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Kaiser Foundation Health Plan
Program Offices

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Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
ATTN: Strategy on Reducing Burden Relating to the Use of Health IT and EHRs
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Submitted to https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

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

Kaiser Permanente offers the following comments on the Draft *Strategy on Reducing Burden Relating to the Use of Health IT and EHRs*

The Kaiser Permanente Medical Care Program is the largest private integrated healthcare delivery system in the U.S., with 12.2 million members in eight states and the District of Columbia.[1] Kaiser Permanente has implemented a secure Electronic Health Record (EHR) system, KP HealthConnect® to support the delivery of healthcare services to our members and to enhance communications among providers.

We appreciate HHS' efforts to address regulatory burdens related to the use of Health IT by clinicians and improve interoperable health information exchange, pursuant to the requirements of the 21st Century Cures Act (Cures Act).

CLINICAL DOCUMENTATION

Current regulations favor documentation to support reimbursement, while paying less attention to clinical documentation that improves care delivery, patient safety and health outcomes. As

[1]Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente's members.

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EHR reporting matures and moves beyond traditional claims-based data (e.g., ICD-10, CPT codes), clinical documentation requirements could become more burdensome. Currently, we find the additional "mapping" to industry-standard codes to denote specific diagnoses, procedures, medications, etc., consumes disproportionate resources. Streamlining documentation and reducing administrative burdens on physicians will be an important challenge for regulators and other stakeholders.

The efficiency of reporting could be improved by ensuring that requirements conform as much as possible to existing clinical workflows. For example, the EHR Incentive Program (Promoting Interoperability (PI), formerly Meaningful Use) includes measures, such as medication reconciliation, that burden clinical workflows without adding significant benefit to patients or providers. Other examples include E/M coding requirements that add unnecessary documentation steps (a.k.a. "clicks") during a patient encounter. Similarly, ICD-10 documentation requirements should balance benefits for clinicians, coders, and auditors with reducing "note-bloat." ICD-10 guidelines should give physicians discretion to determine which diagnosis code (s) support an encounter.

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

Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.

Regulations should leverage information already contained within the EHR and acknowledged by the clinician during an encounter. Kaiser Permanente strongly supports efforts to ensure that clinical documentation improves rather than impedes effective and efficient clinical care delivery. We would welcome future opportunities to work with HHS to optimize clinical documentation requirements.

Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.

Kaiser Permanente supports this recommendation as one approach to reducing the documentation burden on clinicians. The mere act of reviewing information already in the record should trigger the system to record automatically that a required review has been done (e.g., medication reconciliation), so the clinician does not need to perform an additional step of clicking a box to demonstrate that the information was reviewed.

Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.

Kaiser Permanente supports this recommendation. Appropriate, timely feedback will strengthen and streamline regulatory requirements.

Recommendation 4: Waive documentation requirements as may be necessary for purposes of testing or administering APMs.

Kaiser Permanente supports this recommendation. APMs should not require additional documentation that might interfere with clinical workflows. Reducing the amount of required medical review burden for certain APM participants supports the effort to keep documentation requirements at a minimum.

Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.

Clinicians will benefit from other key stakeholders addressing some basic documentation challenges. For example, improving efficiencies in clinical documentation will involve identifying common standards that are clinically meaningful and provide direct value to the patient; that effort will require coordination and cooperation among federal and states agencies, quality reporting organizations, and payors.

Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.

Best practices should evolve from evidence-based care, not from regulatory mandates. It is important to balance requirements for documentation with ensuring that they are not overly burdensome. This effort could also improve efficiencies for clinicians and ensure patient safety.

Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.

Kaiser Permanente supports this recommendation. However, learning curricula should not be limited to CMS or other federal agencies. CMS should also consider circumstances where requirements should be waived to facilitate more rapid learning. We also strongly recommend that any practice labeled as "best" must clearly and unambiguously be linked to the desired outcome, preferably in a well-designed study.

