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Donald W. Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
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

Submitted electronically via https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

Dear Dr. Rucker,

UnityPoint Health ("UPH") appreciates this opportunity to provide feedback on the proposed strategy. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 38 hospitals in metropolitan and rural communities and 15 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, central Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

UPH appreciates the time and effort of the Office of the National Coordinator for Health Information Technology (ONC) in developing and proposing this strategy and respectfully offers the following comments.

GENERAL COMMENTS

UnityPoint Health has reviewed the overall strategy and agrees with the four identified areas targeted as issues/challenges – clinical documentation; health IT usability and the user experience; EHR reporting; and public health reporting. **We also believe that the broad strategies and aligned recommendations under each issue are directionally correct** and, in this letter, we have provided additional thoughts on each area. We would note that because both strategies and recommendations lack sufficient detail to understand impact, it is difficult to offer recommendations with any specificity. **We do, however, want to raise a few areas for which the overall strategy is silent, namely operational concerns, patient / consumer engagement and access to claims data.**

- Operational Concerns – As stated, we believe the strategies and their recommendations are directionally correct, but this does not mean that there is necessarily the capacity for providers to adopt them. That said, we cannot comment on how they are or should be prioritized since they do not include considerations of practical feasibility or operational impact. To inform our feedback, we would want fiscal information related to funding amounts, availability of incentives to promote adoption and stability of funding sources. As providers, we would also want to know the timing of these strategies – are they to run in a hierarchical, one-at-a-time fashion or would these be concurrent initiatives? What is the total timeframe for completion? Many of these initiatives are dependent upon IT platforms or infrastructure that require builds by vendors, and there needs to be sufficient time to develop, test, training and go live as well as the resources to put towards these efforts. Also omitted is the overall readiness across geographies, site of service and service lines to participate in these strategies and recommendations. For instance, some providers / service lines have not been incentivized to adopt EHRs. Overall, providers have limited resources and how this strategy is intended to be rolled out could greatly impact our organization. As such, we encourage ONC to release an implementation plan with comment period to provide insight into these operational issues for the overall strategy. We are concerned that there will be regulatory fatigue if all strategies and recommendations are pursued at once and that, despite the intent to reduce burden, there are some recommendations that require additional costs.

- Patient / Consumer Engagement – The central role of the patient / consumer as an engaged participant in healthcare is lacking from the overall strategy. When the patient is referenced, it is usually in a passive role as a recipient of care or services. We believe this is a missed opportunity to empower patients as owners of their records and to place some responsibility on patients / consumers to assure that certain information is provided and accurate. Although we appreciate mention of the BlueButton 2.0 initiative in the introductory letter from CMS Administrator Verma, it is absent from this strategy. We have offered more specific comments under "Health IT Usability and the User Experience."

- Access to Claims Data: This strategy seems like the perfect opportunity to set strategy for a more robust system to share claims data, which should include sharing both raw claims-level data and claims summary data. UnityPoint Health has used claims data to monitor trends and pinpoint areas where care practice improvement is appropriate as well as to assess cost drivers. We believe that claims data should not be subject in an opt-in process, but rather should be routinely available and provided, which allows and encourages providers / organizations to access and utilize this information. The untimely receipt of data and any variance from standardized formats has hindered our ability to drive innovation within payment models and measures. We encourage CMS to advance the following concepts for providers participating in value-based arrangements:
    - Access to All-Payer administrative claims data.
    - Access to substance abuse records by treating providers.

- Permit the sharing of patient medical information within a clinically integrated care setting.
- Sharing of Part D data for lives attributed to certain population health entities, namely down-side risk ACOs.

While we understand that this is not an implementation plan, we encourage the ONC to consider incorporating these concepts throughout the overall strategy or issue a separate detailed implementation plan to recognize these concepts and their potential impact.

We also want to state upfront that the **standardization of data elements and definitions should be prioritized, as standardization is foundational to many of the recommendations**. As a multistate integrated healthcare system, we urge standardization to occur at the national (federal) level. When individual states are allowed to establish different standards or to deviate from national standards, this creates administrative burden and additional costs for providers. It also creates issues for patients / consumers who travel among states and whose health record may have discrepancies due to different standards. As a result, patients / consumers may potentially have delays in care or, at an extreme, less than ideal care that could affect health outcomes due to incomplete or confusing records.

CLINICAL DOCUMENTATION

ONC is proposing three strategies: (1) Reduce regulatory burden documentation requirements for patient visits; (2) continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements; and (3) leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

- ***Comment***: While it is difficult to raise issues with reducing regulatory burden generally, we believe that the recommendation around documentation for patient encounters is not a complete panacea for the reduction of administrative burden. In our comments to the 2019 Physician Fee Schedule (PFS) Proposed Rule, we supported the removal of redundant documentation, but we requested delay on other portions of the proposal to permit more modeling and feedback related to implementation. First, it should be noted that clinical documentation for encounter data has standards outside EHR/billing requirements, like malpractice and clinical care standards. We question how much this proposal will impact note bloat in practical terms. Second, some of the proposed framework within the 2019 PFS for reducing burden do have additional costs. One example is documentation relative to Medical Decision-Making (MDM), Time or Current Framework. We do believe that the impact of a complete unhooking of payments related to E/M codes would lift significantly the burden of documentation on practitioners; however, due to the multiplicity of coding options to use under the proposed change framework and in the face of other payers not providing similar options, we anticipate that this will lead to provider confusion (multiple different documentation requirements) and negate a large part of the intended value of the change. It is these implementation details that result from larger agency strategies, initiatives and blueprints that cause us pause when providing response to policy documents.

