January 28, 2019

Don Rucker, MD
National Coordinator
Office of the National Coordinator for Health Information Technology
330 C Street, SW
Washington, DC 20201

Re: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear National Coordinator Rucker:

On behalf of the American College of Physicians (ACP), I am pleased to share our feedback on the Office of the National Coordinator for Health Information Technology's (ONC's) Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health Information Technology (IT) and EHRs. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We would first like to thank ONC and the Centers for Medicare and Medicaid Services (CMS) for their continued efforts to address and reduce administrative and regulatory burden throughout the health care system. The College is encouraged by your combined efforts over the past few years to put forward initiatives aimed at reducing administrative burden and engage with the health care stakeholder community to gather the necessary information to better understand the issues and develop policies to address them. ACP has long advocated for reducing unnecessary administrative and regulatory burden through our Patients Before Paperwork Initiative, launched in 2015, aimed at restoring the patient-physician relationship through policy development, ongoing advocacy, and collaborations with health care stakeholders, as well as developing tools and resources for ACP members to use in their practice. When ACP initially launched Patients Before Paperwork, we began by surveying ACP membership to better

understand the major administrative burdens they face on a regular basis and unsurprisingly found that using their clunky electronic health records (EHRs) was at the top of their list. The College continues to collect information from ACP membership regarding the administrative tasks they face on a daily basis through our Administrative Tasks Data Collection tool hosted on the ACP Patients Before Paperwork [website](). As outlined in the draft strategy from the ONC, EHR functionality remains at the top of the list of burdensome tasks – among other key issues including clinical documentation and prior authorization hurdles. Specific examples of these administrative tasks are included as an attachment to our feedback and comments – and provide additional insight into the four key issue areas highlighted in this draft strategy (clinical documentation, EHR usability, EHR reporting, and public health reporting).

The draft strategy is evidence of the combined efforts and ongoing field research of both ONC and CMS and – having participated in a number of stakeholder listening sessions as well as hosting one of those sessions at the ACP annual meeting – we appreciate the ongoing stakeholder engagement across the industry. The following letter contains feedback on the overarching strategies as well as specific comments and further recommendations for each of the four key areas of focus including clinical documentation, health IT usability and user experience, EHR reporting, and public health reporting.

I. ACP General Comments

The draft strategy begins by citing the definition of interoperability outlined in the 21st Century Cures Act[1] as, "the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user," and how the strategies and recommendations outlined within will help achieve true interoperability. **The College would like to reiterate our ongoing concerns around the federal government's definition of interoperability. Specifically, the College believes the definition and measurement of interoperability should not focus solely on volumes of data transferred or access to every piece of health information ever collected. Interoperability should focus on the breadth and depth of information involved in useful clinical management of patients as they transition through the healthcare system, the exchange of useful, meaningful data at the point of care, the ability to incorporate clinical perspective, and query health IT systems for up-to-date information related to specific and relevant clinical questions.** There remains a fundamental misconception that indiscriminately sending data is promoting or enhancing interoperability and improving patient care. From a technical perspective, once the full set of clinical data is sent from the source, it is considered historical data. A critical piece of information may have changed since the latest copy was received that could completely change a medical decision. This current definition of interoperability also does not recognize that accessing every aspect of a patient's information can sometimes actually hinder a clinician's ability to find useful and actionable information in a timely manner. A health system in which health IT is measured and graded on its ability to consistently, securely, and

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[1] HR 34 21st Century Cures Act: https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf

electronically transfer an abundance of clinical information at one point in time does not meet what is necessary for practical interoperability.