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

In general, Kaiser Permanente supports these recommendations. However, we strongly recommend that any efforts to address these processes should not create new requirements or workflows that increase burdens unnecessarily, particularly in organizations like ours, where prior authorization is rarely performed.

We support interoperable documentation and reporting among different EHR vendors. Currently, data fields for quality, safety, and disease reporting are not well standardized. This requires health systems and EHR end users to purchase third-party software to translates EHR data into a common clinical document architecture (CDA) format – a costly and burdensome necessity. EHR vendors should standardize data fields and workflows for public reporting requirements.

We also recognize that efforts to standardize documentation elements would improve interoperability for providers who need to document in two or more different systems. Patients may receive care at multiple venues, where system differences limit or prevent access across EHRs. Improved standardization, particularly of clinical data using SNOMED CT, LOINC, and RxNorm as national standards, will increase interoperability.

We are also concerned about requirements for procedure ordering that disproportionately burden certain providers. For example, physicians with low volumes of applicable Part B imaging services should not be required to meet appropriate use criteria (AUC) requirements for reimbursement. Clinicians who practice evidence-based medicine generally do not find that the additional steps required by the AUC program add value to the process of ordering services at the point of care.

As we noted above, within Kaiser Permanente's capitated, prepaid reimbursement model and integrated delivery system, prior authorization is very uncommon. Therefore, we have no specific comments on *Recommendations 1-4.*

HEALTH IT USABILITY STRATEGIES

Kaiser Permanente strongly recommends adopting an approach to EHR design that allows clinical workflows to shape and inform EHR development rather than establishing federal requirements to drive the development process. We believe providers are well positioned to determine the clinical appropriateness of user requirements. We also encourage CMS to promote designs that focus on interoperable exchange among providers and between providers and consumers.

Overly prescriptive development requirements could impede innovations and improvements that can be accomplished through a combination of clinical care delivery improvements and market forces. Ultimately, end users – providers, payers, and patients – will dictate useable and reliable product design.

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.

Kaiser Permanente generally supports this recommendation in concept. We suggest that ONC look for ways to leverage the excellent work NIST has done on EHR workflow and usability.[2] Those efforts have examined ways to optimize design to align with clinical workflow and balance flexibility with standards that can support interoperability, address safety concerns and solicit feedback about performance gaps.

Recommendation 2: Improve clinical decision support usability.

[2] https://ws680.nist.gov/publication/get_pdf.cfm?pub_id=909701

Kaiser Permanente supports this recommendation. IT vendors have gained considerable experience with clinical decision support (CDS) as the evidence base has grown and feedback mechanisms have become more sophisticated; those lessons have yielded improvements in usability for our clinicians.

Recommendation 3: Improve clinical documentation functionality.

Kaiser Permanente supports this recommendation. We also suggest promoting institutional policies for the management of copied text that balance efficiency with safety. We suggest ONC refer to research done by NIST and ECRI on best practices for copy-and-paste functionality.[3]

Recommendation 4: Improve presentation of clinical data within EHRs.

Kaiser Permanente supports this recommendation. We agree there is a need for much better presentation of clinical data, especially meaningful graphical representations of lab and numerical data. This is an improvement that should be based on input from stakeholders, such as IT developers and health care providers; design recommendations should come from industry guidelines rather than regulation.

Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.

Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.

Kaiser Permanente supports this recommendation in concept. Harmonization of user actions seems a reasonable goal, but, so long as regulations or sub-regulatory guidance to promote harmonization allows developers and providers flexibility when designing or using EHR systems for diverse populations treated across a wide array of care settings. We recommend that CMS provide more detail about the scope of "basic clinical operations."

Kaiser Permanente *supports Recommendations 2-4.*

Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.

Standardization of clinical content should be balanced with flexibility that allows providers to configure this functionality for their unique care setting and to reflect the needs of their patient population.

