

June 5, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Recommendations for Reducing the Burden of Clinical Documentation

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to recommend policies that would measurably reduce the documentation burden that clinicians face.

In the calendar year (CY) 2019 physician fee schedule (PFS) proposed and final rules, the Centers for Medicare & Medicaid Services “strived to reduce the significant burden associated with documentation for payment purposes.”¹ The AHA greatly appreciates CMS’s recognition of the documentation challenges that clinicians face and supports the agency’s efforts to free providers from repetitive documentation requirements and enable them to focus on the issues that are most pertinent to patient care. However, we believe more needs to be done to significantly reduce documentation burden, and we urge you to include additional policies, as described in detail below, in your CY 2020 PFS proposed rule.

As you have acknowledged, clinicians today face ever increasing documentation standards, which require them to spend significant portions of their days meeting detailed requirements. Research has found that primary care clinicians spend more than half of their workdays interacting with electronic health records (EHR), with a

¹ 83 Fed. Reg. 59452, 59628.



significant portion of that time occurring after hours.² The time spent documenting patient visits is time that providers cannot spend in face-to-face interaction with patients – negatively impacting patient care and provider well-being. **Several studies indicate that the increased time providers spend on EHR documentation – both during and after their workdays – is associated with lower career and work-life satisfaction, higher rates of burnout and poorer patient outcomes.**³

Specifically, the “depersonalization” aspect of burnout, which arises from providers interfacing with a computer instead of with patients, is associated with lower patient satisfaction and longer post discharge recovery time, after controlling for disease severity and other demographic factors.⁴ In addition, dense EHR communication patterns that replace regular and deep face-to-face communication between providers are associated with poor patient outcomes, such as less effectively controlled cholesterol levels and more emergency department visits.⁵ As shown in these studies, the patterns of EHR use that result from current documentation requirements are putting providers and patients at risk for real harm.

RETURN THE MEDICAL RECORD TO THE DYNAMIC PATIENT NARRATIVE IT WAS DESIGNED TO BE AND A TOOL THAT SUPPORTS PROVIDER-TO-PROVIDER INTERACTION

In light of the breakdown of the usefulness of EHRs due to the reasons described below, we strongly encourage CMS to explore ways to return the medical record to a tool that captures patients’ dynamic narratives and supports communication between providers. We commend CMS for beginning to make these changes in the CY 2019 PFS final rule by introducing separate payment for certain interprofessional consultations and by eliminating requirements that incentivize providers to repeat information entered by patients or staff, but more needs to be done to make these changes meaningful.

Specifically, we recommend CMS consider taking the following actions:

1. Remove requirements that result in providers repeating one another’s documentation and instead develop documentation and/or payment requirements

² Arndt, Brent G., et al. “Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations.” *Annals of Family Medicine* 15 (2017): 419-426.

³ Shanafelt, Tait D., et al. “Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction.” *Mayo Clinic Proceedings* 91 (2016): 836 – 848.

⁴ Halbesleben, Jonathan R. B. and Rathert, Cheryl. “Linking physician burnout and patient outcomes: Exploring the dyadic relationship between physicians and patients.” *Health Care Management Review* 33 (2008): 29-39.

⁵ Mundt, Marlon P., et al. “Effects of Primary Care Team Social Networks on Quality of Care and Costs for Patients With Cardiovascular Disease.” *Annals of Family Medicine* 13 (2015): 139-148.

that enable providers to produce a single, synthesized, dynamic patient narrative, such as by allowing a primary care or admitting physician to enter a patient's history and requiring subsequent providers to review and confirm the accuracy of the history and add only the information that may expand on or change the patient story.