Related to Strategy 3, Recommendation 5 (*Coordinate efforts to advance new standard approaches supporting prior authorization)*, we have some thoughts. Foremost, given the recommendation to streamline the prior authorization process, this embeds an assumption that prior authorization is appropriate and should be encouraged. For some cases, we believe that prior authorization should be eliminated altogether to outright avoid these costs, remove third-party administrators from healthcare decisions and reduce service delay. Not only will this be provider satisfier, but it will also enhance the patient experience. With the emphasis on Advanced Payment Models and value-based contracting, prior authorization is an area that should be left to the discretion of practitioners in treating their patients and we would suggest that this could be accomplished through embedded decision support tools and revisions to internal workflows.

HEALTH IT UASBAILITY AND THE USER EXPERIENCE

ONC is proposing four strategies: (1) Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools; (2) promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction; (3) promote harmonization surrounding clinical content contained in health IT to reduce burden; and (4) improver health IT usability by promoting the importance of implementation decisions for clinical efficiency, satisfaction, and lowered burden.

- ***Comment***: In general, the recommendations require changes to the EHRs and technology platforms, and again there are costs associated with these burden-reduction recommendations. The financial impact of implementing EHRs for health systems, hospitals and practitioners has been widely reported and has added significant downward pressure to ever tightening operating margins. We believe that this issue has been skirted in Strategy 4, Recommendation 2 (*Promote understanding of budget requirements for success*). As ONC, HHS and CMS continue to mandate changes, even under the banner of burden reduction, the associated costs to providers need to be transparent prior to implementation. While proposed rules do a nice job of estimating burden to the government, these estimates do not always accurately reflect the comprehensive costs of implementation, including infrastructure costs, to healthcare providers. The government abdicates its role when it does not consider and make transparent implementation costs, but rather counsels healthcare practitioners via a publication, *EHR Contracts Untangled*. What this signals is that these recommendations are fraught with complexity and that there are also associated legal fees that need to be incorporated in estimated implementation costs.

  We encourage ONC to revisit its narrative under *EHRs and Cognitive Support for Clinical Workflow*. On page 32, it states:

  > . . . In addition to the large amount of data that resides within a single patient record, **clinicians are constantly receiving additional patient data from other health care institutions and from patients themselves, which takes time and effort to review, reconcile, and incorporate into the existing patient record**. EHR systems offer varying degrees of support for organizing and reconciling information, but often clinicians must spend time with the EHR after business

hours to locate and organize the relevant information, which can be burdensome and frustrating. [*bold added to text for emphasis*]

As a data driven organization, we are concerned that this language may be misconstrued to suggest that data from other health care institutions and patients are not needed or valuable. Contrary to this, we find much of this information to be valuable and would rather have an overabundance of information than a poorly populated record. Information harvested from MyChart, our patient portal, has been an important enrichment to our data and we would like to see its use further encouraged. And as we suggested under General Comments, we would hope that ONC would encourage an expanded role for patients / consumers in populating and being responsible for certain portions of data contained in their medical records. Gone are the days when the health industry viewed patients / consumers as being acted upon by practitioners and instead patient-centric models of care place patients / consumers at the center and encourage engagement and shared decision making. **We would suggest that ONC include clarifying language that reiterates the importance of holistic patient information and, in particular, data which is provided by patients / consumers themselves**. Aside from patient information, **ONC may want to consider adding language that encourages social determinants of health data**, which can be harvested from a wide range of community organizations and should not be relegated to discussion as primarily a public health function.

EHR REPORTING

ONC is proposing three strategies: (1) Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians; (2) leverage health IT functionality to reduce administrative and financial burden associated with quality and EHR reporting programs; and (3) improving the value and usability of electronic clinical quality measures while decreasing health care provider burden.

- ***Comment***: **While we are supportive of these strategies, we urge ONC to continue to seek stakeholder input to determine operational costs and to develop reasonable implementation timeframes**.

PUBLIC HEALTH REPORTING

ONC is proposing three strategies: (1) Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow; and (2) Inventory reporting requirements for federal health care and public health programs that rely on HER data to reduce collection and reporting burdens on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

- ***Comment***: Under Strategy 1, Recommendation 1 (*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*), we have been concerned with existing differences

among states related to PDMP standards. **We would like to see stronger language in this section related to national standards, making it more difficult for states to customize PDMP platforms.** As previously stated, differing standards impose administrative burdens for health systems and practitioners that practice in multiple states. We would highly encourage that ONC and CMS institute a centralized repository for prescribers as part of this streamlining process.

Under Strategy 2, Recommendation 3 (*HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care*), this is an area where further guidance and flexibility would be appreciated. Especially for patients under value-based arrangements, including ACO beneficiaries, Medicare Advantage enrollees with a plan participating in VBID or DSNP programs, or Medicaid enrollees subject to managed care value-based contracts, care cannot be effectively managed in the absence of substance abuse disorder data.

We are pleased to provide comments to the proposed strategy and its impact on our patients and integrated healthcare system. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

Laura Smith
Chief Information Officer

Sabra Rosener, J.D.
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