Kaiser Permanente supports *Recommendations 1-4.*

[3] *See* https://www.nist.gov/publications/examining-copy-and-paste-function-use-electronic-health-records; *see also* the published findings and recommendations of the ECRI Institute studies. NIST tested their work and support their findings. https://www.ecri.org/components/HRCAlerts/Pages/HRCAlerts021517_Usability.aspx; *see also* American Health Information Management Association toolkits: http://library.ahima.org/doc?oid=87789#.XEuM8VxKg2w

Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.

Recommendation 1: Increase end user engagement and training.

Kaiser Permanente supports this recommendation. We agree that the importance of engagement and training should not be under-estimated. However, EHR design and workflows should also be as intuitive and consistent as possible to avoid the need for excessive training to understand and use the system.

Recommendation 2: Promote understanding of budget requirements for success.

Kaiser Permanente supports this recommendation.

Recommendation 3: Optimize system log-on for end users to reduce burden.

Kaiser Permanente supports this recommendation, so long as optimization preserves strong system protections. Log-on policies and procedures should balance the need for system security with reducing the burden on end users, based on an appropriate assessment of risk.

Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.

Kaiser Permanente supports this recommendation.

EHR REPORTING STRATEGIES

There is substantial reporting required by federal programs, plus additional layers of state-mandated reporting. Kaiser Permanente strongly supports efforts to align reporting requirements across programs to minimize the burden on providers and to optimize the impact of reporting on improving patient care. For example, CMS should analyze these regulations[4] for the specific purpose of streamlining mandatory workflow processes.

We also recommend that CMS and ONC re-evaluate current reporting requirements to focus on fewer measures with greater potential impact on health outcomes

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.

[4] E.g., Conditions of Participation (CoP), State Operations Manuals (SOM), and Office of Inspector General Work Plan (OIG-WP)

We strongly support CMS' recent efforts to simplify PI scoring. The 2019 Inpatient Prospective Payment System (IPPS) final rule establishes a scoring system for Eligible Hospitals (EH) participating in the EHR Incentive Program that provides a simple, flexible and fair model for all participants. We recommend that CMS also adopt the point-based approach for Medicare Advantage Eligible Professionals (MA-EPs) participating through Medicare Advantage organizations (MAOs). CMS objectives – to reduce burden, increase flexibility, and promote interoperability – should be consistent across all providers. If CMS chooses not to adopt the point system for MA-EPs, we strongly recommend that MA-EPs be offered equivalent flexibility in objectives and measure options, with no increased thresholds in 2019, and the ability to meet program requirements by passing most but not all measures. Additionally, we recommend offering a group reporting option for MA-EPs.

We also recommend that CMS discontinue certain measures for MA-EPs, including those it has already removed for other providers (CPOE, Clinical Decision Support), plus the measures removed for EH and MIPS eligible providers (Patient Education, Secure Messaging, Patient View/Download/Transmit, and Patient-Generated Health Data). By applying the same scoring, metrics and reporting timeframes across all providers, CMS will ensure consistency in achieving its goal to promote and support greater interoperability, flexibility and simplicity.

Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.

Kaiser Permanente agrees with the general concepts in this recommendation. We typically utilize various technologies to maximize interoperability. In addition to meeting all PI required health information exchange (HIE) and application programming interface (API) measures, we also utilize other mechanisms, such as eHealth Exchange or regional networks to connect with external partners We agree with the proposal to explore opportunities to reward innovation that advances interoperability (e.g., participation in the Trusted Exchange Network with an appropriate health information network (HIN)), so long as those incentives do not include requirements that add to the reporting burden. A better way to reduce burden and encourage innovation would be to enable greater regulatory flexibility.

Finally, there may be conflicts between federal and state requirements; resolving these can be burdensome. Where state reporting requirements exist, federal agencies should carefully consider whether new federal requirements will duplicate effort and/or lead to health providers having to navigate different reporting processes.

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.

We appreciate any efforts to avoid changing clinical workflows to facilitate reporting. Measures that require physicians to perform a step, then click to acknowledge taking that step, are poorly designed and should be removed or modified. For example, a recently adopted PI measure of whether a clinician "seeks to identify an opioid agreement" is confusing and does not reflect

clinical practice. The system can measure whether such an agreement was found/uploaded but cannot determine whether a search was conducted.

