January 28, 2019

Don Rucker, M.D.

National Coordinator for Health Information Technology

U.S. Department of Health and Human Resources

330 C St SW, Floor 7 Washington, DC 20201

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

Dear Dr. Rucker:

Dr. Alain Chaoui, President of the Massachusetts Medical Society (and a practicing family physician) and I, Vice President, Clinical Integration of the Massachusetts Health & Hospital Association (and a practicing radiologist) co-chair the **Massachusetts Medical Society - Massachusetts Health & Hospital Association Joint Task Force on Physician Burnout.** This task force includes a diverse group of 15 physicians from across the Commonwealth of Massachusetts and one medical student (member list attached). We’ve been meeting for over a year and have been making progress towards achieving our goals.

**Our mission statement is as follows:**

**MMS-MHA Joint Task Force on Physician Burnout Mission Statement:**

The goal of the Task Force is to identify and prioritize effective strategies to combat physician burnout and advocate for statewide adoption of identified strategies and practices.

To fulfill this goal, we will review the root causes of physician burnout; consider what has already been written and published as well as our experience and efforts in this regard. We will then review and consider strategies and practices for those areas we choose to focus on and then prioritize accordingly. The Task Force will make recommendations to the MHA Board of Trustees as well as the MMS House of Delegates. Beyond serving our own constituencies, our hope is that we can share our recommendations with other state associations and perhaps other clinicians as well.

**Comments:**

The MHA welcomes and strongly supports the goals outlined in the draft “Strategy on Reducing Regulatory and Administrative Burden Relation to the Use of Health IT and EHRs”. The problem framing statements and strategies outlined indicate that the Office of the National Coordinator for Health Information Technology has clearly understood the concerns and burdens experienced by clinicians and we are grateful for continued efforts to reduce the documentation requirements for reimbursement, simplify quality reporting requirements and improve EHR workflow.

**CLINICAL DOCUMENTATION:**

The MHA appreciates ONC’s recognition of the double-edged sword providers encounter in their use of health IT and EHRs, namely that these technologies support care delivery, but also increase the burden of providing and documenting care. We support ONC in its efforts to reduce EHR-related burden while simultaneously optimizing the usefulness of EHRs for patient care and reducing the contribution of IT tools to physician burnout.

With regard to the proposals outlined to simplify documentation requirements, we support the proposals to simplify E/M guidelines which results in burdensome click-overhead to enter extraneous data in an effort to either avoid inappropriately reduced reimbursement or badgering by professional coding personnel. Further, the cluttering of the electronic record with extraneous and duplicative data further burdens our providers with time spent reviewing the chart to deduce the essential patient narrative.

We also encouraged CMS to engage in a broader effort to understand and implement proposals that would reduce providers’ documentation burden in a meaningful way, such that providers have more time to spend with patients. **Therefore, we support ONC’s recommendation to obtain ongoing stakeholder input into updates to documentation requirements. We recommend, however, that any task force or other mechanism to gather stakeholder input be composed of a range of viewpoints (providers, vendors and payers), but include a majority of participants from the clinical community, hospitals and health systems.**

**Prior authorization (PA):**

**We commend ONC’s focus on reducing the administrative burden of PA and the agency’s recognition that the PA process lacks standardization and suffers from limited automation due to lack of an adopted health care standard for claims attachments.** We also support the focus on reducing the documentation burdens of pre-authorization and utilization review. The variability of the data requirements from payor-to-payor, the variability of duration or number of interventions authorized, as well as the volume of data required have rendered automation of this data acquisition and submission process rather daunting for providers, support staff, and vendors alike. We support advancing the electronic submission process and also recommend additional attention be paid to reducing the volume and variability of clinical necessity guidelines for the required data submitted to reduce this burden.

**Finally, while we agree with and support the need for standardized data and processes, we are concerned that ONC’s recommendation to advance new standards to support prior authorization does not adequately address the issues around broadly applied prior authorization programs that impose significant administrative burdens on all health care providers.**

Today, there is significant variation between utilization review entities’ prior authorization criteria and requirements in addition to the extensive use of proprietary forms. This lack of standardization places significant administrative burden on providers, who must identify and comply with each entity’s unique requirements. While there is a need to support more automation around these processes, it will not address the lack of transparency or uniformity around payer requirements for prior authorization.

The MHA strongly recommends that HHS expand its work with clinicians, payers, medical product manufacturers and health IT developers on ordering services and PA processes to include a focus on bringing standardization to both the process and the information required by utilization programs. All stakeholders also should consider how to reduce the need for prior authorization, particularly as we improve documentation and move to new models of care that put more financial risk on providers.

**Both a fundamental transformation that encourages standardization of PA criteria across utilization review entities and standardized electronic communication and transfer of information are needed to promote uniformity and enable timely, transparent, and simplified communication between key stakeholders.** We are encouraged that ONC recognizes this need and stand ready to participate in continued efforts to reduce burden in this area.

**Electronic Health Records usability**:

Our members report that clinical teams – including physicians, nurses and other clinicians – routinely experience lack of usability. For example, many report changing their clinical workflows to accommodate the EHR, rather than having EHRs that support their optimal clinical workflow.

