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Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Baltimore, MD 21244-1850

Donald Rucker, MD
National Coordinator for Health Information Technology
US Department of Health and Human Services
Washington, DC 20201

Dear Administrator Verma and Dr. Rucker:

On behalf of the Healthcare Information and Management Systems Society (HIMSS) and the Association of Medical Directors of Information Systems (AMDIS), we are pleased to provide written comments on the Patients Over Paperwork Initiative, specifically focused on ideas to help reduce the burdens placed on clinicians—as time and attention clinicians spend on burden resolution is time and attention diverted from patient care. We look forward to initiating a dialogue with the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on how our organizations can contribute to the discussion around alleviating clinician burden and advancing the healthcare enterprise towards the goal of a value-based care system.

HIMSS is a global voice, advisor, and thought leader of health transformation through health information and technology with a unique breadth and depth of expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare, and care outcomes. HIMSS designs and leverages key data assets, predictive models and tools to advise global leaders, stakeholders, and influencers of best practices in health information and technology, so they have the right information at the point of decision.

Founded in 1997, AMDIS is the premier professional organization for physicians interested in and responsible for healthcare information technology. AMDIS Members are the thought leaders, decision makers and opinion influencers dedicated to advancing the field of Applied Medical Informatics and thereby improving the practice of medicine. With our symposia, blogs, on-line forum, journal, presentations, sponsored and co-sponsored programs, and networking opportunities, AMDIS truly is the home for the "connected" chief medical information officer (CMIO).

HIMSS and AMDIS appreciate that healthcare is complex and often requires hard work and extraordinary effort on the part of clinicians to arrive at the right diagnoses as well as to provide appropriate treatment. We believe this level of effort defines us as professionals. That said, we share the belief of CMS and ONC that much of the work that clinicians face today is unnecessarily burdensome, where burden is defined as clinician activity that does not serve patient interests, does not improve quality or safety, or regardless of intent, is highly inefficient. Our organizations want

to work with the Department of Health and Human Services (HHS) to eliminate these unnecessary actions that occur in the course of clinical practice. Ultimately, HIMSS and AMDIS want clinicians to be able to focus their time on actions that make sense, such as caring for patients and delivering better outcomes. We want to help CMS and ONC reduce burden so that our members and other practitioners can deliver better care.

HHS must also consider the additional burdens placed on clinicians from requirements from other entities, such as accreditation organizations (e.g., the Joint Commission), private payers, and state governments. Moreover, aligning government regulatory and reporting requirements with the obligations from other entities is a real opportunity to advance better outcomes for patients while reducing overall reporting burden for providers. Burden should be evaluated in a comprehensive way to ensure a holistic accounting of all requirements placed on clinicians that take their time away from patients.

HIMSS and AMDIS appreciate the work undertaken thus far at your agencies to address clinician burden issues. For our public comment, we offer the following thoughts and recommendations on creating an environment wherein the burden on clinicians is minimized while promoting streamlined regulations, increased efficiencies, and an improved beneficiary experience:

- **Leverage Information and Technology, Now and in the Future**

Technology is part of any solution to address reducing clinician burden and should be recognized as such when developing public policy initiatives. Electronic health records (EHRs) and other health technologies are designed not just to serve as documentation records, but to improve care and ultimately improve health as well as help streamline the extra layer of unnecessary efforts that regulatory requirements often demand.

The future state of health information and technology builds on our work thus far and advances an end-game where a more advanced information and technology infrastructure can help deliver even better and safer care. It should also incorporate the constructs of increasing focus on the patient and supporting better decisions and shared decision-making, and improving the efficiency of normal healthcare operations, which includes reducing or eliminating burden.

In addition, there will be greater demands placed on technology to help make the right information more accessible at the right time so it is more meaningful and impactful to patients and providers. Outside of healthcare, there are tools that help give us focus on important pieces of information using data. For example, consumer-facing technologies using big data and analytics aggregate information about what television shows that a particular user would enjoy based on what they have watched or what their peers have viewed, or services that create a calendar invite for a user after signing up for a conference or making a dinner reservation. We need to encourage development of these sorts of technologies that will create a *signal* out of the health data *noise* to make our system safer, easier to use, and more efficient.

Moreover, telehealth should be viewed as another opportunity to leverage technology and address clinician burden. CMS took great strides by adding several codes to the list of telehealth services

in the 2018 Physician Fee Schedule and also eliminated required professional claims reporting in an effort to reduce the burden on clinicians. As CMS reviews additional steps that the agency could take to expand access to telehealth services within its current statutory authority and pay appropriately for services that take full advantage of communication technologies, it should also consider telehealth as a means to reduce clinician as well as patient burden, especially for geriatric populations and chronically ill patients.

Overall, HIMSS and AMDIS want to contribute to efforts to develop more advanced tools so clinicians can be more effective and manage patient care better with fewer resources. Innovations focused on advanced visualization and clinical decision support solutions will become a larger part of the health information and technology infrastructure moving forward and should be capitalized on to help address burden issues. In many ways, the current health information and technology regulatory burden actually distracts and pulls resources away from our ultimate goals.