Moreover, the College believes that interoperability should not be an endpoint in and of itself – and that true practical interoperability can only be achieved when it can show improvements in value and safety of care, as well as efficiency in practice. This draft strategy highlights a number of important issues and challenges that need to be addressed to enhance interoperability – but for interoperability to serve the interests of patients and promote high-value patient-centered care, it should be developed and implemented iteratively, so that its effects on patient care are adequately demonstrated and the risks of data overload and data without context are mitigated. **To that end, ACP believes ONC is missing an important opportunity within this report to frame interoperability in the context of burden reduction and therefore recommends ONC consider adding improved interoperability as an overarching strategy.**

Recommendations under the improving interoperability strategy could include:

- promoting the adoption of Fast Healthcare Interoperability Resource (FHIR) standards;
- promoting the use of open application programing interface (API) functionality;
- targeting the high-yield clinical data that have shown to be the most useful in current health information exchange practices;
- developing through the ongoing maintenance and publication of the Interoperability Standards Advisory, standards to ensure that important clinical and institutional context moves along with the data elements that are deemed necessary for exchange; and
- promoting best practices for data reconciliation (i.e., develop and universally implement best practices for detailed data reconciliation as well as best practices for medication and other data deduplication to prevent sending back the same information already shared from a data source).

Data provenance is another important concept to consider as health data become more available and shareable. Provenance data are included in Clinical Document Architecture (CDA) and FHIR standards and can be attached in order to track the source of each observation. Any data received or sent has a marker of the origin associated with the data that would be evident to subsequent users of that information – providing great clinical value when exchanging health information and helping to mitigate challenges with reconciliation as well as any issues with inaccurate data. **ONC should work with industry stakeholders to develop industry guidance on best practices for implementing and managing provenance functionality in systems as a strategy to improve practical interoperability.**

It is clear that ONC and CMS are very active in this space and have a number of ongoing initiatives to enhance interoperability, as outlined in ONC's recent 2018 Report to Congress.[2]

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[2] ONC 2018 Report to Congress: https://www.healthit.gov/sites/default/files/page/2018-12/2018-HITECH-report-to-congress.pdf

However, the data recently reported in another ONC issue brief[3] shows that fax and mail remain a primary form of data transmission across hospital systems that have methods to exchange the data electronically. **There are still a number of hurdles to jump to improve interoperability across the industry, but the College believes highlighting interoperability as a strategy to reduce burden can help reframe the government's broader definition of interoperability and guide the iterative implementation of interoperability initiatives to assess whether they are improving care delivery, value, and efficiency in practice.**

II. Clinical Documentation Strategies

> ONC Strategy: Reduce regulatory burden around documentation requirements for patient visits.

ACP Comments:
ACP appreciates the actions taken to reduce documentation burden in CMS's 2019 Physician Fee Schedule (PFS) final rule, but we still have a number of concerns with the payment changes tied to the documentation updates – outlined in our comments on the proposed and final 2019 QPP and PFS rules. **However, we believe this is a critically important opportunity to improve documentation through enhancements in health IT. Sufficient time is needed to engage the physician community to develop and pilot-test alternatives that improve documentation clarity and value, decrease burden, and further EHR usability, interoperability, and better care – all while maintaining the principle that more complex and time-consuming Evaluation and Management (E/M) services must be paid appropriately while simplifying E/M documentation and ensuring program integrity.** ACP and other clinical societies should be actively involved in developing guidelines for what is necessary to improve clinical documentation based on elements relevant to their practice and what is needed to optimize clinical care rather than meet billing requirements – and they should be involved in the ongoing governance of the established documentation requirements.

Given the opportunity provided in the 2019 PFS, ACP's Board of Regents is forming a task force titled, "Restoring the Story Task Force," focused on developing resources to promote clinical documentation that tells the patient's story in a meaningful manner as well as developing strategies for the effective dissemination and uptake of best practices in documentation. Another component of ACP's work in this area is to develop specific examples of modifications to EHRs and health IT to improve clinical documentation. An example of where health IT can improve clinical documentation includes incorporating the patient narrative and including patient-generated data. **EHR systems must facilitate the integration of patient-generated data, maintain the identity of the source,[4] and ONC should consider additional policies that**

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[3] Methods Used to Enable Interoperability among US Non-Federal Acute Care Hospitals in 2017: https://www.healthit.gov/sites/default/files/page/2018-12/Methods-Used-to-Enable-Interoperability-among-U.S.-NonFederal-Acute-Care-Hospitals-in-2017_0.pdf

[4] Kuhn T, Basch P, Barr M, Yackel T, for the Medical Informatics Committee of the American College of Physicians. Clinical Documentation in the 21st Century: Executive Summary of a Policy Position Paper From the American College of Physicians. Ann Intern Med. ;162:301–303. doi: 10.7326/M14-2128

promote inclusion of patient-generated documentation via electronic portals. The content in the e-portal should be seamlessly and practically integrated into the EHR and medical record with no need to re-document the information. Patients can also be a valuable resource in reviewing and identifying errors or issues within their medical record and initiatives to include patients in the process of maintaining the most accurate medical record should be considered.

