Amy Merlino, MD, FACOG
Enterprise Chief Medical Information Officer
25900 Science Park Drive, AC220
Beachwood, OH 44122

January 28, 2019

Donald Rucker, MD
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Mary E. Switzer Building, Mail Stop 7033A
330 C Street SW
Washington, DC 20201

RE: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, Draft Released for Public Comment

Submitted electronically via: HealthIT.gov public reporting portal

Cleveland Clinic (CC) is a not-for-profit, integrated healthcare system dedicated to patient care, teaching, and research. Our health system is comprised of a main campus, 10 community hospitals, and 21 family health and wellness centers with over 3,600 salaried physicians and scientists. Last year, our system had 7.6 million patient visits and over 220,000 hospital admissions.

Cleveland Clinic appreciates the recognition of, and efforts to reduce, administrative burden on the healthcare system, by the Department of Health and Human Services (HHS) and its family of agencies, including the Office of the National Coordinator for Health Information Technology (ONC). We support the ONC's draft strategic framework to streamline the regulatory requirements for the use of health information technology and believe the Agency's recommendations will have a positive impact on providers and patient care. We present our comments with respect to specific recommendations within the ONC strategic framework below.

Clinical Documentation

Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.

Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.
Cleveland Clinic Comment: Overall, Cleveland Clinic supports the reduction of regulatory and administrative burden on providers, but any reforms must be executed thoughtfully to ensure that specialists who need to expend additional time and resources with patients are not penalized. Administrative reform should take into consideration complex care and avoid the unintended consequence of inducing perverse incentives to reduce time with patients.

Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.
Cleveland Clinic Comment: Cleveland Clinic particularly supports this recommendation. Clinical professionals and healthcare systems in conjunction with specialty societies can inform HHS about how documentation is operationalized and impactful from the provider perspective and offer insight on innovative best practices.

Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

Cleveland Clinic Comment: Overall we agree with this strategy and the related recommendations for prior authorizations. However, it is important to keep in mind the challenges that come with adjusting to new systems. We urge that any new standards and processes allot enough time for providers to prepare to implement any adjustments to electronic prior authorizations. We recommend phasing in any new requirements.

Health IT Usability and the User Experience

Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.

Recommendation 1: Better align EHR system design with real-world clinical workflow.

Cleveland Clinic Comment: We generally agree but caution that it could be unwieldy to manage over-personalized workflows, especially within large integrated health system. We would support a standardized approach.

Recommendation 2: Improve clinical decision support usability.

Cleveland Clinic Comment: This is an important recommendation but needs more study. We do not recommend requiring submission of CDS data. Implementation should be thoughtful to avoid inadvertently creating additional administrative burden. Any reporting requirements should be aligned with reporting of other quality outcome measures to avoid additional burden.

Recommendation 3: Improve clinical documentation functionality.

Cleveland Clinic Comment: We have concerns with the following statement and disagree with it as currently written: "**Policies** regarding copy-and-paste functionality should be put in place at an institutional level for the management of copied text that balances efficiency with safety." We recommend replacing the word "Policies" (in bold) with "Guidelines."

Recommendation 4: Improve presentation of clinical data within EHRs.

Cleveland Clinic Comment: We are concerned about the following statement: "Data contained in documents such as scanned reports should be extracted and indexed for better retrieval." We caution that this capability has the potential to increase administrative burden on providers. We recommend that ONC clarify that any new policy establishing a requirement around this capability should apply to developers and vendors, not providers.

EHR Reporting

Strategy 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.

Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.

Cleveland Clinic Comment: Referring to the statement in the last paragraph that CMS is working closely with stakeholders to improve the Promoting Interoperability program, we inquire about who those stakeholders are. The stakeholders with whom CMS should engage must include clinicians who are required to understand the scoring methodology in the Promoting Interoperability program.

Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.
Cleveland Clinic Comment: We have questions about the term "incentivize" in this context. Would incentives for health IT and interoperability innovation strictly have to be monetary, or are other avenues feasible? ONC should consider a broad scope of approaches to encourage innovation. For instance, a data mart or clearinghouse of best practices in documentation or clinical practice improvement, accompanied by technical assistance from ONC, could be made available to providers at no cost. A one-stop source of such data could assist clinicians seeking best practice models to adopt while recognizing experts who develop creative solutions.

Recommendation 3: Reduce burden of health IT measurement by continuing to improve current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow.
Cleveland Clinic Comment: The original reason for meaningful use was to encourage providers to adopt certified electronic health records systems and use them in a meaningful way – i.e., in ways that benefit patients. Efforts to improve interoperability should not be imposed on providers, but on developers and vendors. Vendors should be held accountable for developing the capacity for interoperable health IT systems. End users, meaning providers and patients, should not have to figure out how to improve the interoperability of electronic medical records systems.

Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.

Recommendation 3: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.
Cleveland Clinic Comment: We recommend the addition of a statement under this recommendation to the effect of: "HHS should encourage vendors to continue to develop their caregiver point of care reporting tools and capabilities."

Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden

Recommendation 2: Continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project
Cleveland Clinic Comment: We advise that ONC align with the CMS Meaningful Measures Initiative, as it implements this recommendation. We also recommend that ONC encourage and take into consideration input from private payers who have their own quality measure reporting requirements.

Public Health Reporting

Strategy 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.

Recommendation 2: HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.

Cleveland Clinic Comment: We agree with the importance of this recommendation but foresee difficulties in its implementation. While e-prescribing controlled substances is legal in all 50 states, states have enacted varying requirements regarding e-prescribing and engagement with Prescription Drug Monitoring Programs, with some imposing highly stringent standards. Given the wide variability in state e-prescribing requirements and standards, encouraging broader adoption of e-prescribing could prove to be an uphill battle.

Strategy 2: 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.

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.

Cleveland Clinic Comment: We robustly support this recommendation as a positive step toward harmonizing the privacy and security provisions under HIPAA with the confidentiality protections afforded to patients with substance-use disorder under 42 CFR Part 2. We agree that aligning these rules would better facilitate the integration of care and services, including electronic medical information, for patients with behavioral health issues, while protecting their privacy.

Thank you for conducting a thoughtful process that allows us to provide input on such important issues. Should you need any further information, please don't hesitate to contact me.

Sincerely,

Amy Merlino, MD, FACOG
Enterprise Chief Medical Information Officer