Metrics that rely, in whole or in part, on manual tasks (e.g., like calling the patient's prior providers, documenting the call, and noting any information obtained) do not measure interoperability, plus they force clinicians to perform additional tasks to increase performance. Moreover, these tasks may not provide any new benefits to patients. Others are the bonus e-prescribing measures in the PI category; that and other measures would be improved by involving clinicians and vendors in the design.

Current health information exchange (HIE) metrics do not measure whether the goals of interoperability have been achieved. Rather, these measures reward pulling/pushing duplicated data extracts between individual providers and individual encounters, and data reconciliation. A more efficient interoperability measure would gauge availability of comprehensive patient information for clinical uses rather than transactions that send or receive duplicate data. In this shared access model, clinicians would have access to the data they need without exchange transactions.

Kaiser Permanente supports implementing a smaller number of valid, reliable, evidence-informed measures, rather than a "cafeteria" of poorly specified measures. In addition, we recommend tailoring measures to leverage EHRs data and prioritize public health objectives. Focusing on fewer, higher quality measures will allow accountable entities to select applicable metrics that meet their specific needs, while also embodying national, regional, and institutional clinical quality improvement strategies and imperatives.

Recommendation 4: To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers.

Kaiser Permanente supports this recommendation, with the same caveat as above: to ensure that such support does not come with additional burdens for Medicaid providers.

Recommendation 5: Revise program feedback reports to better support clinician needs and improve care.

In general, we strongly support improvements that will ease clinician burden and promote better care. More specifically, we recommend that CMS consider providing program feedback to MA EPs, who are still subject to the older EHR Incentive Program requirements (a.k.a. Meaningful Use).

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

Recommendation 1: Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.

We support CMS/ONC recognizing industry-approved best practices for data mapping and data integrity. The need for any direct agency involvement in the process is obviated by existing private sector initiatives that actively promote best practices reflecting broad stakeholder consensus.

Recommendation 2: Adopt additional data standards to makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.

We support an expanded use of HL7 FHIR-based APIs to achieve greater interoperability and to help address myriad data challenges. Any specified set of common data classes must be flexible enough to accommodate clinicians with different workflows and documentation needs, with the ultimate aim to decrease burden and minimize disruption to existing clinical workflows (e.g., PI program API requirements for a common clinical data set). These are important considerations as the industry moves to US Core Data for Interoperability (USCDI) and the Trusted Exchange Framework and Common Agreement (TEFCA).

Recommendation 3: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.

We support the use of APIs for bidirectional integration of HHS systems such as NPPES and PECOS with Health IT systems, however, flexibility should allow for further innovation.

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

Recommendation 1: Consider the feasibility of adopting a first-year test reporting approach for newly developed electronic clinical quality measures.

Kaiser Permanente strongly endorses the concept of first-year test reporting, where entities are required to report, but the results are not made public. Results would be validated, specifications modified if necessary to improve validity and reliability, and results would be publicly reported only in Year Two (if appropriate). This approach is commonly followed by several entities, including both NCQA and CMS, plus it has been well-understood and well-received by industry and the public.

AS we state above, CMS should support implementation of a smaller set of valid, reliable, evidence-informed measures versus a large set of measures providers could select from. Metrics should reflect national, regional, or local clinical quality improvement strategies and imperatives.

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.

We endorse this recommendation if the evaluation process includes stakeholder representation. As an integrated delivery system with a long experience with both EHRs and quality

measurement/quality improvement, we would welcome the opportunity to be a part of this process.

Recommendation 3: Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.

We endorse this recommendation if the evaluation process includes stakeholder representation. As an integrated delivery system with a long experience with both EHRs and quality measurement/quality improvement, we would welcome the opportunity to be a part of the process to explore way to improve reporting requirements.