Another key concept to consider when addressing documentation reform is that the guidelines themselves are burdensome, but there is also a great deal of burden associated with the lack of clarity and differing interpretations on what is required. **Documentation updates and auditing requirements need to be implemented uniformly across payers and vendors in order to burden to be reduced.** Best practices for auditing processes and requirements must also be maintained and shared widely. ONC and CMS should engage with private payers and health IT vendors and commit to adopt and implement uniform clinical documentation requirements and technical functionalities.

Furthermore, the College strongly supports the recommendation to waive clinical documentation requirements necessary for payment in order to test or administer alternative payment models (APMs). Many requirements may no longer be necessary or valid overall for certain subsets of clinicians who are consistent performers, implement approaches to deliver innovative care, or assume greater financial risk tied to patient outcomes and experiences.[5] In these situations, clinical documentation should only need to reflect what is needed to optimize care and communication between the patient care team.

> ONC Strategy: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

ACP Comments:
Ideally, as the health care system continues to evolve to a more widespread value-based payment system, the need for prior authorization would decrease, particularly for clinicians participating in risk-bearing alternative payment models. **A great first step toward the ideal would be for ONC and CMS to collaborate with private payers, EHR vendors, physician organizations, and other necessary stakeholders to establish agreed upon clinical definitions for data elements and report formats so that the health IT could be programmed to generate and send data automatically. This agreement and process should be done in a transparent manner and include input from all necessary stakeholders.** If prior authorization reporting requirements are standardized, and stakeholders agreed to use the same data and structure definitions, the burden of prior authorization would be reduced dramatically and EHRs could become one of the key solutions to reducing administrative burden. Moreover, this harmonization would reduce practice costs for data interfaces; reduce the time clinicians and their staff spend completing additional forms; and reduce the time payers spend reviewing

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[5] Erickson SM, Rockwern B, Koltov M, McLean RM, for the Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. Ann Intern Med. ;166:659–661. doi: 10.7326/M16-2697

requests – freeing up time and resources to promote high-value patient care such as care management services.

As ONC notes, prior authorization rules are imposed by payers and vary by state with local regulatory requirements affecting how prior authorization is deployed. **The College agrees with the recommendation for payers to disclose publicly, in a searchable electronic format, a payer's requirements (including prior authorization requirements and patient cost-sharing information) for coverage of medical services.** This publicly available information will be useful and necessary for vendors to begin to automate the process. Additionally, the various portals of data transmission across payers are a significant burden and there is not only a need for standardization in processes and requirements, but also standardization of methods of data transfer across payers.

The adoption and consistent implementation of standards will reduce variability across EHRs and health IT systems – and ensure the functionality meets necessary requirements and does not end up decreasing EHR usability and increasing clinician burden. However, industry standards and agreed upon value sets for these processes alone will not reduce burden – as it is not useful if the data received through these transactions is inaccurate or incomplete. If there is no requirement for the other participants in the exchange (e.g., health information exchanges, pharmacies, pharmacy benefits managers) to implement the standard consistently or even implement the standard at all, then the process will not function as it is intended and will likely increase unnecessary burden. Pharmacies, pharmacy benefit managers, and other stakeholders involved in the prior authorization exchanges must be held to the same certification and standards requirements as clinicians, health systems, and EHR vendors. Further, technology will not improve this process when the information provided is inaccurate and misleading. Payers should be responsible for maintaining and synchronizing beneficiary plan information to keep accurate formularies and provide up-to-date beneficiary information so that everyone in the care continuum has the exact same information at the same time. An example of this could be requiring a process in which insurance plans provide the medication prior authorization and formulary information for beneficiaries that change insurance plans at the beginning of every plan year. The updating and synchronization of beneficiary plan information by payers and pharmacy benefits managers must happen in real time and be complete before the information is incorporated into the EHR functionality and clinical experience.

