improving Usability of Clinical Decision Support

We agree with the *Strategy's* recommendations for improving the usability of CDS software as they pertain to continued development and adoption of technical standards, the creation of a common artifact repository for the most common CDS interventions, and additional research into CDS safety, productivity and implementation.

On the development of usability metrics for CDS, we urge caution. Such metrics can be subjective based on the user's comfort with technology. A newly minted physician just out of medical school may find it relatively simple to use a type of software in her practice that would be a challenge to an older colleague nearing retirement.

The amount of time a user spends interacting with health software is one possible way to gauge usability and using an average of the time clinicians spend on completing a task might be one approach to address subjectivity, but this would still provide an inaccurate picture of the software's usability for clinicians who are uncomfortable using technology.

Similarly, using time to measure usability of CDS software is also problematic. For example, the time a clinician spends perusing and reviewing contextual background data in support of a CDS diagnostic or treatment recommendation will vary significantly. And what if the clinician does not ultimately follow the CDS recommendation? Such information is still useful in the larger context of the patient's treatment (or in generally expanding the clinician's knowledge base), but the extra time spent on obtaining and reviewing the information could create the perception that the software is not user-friendly.

Given the difficulty in arriving at accurate and objective metrics for software usability, whether it be CDS or other types of health software, we believe ONC should give greater weight to whether user-centered design principles were used in developing the product, including whether potential end users of the product were consulted during the design and testing phases, and end-user feedback on usability is routinely gathered after the software's release and incorporated into future re-designs and upgrades.

Again, we appreciate the opportunity to comment. If ONC has questions or would like to discuss our comments in more detail, please contact Bob Hussey at (612) 281-8741 or bob@bobhussey.com.