- **Addressing Burden Can Result from and Contribute to a Learning Health System**

Layering digital infrastructures without streamlining existing healthcare delivery processes has often resulted in a digitization of the same inefficient processes. In industries outside of healthcare, where the definition of operational efficiency is shared among all stakeholders, technology has led to new and more efficient ways of conducting business—which includes the reduction of burden in transactions.

As our healthcare system continues to shift from volume-based to value-based care delivery and toward a Learning Health System, HIMSS and AMDIS believe that operational efficiencies (the opposite of burden) can evolve. We envision a system that utilizes health information and technology to drive to that future state where patients receive higher quality, safer, and more efficient care and clinicians can focus on better outcomes. As CMS continues to change its focus, the need to institute broader quality outcomes or process reporting requirements wanes, thereby contributing to the overall easing of burden on clinicians.

It is difficult to overemphasize the importance of value-based care and a learning health system to discussions on burden reduction. As federal and state requirements allow clinicians to focus more on outcomes, systematically integrating data as well as experience into practice, and putting that new knowledge into a cycle of continuous learning and improvement, clinicians can spend more time with patients and improve care delivery processes as well as the resultant patient experience.

CMS has made great strides to push in these directions with the focuses of the Quality Payment Program, the Promoting Interoperability Program, and alternative payment models being developed at the Center for Medicare & Medicaid Innovation (CMMI). HIMSS and AMDIS want to continue to help CMS and ONC ensure its requirements meet the goals of a Learning Health System and improve quality as well as patient outcomes. Any tools that health information and technology can contribute to these goals to allow clinicians to spend more face-time with their patients will be welcomed by our memberships.

- **Build Momentum Toward Team-Based Care by Placing a Greater Emphasis on Reporting from the Entire Clinical Staff**

CMS has an opportunity to reinforce the importance of team-based care in all settings by emphasizing and equalizing reporting across the entire licensed clinical staff. Rather than focusing requirements solely on reporting from individual physicians, CMS should alleviate overall clinician burden by broadening its acceptance of clinical notes in EHRs from the entire team for the services rendered to the patient, as well as coverage, treatment, and reimbursement decisions.

All this documentation does not have to be contained exclusively in the physician-specific note. Without shifting the reporting burden from physicians to nurses and other clinical staff, HIMSS and AMDIS want to emphasize the value of clinical notes from the entire team. The quality of the clinical notes from nurses, pharmacists, and the rest of the care team will contribute to documentation that represents interprofessional practice in support of optimal patient care. There is no value added to have a physician (or any team member) re-write a note to meet documentation requirements to comply with rules related to the level of billing.

In addition, under current guidelines, physicians may worry that they have to re-write another team member's notes in order to justify payment. CMS should make its policy requirements clear so that physicians do not have to re-document information from another clinical note to meet its requirements—physicians should be able to reference another team member's note and therefore report in a shorter, more succinct way.

This idea echoes the recent policy change that CMS made on Evaluation and Management (E/M) documentation to allow teaching physicians to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the student's entire medical record note. In the new policy, students would continue to document services in the medical record and the teaching physician is required to verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work. CMS should explore expanding this policy to other clinical staff in light of efforts to reduce clinician burden.

HIMSS and AMDIS want to move away from the perception that if a physician did not document specific services in a patient's EHR, that physician did not perform those services. Allowing physicians the option to re-document or simply verify information in the EHR on the services performed by other clinical staff will help to address burden, and allow physicians to focus their energy on documenting and accessing other key pieces of clinical information that should be in the EHR and could help improve patient outcomes and meaningfully contribute to a learning health care system. These data will likely be helpful in uncovering new knowledge and evidence that may otherwise remain hidden.

- **Proposed Changes in Quality Reporting and the Promoting Interoperability Programs are a Step in the Right Direction**

The 2019 Inpatient Prospective Payment System (IPPS) Proposed Regulation includes positive changes to several programs that have historically added to the administrative and reporting burden

placed on clinicians in acute care hospitals. The Meaningful Measures Initiative and Hospital Inpatient Quality Reporting (IQR) Program proposed to eliminate several claims-based or chart-abstracted measures beginning in 2018, and reduce reporting requirements for electronic clinical quality measures (eCQMs). For the Promoting Interoperability Programs, the proposed scoring and measurement policies move beyond the three stages of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving an individual's access to health information.

Further steps that CMS could take to reduce the burden associated with these programs would be to ensure that the hospital quality measure reporting requirements, specifications, and timelines align with the requirements from other entities, such as accreditation organizations (e.g., the Joint Commission), private payers, and state governments. Until such an alignment occurs, many hospitals will be required to report an equivalent similarly-focused quality measure using different specifications, data definitions, and timelines in different programs.

In addition, CMS should design new eCQMs to collect and report data as part of a normal clinical workflow, as eCQMs are much richer and more timely measures of care than claims data. Significant progress has been made to extract meaningful clinical data from EHRs while minimally affecting current workflow and CMS should build on these efforts moving forward when designing programmatic requirements.