By decreasing time spent on documentation necessary for prior authorizations and allocating that time to more useful and productive tasks that improve care, the industry will be able to achieve the end goal of providing high-value patient-centered care. **Moreover, ONC's recommendation to waive documentation requirements for those participating in APMs should also apply specifically to prior authorization processes as well.**

II. Health IT Usability and User Experience Strategies

ONC Strategies:
- Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.
- Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.
- Promote harmonization surrounding clinical content contained in health IT to reduce burden.
- Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.

ACP Comments:
Useful health IT for internists should include features that help clinicians to make better care decisions with patients and to share information effectively and securely with colleagues and patients. Enabling better care with health IT also means that the experience of care is improved for both the patient and physician. EHRs and other health IT should help to engage patients with their information and shared decision-making – and not serve as a barrier to care or communication. By improving the efficiency of EHR-enabled care, physicians and other healthcare professionals will have the time and focus necessary to take the next step with EHRs, which is to leverage EHRs to make care better, safer, and more value laden.

Health IT developers, particularly those who develop EHRs, must comply with requirements for user-centered design and the science of usability. In addition to improved physician-EHR user interfaces and more uniform presentations of information – another critically important element of health IT usability is whether the system it is clinically useful. Clinicians need new tools within their EHR, including workflow support, data visualization tools, and shared decision-making tools that leverage existing data within the EHR – and remove the need to click through numerous pages and templates to try to find the truly useful and actionable data. Vendors should be strongly encouraged to partner with cognitive and memory scientists in improving this functionality as other industries have done. Screen views and data management are all enhanced by implementing knowledge available on both human computer visualization and memory methodology.

Value-based payment arrangements, APMs, as well as the promotion of team-based, coordinated care is changing the way physicians work and health IT developers need to understand this change to provide innovative and useful functionalities. As it stands, how our healthcare system measures value is limited to the data currently available within the EHR system (which is insufficient) and clinicians are stuck with workflows designed to generate data largely for the sake of reimbursement, performance measurement, and reporting and not to improve patient care. **ONC, CMS, and health IT developers need to continuously engage with organizations such as ACP to fully understand how health IT can be best implemented to support clinical work and to improve care delivery. Frontline clinicians need to be involved throughout the entire usability testing process and their needs, not just the needs of the**

larger hospital system, must be incorporated into the design process. ONC has the opportunity to improve the EHR certification program by redirecting its focus to usability and useful interoperability and ACP supports the initial efforts of ONC to include aspects of usability testing within certification requirements. However, the College strongly urges ONC not to over-specify what vendors should do for usability. Instead, ONC should promote transparency around vendors' methods for usability improvement and provide a mechanism for clinical experts to provide ongoing feedback to vendors on what is clinically useful based on their specific needs.

ONC, possibly through the EHR Reporting Program and further promotion and dissemination of health IT product usability information, should drive competition within the market to make products more user-friendly and seamless. To reiterate our [comments](#) provided in the Request for Information regarding the EHR Reporting Program, ONC should focus their efforts on developing criteria around how fully implemented EHRs function in real-world settings with real patient data. Additionally, ONC should require health IT vendors publicly report the potential error issues with their systems including the methodology and decision-making processes for identifying and correcting errors, and how they notify users of these issues. Currently, there is no standard methodology for "near miss" and error reporting, nor is there a standard methodology for the vendor's response. Transparency around these processes could promote best practices across the industry and enhance clinician involvement in the evaluation of errors, as well as response and design improvements. Once an EHR system is purchased and implemented, smaller ambulatory practices do not have the support or flexibility to then shop around for an entirely new system if it is not meeting their needs. This is due to the significant costs and the substantial amount of time it takes to implement EHR systems as well as the time to roll out any system upgrades, including effectively deploying the new technology, staff training, and workflow adjustments – all leading to potential risk to patient health if not done properly. Not to mention the issues and time it takes to obtain patient data and migrate that data to an entirely new system. Having vendors report on how their systems function in real-world settings with real-world clinical variables at play will not only provide more useful information for the end user, but also provide a better mechanism for holding health IT vendors accountable for developing truly usable products and drive market competition.