PUBLIC HEALTH REPORTING STRATEGIES

CMS/ONC should focus on adopting and using existing industry standards that all state PDMPs can use to operate and access information. (e.g., NCPDP's PDMP Facilitator Model). Any reporting requirements should be vendor neutral. Mandatory technical specifications are burdensome and can impede innovation. As we have commented throughout, eliminating duplicative reporting and harmonizing data elements will result in reducing the burden on clinicians and health systems.

Strategy 1: Increase adoption of electronic prescribing of controlled substances (EPCS) and retrieval of medication history from state PDMP through improved integration of health IT into provider workflow.

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. States should also leverage funding sources, including but not limited to 100 percent federal Medicaid financing under the SUPPORT for Patients and Communities Act, to facilitate EHR integration with PDMPs using existing standards.

We agree in principle; however, these recommendations will incur costs both at the federal and state levels, as well as for impacted organizations. States historically have limited funds for systems changes. HHS should consider providing grants or other assistance to states to affect these improvements. One step CMS/ONC could take would be to identify, and where possible, reduce duplicate reporting. The variability among state regulatory requirements presents a significant challenge; however, the immediate benefits could include cost savings, less confusion, and fewer conflicting performance results.

Kaiser Permanente recommends that ONC consider the "NCPDP Standards-based Facilitator Model for PDMP, An Interoperable Framework for Patient Safety" for using existing standards to further enhance PDMPs and improve the information available to prescribers.

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.

Kaiser Permanente agrees that increased adoption of electronic prescribing of controlled substances (EPCS) with better access to PDMPs will improve appropriate controlled substance prescribing. EPCS adoption significantly lags that of ePrescribing.[5] State EPCS mandates will reduce the lag, but not evenly across the nation. Also, some prescribers will cite costs as a rationale for eliminating their prescribing of controlled substances. CMS/ONC should consider working with DEA on options to address the incremental costs associated with EPCS, especially credentialing, software certification, and two-factor authentication tokens.

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.

We agree it would be extremely helpful to streamline requirements; however, in addition to federal health care and public health programs, we are also required to report to many state and local jurisdictions. CMS/ONC should look for opportunities for where federal, state, and local programs could collaborate on these burden-reducing efforts.

Recommendation 1: HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.

Kaiser Permanente supports convening stakeholders to identify duplicative reporting and align parameters for similar reports. For example, to measure opioid overuse, the Pharmacy Quality Alliance (PQA) has a metric that sets a 90-milligram morphine equivalent dose (MME) cut-point; NCQA and HEDIS specify a similar metric with 120 MME as the cut-point; we have internal programs that use a 90 MME cut-point. Standardizing the metric and the cut-point would reduce confusion and duplicative reporting, while also improving the ability to compare the metric across multiple organizations.

A significant drawback to a stakeholder assessment is time; government-sponsored stakeholder assessments can take a long time (wo years is not uncommon). With the proper facilitation and an investment in preliminary work, the timeframe could be shortened to 6-12 months. Implementation of reporting changes also take time. Ideally, changes could be put into effect within two to three years of the final assessment being published.

Recommendation 2: HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.

[5] By 14% versus 64% per http://www.healthtechzone.com/topics/healthcare/articles/2018/04/03/437665-three-factors-contributing-lagging-provider-adoption-epcs.htm.

KP agrees with this recommendation. A systematic review of all federally funded program reporting requirements would identify similar data elements and similar reporting requirements. Alignment of elements (definition, format, etc.) and consolidation of similar reports would reduce the ongoing burden and costs of both reporting and HHS data management.

Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information to better facilitate electronic exchange of health information for patient care.

KP agrees with this recommendation to develop guidance on the confidentiality/privacy overlap between 42 CFR Part 2 and HIPAA. Ideally, 42 CFR Part 2 should be revised to align with HIPAA requirements.

Conclusion

Kaiser Permanente appreciates your willingness to consider our comments. Please contact me at (510)-271-5639 (email: jamie.ferguson@kp.org) or Lori Potter at 510-271-6621 (email lori.potter@kp.org) with any questions or concerns.

Sincerely,

Jamie Ferguson
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