HIMSS and AMDIS also encourage CMS to include these proposed changes in the next iteration of the 2019 Quality Payment Program and the new Promoting Interoperability Program performance category for Merit-based Incentive Payment System eligible clinicians.

Overall, HIMSS and AMDIS emphasize that the full shift to an information and technology-enabled environment is nearly complete. CMS reporting and documentation requirements need to catch up to this reality and see how they can be utilized to help address burden-related questions. Information and technology are already built into all care processes, and there is less need now for clinicians to "check the box" that they are using IT and reporting on that fact to CMS and ONC.

- **Reuse and Repurpose Data from Other Sources to Minimize Reporting Requirements**

Given the amount of patient-level data that CMS already collects and compiles from providers, HIMSS and AMDIS encourage CMS to leverage and repurpose that information to replace documentation requirements and eliminate additional reporting.

There is an opportunity for CMS to develop a robust de novo menu measure set of CQMs for use by providers and hospitals that are designed specifically to capture CQM data as part of an EHR-enabled clinical workflow, using data elements already collected as part of the care process and stored in the EHR or other interoperable clinical and financial health information technology. Data used in eCQMs should be easily extractable for reporting purposes so re-using these data elements as "byproducts" to meet other requirements would significantly reduce provider burden.

HIMSS and AMDIS ask if there are other data elements that CMS already collects that the agency could repurpose to replace required reporting. For example, in the MIPS 2018 Performance

Year/2020 Payment Year, CMS finalized a 10% weight for the cost performance category in the final score in order to ease the transition to a 30% weight. However, the agency requires no separate submissions for the cost performance category, which minimizes the burden on clinicians—cost performance is calculated using administrative claims data.

In addition, CMS is currently able to do beneficiary-level data collection from across all Medicare providers for risk stratification scoring purposes, but does not apply that same principle to CQMs. For quality reporting, CMS requires each provider who sees a specific beneficiary to report the information they compiled from each encounter with that beneficiary. Rather than developing policies that facilitate data exchange between providers and minimize burden, CMS requires duplicative reporting on each beneficiary from multiple providers. HIMSS and AMDIS call on CMS to use its technological capabilities and resources to capture beneficiary-level quality data and compile it across all providers to minimize the reporting from those providers.

Moreover, CMS and ONC should look to the evolving field of patient-generated health data (PGHD) as an additional opportunity to reduce clinician burden. The PGHD future state includes a greater usefulness for this kind of data and fully integrating it into clinical practice can contribute to replacing additional documentation burden and serve to further engage patients in shared decision-making about preventive and chronic care management. Innovative criteria in PGHD capture and use are included in the 2015 Edition Health IT Certification Criteria and the Quality Payment Program. We encourage CMS and ONC to build on these programs and enable Medicare and Medicaid reimbursement of mobile health programs that could collect PGHD in a patient's home.

- **Simplify E/M Coding and Documentation Requirements**

Although E/M documentation is part of broader payment policy and not strictly an information and technology issue, HIMSS and AMDIS want to emphasize how critical it is as part of discussions around minimizing the clinician burden. E/M documentation requirements and coding concerns are a significant source of burden, and we ask CMS to review and revise E/M policies and call on our organizations as well as other stakeholder groups to collaborate on developing workable solutions.

The unintended consequences that E/M coding have had on EHR usability is significant, especially with what should be digestible information about a patient encapsulated in a clinical note. However, these notes are often providing only minimal value to collaborating clinicians given the extreme length of some notes that are used to justify payment or the medical necessity of a service instead of being used to derive benefit for other practitioners or to improve the patient experience.

For example, physicians often receive templated clinical notes from their consulting physicians that document voluminous past medical history, family history, and physical exam results that are often non-pertinent to the current clinical issue and duplicative with the information already existing in the recipient's clinical note, but documented to prove the services were provided by and to justify payment for the consulting physician. What the physician most needs is the focused patient assessment and treatment plan contained in the clinical note, but they must wade through significant amounts of extraneous data to find that information. This non-pertinent noise

negatively impacts provider-to-provider communication, and will increasingly have a negative impact on patients' own understand of their care as they gain greater access to their clinical notes.

Some reporting requirements are structured in such a way that they necessitate a level of documentation that is not workflow-informed and is more burdensome than completing the actual service(s) for the patient. The impact that the current regulatory environment has had on EHR systems and technology use has taken the clinician's focus away from the ultimate goals of delivering better outcomes, higher quality, and more cost-effective care. CMS needs to address refinement and reduction of E/M documentation requirements in any discussion focused on alleviating clinician burden.

HIMSS and AMDIS appreciate the opportunity to contribute our ideas about how CMS and ONC can address clinician burden issues. We remain committed to fostering a culture where health information and technology are optimally harnessed to transform health and healthcare by improving quality and care, enhancing the patient and clinician experience, containing cost, improving access to care, and optimizing effectiveness of public payment.

We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Jeff Coughlin, HIMSS Senior Director of Federal & State Affairs, at 703.562.8824, or Eli Fleet, HIMSS Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,

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