Additionally, there is an abundance of new technologies and functionalities that have the potential to enhance health IT usability, but ONC should not lose sight of the widespread health IT functionalities, such as e-prescribing, that are assumed to be successful but still require significant fixes. **ONC should continue to critically assess the efficiency and operability of these widely adopted and used functionalities to continue to improve health IT usability.** For example, there are requirements on the physician to use the CancelRx transaction when e-prescribing; however, there is no requirement on the pharmacy to accept the transaction which leaves gaps and delays in the overall functionality of e-prescribing. **ONC should work with pharmacy stakeholders to promote and/or require the adoption and consistent implementation of the CancelRx transaction.**

IV. EHR Reporting Strategies

> ONC Strategy: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.

ACP Comments:
The use of EHR data collection capabilities for secondary or alternative purposes, such as for billing documentation, measure and public health reporting, regulatory requirements, and others, must be redesigned in a manner that does not distract or detract from patient care and that also effectively and efficiently provides patients access to their own information. As we noted in our comments on both the [proposed] and [final] CMS 2019 Physician Fee Schedule and Quality Payment Programs rules, ACP is encouraged by the attempts at promoting interoperability (PI), aligning the programs across individual physicians and larger hospital systems, and improving patient access to health information. While we appreciate the effort to simplify the PI scoring methodology, we remain deeply concerned about a number of other aspects of the PI Category and PI Program and do not believe these updates will help clinicians leverage health IT to improve patient care – or reduce the burden associated with the use of health IT.

The College continues to recommend that the PI Category not be limited to a small set of required measures. As a way to provide more flexibility within the PI Category, ACP urges CMS to incorporate a broader list of optional health IT activities from which clinicians can choose that are most appropriate to their scope of practice and specialty. The PI Program should be used as a vehicle to help practices make the needed transitions with the end goal of improving patient care. In order to move beyond the burdensome reporting elements of the legacy EHR reporting programs that have hindered health IT and EHR innovation and left physicians dissatisfied with their EHR systems, clinicians should be able to select from a larger list of health IT-related activities or clinically-focused measures that are most beneficial to their practice and patients. Doing so would allow participants to focus on key strategic areas for meaningful improvement in care delivery while reducing reporting burden, promoting interoperability, and promoting the use of health IT to improve patient care.

Examples of health IT activities include (these activities are described in more detail in previous [comments]):
- EHR/Health IT educational activity developed/endorsed by medical specialty or professional societies;
- Patient Engagement (e.g., develop a case report describing a patient engagement problem and the actions the practice took, including the use of health IT, to resolve the problem);
- Precision Medicine/Learning Health System (e.g., participation in practice-based research or other observational study efforts);

- Clinical Informatics Improvement (e.g., support of iterative improvement in practical informatics via use of an "EHR feedback" application; or participation in an EHR user group);
- Quality, Safety, Value Improvement Projects that Leverage Health IT;
- Patient Safety and Near-miss Reporting; and
- Development of electronic clinical quality measures (eCQMs) that support Quality Improvement (done within a QCDR).

Regarding questions of how health IT can better support feedback reports, ACP believes that there are multiple functional capabilities within EHR systems that could promote useful feedback mechanisms including workflow management, data analysis, data visualization, shared decision making, and data aggregation. Unfortunately, many of these functional capabilities are generally not available in existing EHR systems and not required by current EHR certification requirements. Instead of adding each of the specific functionalities described above to an already extensive list of EHR certification requirements, **ACP recommends the ONC add a single certification requirement that EHR vendors provide fully functional access to third-party tools, through the use of APIs, that could add these needed functionalities without further complicating the existing EHR system.**

> ONC Strategy: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.