With regard to proposals outlined to improve Electronic Health Records usability, we strongly support all of the strategies and recommendations proposed to improve usability, alignment with clinical workflow, and standardization of the canonical workflows for chart review, ordering and documentation to improve the intuitiveness of use across various EHR platforms.

Many of the members of the EHR vendor community might respond that they employ user-centered design experts and provide configuration tools to make it possible to deliver a high degree of organization-specific and specialty-specific usability to their clinicians. However, many of these vendor configuration tools are highly complex and do not contain the basic functions required to manage user context, dependency tracking, transparency, human readability, auditing, and provenance. These deficiencies increase the expense to support these systems as well as further complicate a healthcare system’s ability to be timely and agile in optimizing the platforms on behalf of usability.

EHR vendors should be encouraged to invest in improving their configuration tools on behalf of implementation teams as well as personalization strategies for end-users. These investments would contribute greatly to improvements in data presentation, documentation and order entry. **Further, while EHR systems may offer many tools for user personalization, very few, if any, have invested in developing the capabilities of their systems to learn from past user behavior, building essentially a user profile leveraging emerging deep learning architectures, such that the system anticipates a user’s needs rather than burdening the user with having to learn and continuously curate the level of personalization required to achieve his or her satisfaction.** These kinds of approaches can potentially be undertaken by EHR vendors within their native application architectures as well as via 3rd party solution integration.

**We strongly support the recommendation emphasize prioritization of investments in implementation and optimization that improve clinician efficiency.** These investments are typically shared across three key domains: vendor investments, implementation and configuration investments, and operational investments. Underestimation of the budgetary requirements to drive clinician efficiency is a common problem. Workforce composition is highly varied in health systems and practices, nationwide, and, it would be helpful to develop national benchmarks for the necessary complement of implementation and operational support staff. While training is clearly essential, and must be funded, usable systems developed according to user-centered design principles should be intuitive and facilitate both rapid onboarding and ease acculturation to changes in the software.

As regards EHR reporting and interoperability, we support the simplification of advancing care information reporting as well as improved interoperability. It is important to note, however, that the focus on data exchange for transitions of care and clinical data reconciliation result in a significant volume of data curation burden which falls on the backs of clinicians. The state of the standards and tools is resulting in a continuous “boomerang effect” of data exchange such that clinicians are being presented with increasing amounts their own data which has been reconciled at other locations as well as duplicative data that is only slightly semantically different from what is already in the receiving-clinician’s EHR. **The EHR vendor community should be encouraged to invest in advancing the capabilities of data reconciliation tools to reduce this burdensome volume of duplicate data curation.**

**Electronic clinical quality measures (eCQMs):**

**We applaud CMS for continuing to evaluate the current landscape and future direction of eCQMs.** We urge the agency to continue to engage those who must report the data in this activity. We strongly agree that any newly-adopted eCQMs be introduced with a testing period and recommend a two-year test period so that providers can understand their performance and implement strategy to improve performance before the results are included in public reporting or payment programs. Furthermore, CMS should adopt only measures that have been tested as electronic measures and received endorsement by the National Quality Forum. Consistent with CMS’s meaningful measures initiative, only a small set of important, valid and feasible measures should be required. And, measures should be continuously evaluated for their value and removed if they no longer serve a clear purpose. The variability of reporting requirements across payers also adds to clinician burden. As a major payer, we urge CMS to work with providers and other payers to standardize and streamline quality reporting requirements across payers.

**We also believe that ONC should improve its certification requirements for eCQMs to be more robust, resulting in systems that generate meaningful data with less effort. Furthermore, EHR vendors should be required to certify against all eCQMs, and not just those of the vendors’ choice.** Otherwise, providers cannot themselves choose what measures to report without paying additional fees.

**Public health reporting:**

**We urge HHS to recognize the need to better standardize and connect prescription drug monitoring programs across state lines.**  In addition to variation across states, Prescription Drug Monitoring Programs (PDMPs) generally are not easily integrated into EHRs, and access fees can be high. We urge ONC to work with PDMPs to improve integration into EHRs and sharing of data across states. We also urge ONC to consider the use of an open, standard application programming interface by PDMPs to enable a provider’s EHR to access the Schedule II opioid prescription drug history of a patient.

**Additional observations and recommendations:**

1.  No other country has the documentation required by the US.  Many of the current requirements are from a pre-electronic era, created originally to minimize fraud.    It's time to rethink what really needs to be documented at each visit.

2.  We need to ensure Medicare and Medicaid reporting requirements are the same, while reducing the number of quality measures and the burden of producing them.

3.  Instead of just requiring a patient-facing API, there needs to be some type of requirements for baseline API access without complex business models, IP constraints, and transaction costs. We should require that every EHR vendor make these APIs available (without transaction fees) so that third party innovators can create tools that reduce clinician burden.

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**In conclusion,** we congratulate ONC and its partner agencies on their work to reduce the burden of health IT for providers and stand ready to work with the agency moving forward.

I would be delighted to answer any questions or be of continuing service to you.

Sincerely,

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**Joint MMS – MHA Task Force on Physician Burnout**

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