ACP Comments:
The processes used for creating, implementing, and reporting quality measures are too complex. Quality reporting should be based upon the data that are routinely collected during care delivery and we continue to reiterate the need for more relevant, accurate, and effective quality measurement, particularly measures based on patient outcomes. ACP is encouraged by CMS's ongoing "Meaningful Measures" initiative and encourages the Agency to consider ACP's framework for analyzing new and existing tasks outlined in ACP's position paper *Putting Patients First by Reducing Excessive Administrative Tasks in Health Care* as they continue to reform quality measures in the context of burden reduction and clinical value. **We implore CMS and others to consider the findings and recommendations of ACP's Performance Measurement Committee (PMC) when considering internal medicine quality measures.** The committee assessed and provided detailed recommendations on many MIPS performance measures with a focus on those applicable to internal medicine. The recommendations are based upon a scientific review process that involves five domains: importance, appropriateness, clinical evidence, specifications, and feasibility/applicability. Of measures considered relevant to general internal medicine, 37% were rated as valid, 35% as not valid, and 28% as of uncertain validity. The PMC assessed a number of additional performance measures reaching similarly mixed reviews. Based on these findings, the committee made several recommendations to improve the measure development process so that measures can drive high quality patient care without creating adverse unintended consequences.

The College further recommends that any measures outside the scope of the PMC recommendations be included in the [consensus core sets](#) of the Core Quality Measures Collaborative (CQMC) and/or recommended by the Measure Application Partnership (MAP). ACP remains concerned that a majority of new MIPS measures finalized for 2019 have received only conditional support from the MAP, and previously adopted measures remain despite being recommended for "continued development" by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. The College further recommends that any measure recommended for continued development be resubmitted to the MAP once redevelopment is initiated. It is imperative that the process to evaluate all measures used in its program be transparent and include all necessary stakeholders. The National Quality Forum (NQF), for instance, evaluates measures against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect.

ACP recommends all stakeholders, including ONC, CMS, and private payers, collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of performance measures with a focus on decreasing clinician burden, ensuring patient- and family-centeredness, and integrating the measurement of and reporting on performance with quality improvement and care delivery. Further, the criteria and processes CMS uses to make its final decisions regarding which measures to remove from the program and which to continue using should also be fully transparent. This would allow stakeholders to better plan their efforts in terms of measure development and review and provide more meaningful feedback to the Agency in the future. This alignment, harmonization, and transparency will better allow health IT to support the collection of data and reporting on quality measures.

> ONC Strategy: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

The College is in support of ONC's and CMS's efforts to reduce the burden of eCQM reporting. eCQMs rarely strike the balance between being meaningful, capturing the complexity of care delivered, and having readily available data sources to populate the measure. Moreover, these measures are costly to build and validate, so the time it takes to update them when guidelines change is significant. **ACP recommends that any new eCQMs should be constructed based on a standard model, including standard structures, vocabularies, expression language, and value-sets that express real-world practice. This then will allow the measures to be certified based on their underlying components rather than against each version of the individual measure.**[6]

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https://www.acponline.org/system/files/documents/advocacy/where_we_stand/patients_before_paperwork/cms-meaningful-measures-feedback-memo-highlights.pdf

V. Public Health Reporting Strategies

> ONC Strategy: 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.

ACP Comments:
Clinicians need access to appropriate, timely, and accurate patient information in order to make the best clinical decisions at the point of care. Unfortunately, the ability to access key information, such as the patient's prescribing history with the state, and integrating that data into a clinician's EHR, is woefully lacking. ACP policy strongly supports reducing administrative burdens associated with the use of prescription drug monitoring programs (PDMPs), as well as other efforts to improve physician clinical workflow. ACP has long-supported the establishment of a national Prescription Drug Monitoring Program (PDMP), but until such a program is implemented, ACP supports efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting (NASPER) program.

ONC's efforts to develop standards through the Interoperability Standards Advisory are an important step in improving the usefulness and effectiveness of PDMP information. However, even if all PDMPs eventually agree to use the same interoperability standards to more seamlessly integrate and extract data within EHRs, variations in state laws and PDMP access procedures will guarantee that the actual experience of clinicians attempting to use these systems will vary significantly. **Due to irregularities in funding, laws, and other state-level variations, PDMPs are not capable of implementing an otherwise agreed upon standard. Therefore, these standards cannot be required for use until PDMP systems are accurate and reliable.**

> ONC Strategy: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

ACP Comments:
In addition to PDMP integration and electronic prescribing of controlled substances (EPCS), there are a number of other public health reporting elements that require improvements including vaccination reporting, D5 measures for diabetes treatment, and disease surveillance. When public health agencies require data from practices and hospitals, they usually require that the data elements be defined, structured, and formatted differently from the way the data are collected during the delivery of clinical care. This means that the reporting clinicians assume the burden, having to manipulate the data in ways that decrease the accuracy and value of the data elements. Clinical data collected at the point of care is relevant for public health research and instead of requiring clinicians to restructure the data to meet the reporting need, public health authorities should present clinicians and health care delivery organizations with a single target for all data reporting. This could be delivered as a single national portal/registry or

local/regional entities such as health information exchanges (HIEs) that all support common data and process standards for all reporting by providers and data query/collection by public health authorities. **Rather than requiring EHRs and other clinical health IT to support multiple separate standards for extracting data for quality, public health, research, payment, administrative, and other reporting purposes, ONC should commission development of a single API for all of the query and data extraction requirements.**

VI. Conclusion

We thank ONC and CMS for their continued efforts to address unnecessary administrative burdens in an effort to improve value – and for the opportunity to provide input on these important issues. We hope that you will find value in our response. As noted earlier in our comments, the College continues to collect information from ACP membership regarding the administrative tasks they face on a daily basis through our Administrative Tasks Data Collection tool hosted on the ACP Patients Before Paperwork [website](#). An excerpt of the examples is included in Appendix A. Should you have any questions, please contact Brooke Rockwern, Associate, Health IT Policy at brockwern@acponline.org.

Sincerely,

Patricia L. Hale, MD, PhD, FACP
Chair, Medical Informatics Committee
American College of Physicians

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ONC Area of Focus	Example of Task	Estimated Time Required	Estimated Additional Expense	ACP Comment
	Appendix A: Excerpt from ACP's Administrative Tasks Data Collection Tool			
Clinical Documentation Requirements	Since I mostly see complex established patients with multiple ongoing problems, I find most chart notes require repetition of the same information in order to satisfy coding criteria. First, I write a "status" of at least three problems in the history of present illness (HPI), including appropriate positives and negatives for review of symptoms and appropriate past/surgical/family history. Then I re-document the full review of symptoms in the review of systems (ROS) portion of the chart and then re-document that I reviewed the contributory past/surgical/family history in that portion of the chard. After, I re-document the status of each of the problems in the assessment/plan portion of the chart. Sometimes I copy and paste the same information in more than one part of the chart. We are required to do this because the coders/billers find it easier in locating the appropriate information to assure it meets the coding requirements, for example, for a 99214 or 99215. Also, since the information or portions thereof are in several parts of the electronic health record, when looking for that information in the future, it is not possible to look in one location; rather, I often have to search both the HPI and assessment/plan for the full history. In the era of EHRs, I think we should establish a better way to document than subjective, objective, assessment, and plan (SOAP) notes and the coding rules should be changed. I would prefer to put all the appropriate information about a problem in one location within the chart note so I can find it easily the next time I see the patient.	5 minutes	$25 per visit	The College appreciates the work CMS is doing in reducing the evaluation and management documentation burdens as finalized in the CY 2019 Physician Fee Schedule/Quality Payment Program rule. Despite the progress, we believe more must be done to incorporate physician feedback in developing and testing documentation alternatives that improve value, decrease burden, further usability and interoperability, and facilitate quality care. At the same time, more complex and time-consuming E/M care must be paid appropriately in any burden reduction efforts. ACP reaffirms its commitment and interest in engaging with CMS and ONC in practical ways to assist them in further addressing clinical documentation requirements and administrative burden through our newly formed task force and advisory group.
Health IT Usability/User Experience	We recently switched EHR vendors. Some of the data is being transferred from the old system to the new system. However, some of the data, such as social history, family history, habits, diet, exercise, and other information, is not being transferred. When I am seeing a patient that requires information be inputted into the chart, I often spend hours the night before manually transferring the data. While the vendor has been made aware of the issue, they have yet to rectify it.	120 minutes	$180	To ensure EHRs can properly assist in the delivery of quality care on the frontlines, ONC, CMS, and EHR developers must engage with stakeholders, such as ACP, in order to understand how health IT can be best implemented to facilitate clinical work. It is critical that the entire design and

Appendix A: Excerpt from ACP's Administrative Tasks Data Collection Tool				
ONC Area of Focus	Example of Task	Estimated Time Required	Estimated Additional Expense	ACP Comment
				usability testing process include the input of individual independent and small practice physicians and not just of the larger hospital systems. To improve usability, vendors must be responsive to the actual users of the EHRs and not just the purchasers and regulators. ONC could address the concerns outlined in this example by incorporating information like this in their EHR comparison tool and by refocusing the certification requirements to focus on usability and usefulness.
EHR Reporting	In order to comply with the quality reporting in MIPS, I must review the CMS website to choose 6 to 10 quality measures that meet all my requirements for successful claims-based submission. I must then create a document within the EHR that lists all of the chosen codes that can be referenced or marked for inclusion in the claim record at the time of patient visit. At the time of the patient visit, I must review and mark this document and revise it at least once a year to accommodate changes in code numbers, deletions, or definitions.	148 minutes	$.04 per report (does not include my time charge)	The College believes that the process for current quality measures are too complex and should rather be based on data that are collected in a regular and routing episode of care. ACP urges stakeholders such as ONC as well as public and private payers to collaborate with physicians, patients, and EHR vendors to develop, test, and implement measures that balance capturing performance and quality while also ensuring minimized burden, patient- and family-centeredness care, and the integration of measurement and reporting with quality improvement and care delivery.
Prior Authorization	If my office receives notification from a pharmacy or a patient that a particular medicine is not—or no longer—covered by their insurer, I am asked to order a different medicine than I have already chosen as best for my patient. This may be for an acute problem the patient is suffering, or it may change a longstanding medicine that has been working well for this	30 minutes	Inestimable - due to the wide-ranging impact described above. Viewed	Varying prior authorization requirements and the lack of EHR automation in the process creates immense burden for physicians in trying to provide the best care for their patients. The College believes that ONC

Appendix A: Excerpt from ACP's Administrative Tasks Data Collection Tool				
ONC Area of Focus	Example of Task	Estimated Time Required	Estimated Additional Expense	ACP Comment
	patient. I am often not provided with a list of covered medicines along with this request (demand). I must request this information from my office staff. There is a delay while my office staff receives the request, searches for the list of approved medications, and sends it to me. I open that email, peruse the list, and enter the order for a hopefully equivalent medicine. Alternatively, I must appeal this request, documenting the reasons I want to keep a medicine from which my patient is benefitting. This appeal is scanned and sent by my office staff to the designated address. The patient often has not been able to fill their prescription during this process, delaying their care. The reason for the request is often not given, so I assume it reflects a change in cost structure to the insurer—a new contract or a different pharmaceutical provider. My staff and I must take time from caring for my patients to go through this process many times a week so that an insurer saved money. This is done to "reduce health care costs," but the costs to my practice and to the practice of medicine are not captured and they are difficult to capture. The accumulated burden of these tasks—being asked to spend my time in service of some organization or insurers' bottom line rather than in service of patient care—is demoralizing. The impact of this "new normal" is not only measured in lost patient care time, but also lost personal and family time as I complete these tasks after office hours. Ultimately it is measured in reduced access to medical services due to the decline in primary care physicians in the United States. Administrative burdens are a big reason that many fewer young physicians choose the once uniquely rewarding primary care role. This leads to increased recruitment costs due to difficulty in recruiting new internists to replace retiring physicians.		narrowly, this issue requires the equivalent of a half-time medical assistant for my 6 physician practice.	and CMS should collaborate with stakeholders like private payers, EHR vendors, physicians, among others in order to create a set of standards for clinical definitions for data elements and report formats so that health IT could be programmed to automatically generate and send data in seeking prior authorization. ACP commends ONC's recommendation that payers publicly disclose prior authorization requirements for coverage of a medical service in a searchable and actionable electronic format.