2. Improve patient engagement and provider-patient interaction by allowing patients – who are the most knowledgeable about their own medical and social history – to input their information into EHR-linked systems and only require providers to review the information with the patient and make note of their review in the medical record, rather than re-enter the patient-entered information. In addition, allow patients to take advantage of this review process by only requiring they confirm the accuracy of their information, instead of having to fill out new forms at each unique provider visit.
3. Create policies that encourage the development of dictation technology to improve the narrative capabilities of medical records and allow patient information recorded in this manner to fulfill documentation and/or payment requirements.
4. Introduce meaningful payment for provider-to-provider interaction conducted within the bounds of the medical record.
5. Clarify existing documentation requirements to ensure CMS and providers share a common understanding of the information that must be documented in patient medical records under current requirements.

When many of today's physician and nursing leaders began their practice of medicine, they relied on the medical record as a means of communication with one another. In addition to details of their clinical decision making, these providers often included a patient's "story" in his or her chart, which demonstrated the thinking and analysis that led them to select a particular approach to care. Together, these elements allowed the patient's next provider to clearly understand his or her treatment history and served as an effective and efficient means of communication between providers.

Today, because billing is so heavily dependent on the medical record, providers are incentivized to focus on documentation that meets the requirements of each and every payer. The result often is lengthy medical records that obscure both the patient story and providers' thoughts around clinical decision making, leaving subsequent providers to act on confusing and sometimes conflicting information. And, to communicate the information that would actually be helpful for the patient's next provider, practitioners regularly need to send additional communications to one another, a time-consuming workaround that increases documentation burden.

Providers also face challenges when sharing records with patients. The Promoting Interoperability Program requires that hospitals give patients the ability to connect to their EHRs using an application of their choice. This option gives patients increased ownership of their medical records, but because providers are currently incentivized to over-document, patients – let alone other providers – barely are able to make sense of the extreme amounts of information stored in their records. Providers also are increasingly inundated with patient-generated data from wearable and other retail devices. These devices, which generally are more commercial than medical in nature, produce large amounts of information that is shared with providers, much of which may not be clinically accurate and is not necessary for them to deliver high-quality care. Recording this information in medical records significantly increases the amount of time that providers must spend with EHRs for little added value.

Requirements to separately and repeatedly record several elements of patient care also decrease the usability of medical records and take away from their ability to tell a patient's story. Currently, providers must record patients' history, their examination, any discharge instructions and other information as separate elements of the medical record. Moreover, many different providers face these same requirements and thus document the same information that other providers already have recorded. This format causes providers to continuously repeat each other in the medical record, producing an overflowing medical record that obscures the patient's narrative.

Thus, the promise that moving from paper to electronic documentation would make it easier for providers to retrieve data has not been fulfilled. Moreover, as providers move increasingly into silos to complete their required documentation, their communication with one another and with patients suffers, reducing the effectiveness of the EHR workaround and threatening quality of care.⁶ One study found wide-ranging impacts from the time and manner providers spend meeting electronic documentation requirements:

Performing [health information technology (HIT)] work in physically isolated spaces, clinicians worked in data silos, writing notes that colleagues from other professions were unlikely to read. HIT-induced social siloing was seen by ICU nurses and doctors as led by an increased focus on computer work that reduced familiarity. The perceived consequences of being unfamiliar, or socially siloed, were reductions in the following: clinicians' situational awareness beyond their professional expertise; communications that supported care coordination, as well as patient safety and quality updates, and opportunities to gather team wisdom and perspectives; and patient and family satisfaction as clinicians were seen as focused on the [digital patient] rather than the physical and social body in the bed.⁷

⁶ Leslie, Myles, et al., "An Ethnographic Study of Health Information Technology Use in Three Intensive Care Units." *Health Services Research* 52I (2017): 1330–1348.

⁷ *Id.*

For these reasons, and those you identified in the CY 2019 PFS rules, our members are ready and eager to work with you to restore the usefulness of the medical record to patient care and improve physicians' work experiences and patient outcomes in the process.

IMPROVE THE ACCURACY AND USABILITY OF MEDICATION LISTS

Medication lists are a key component of patients' medical records and also one of the components most fraught with conflicting and confusing information. Hospitals work hard to perform medication reconciliation in which they obtain information about medications a patient is taking prior to his or her hospital visit and continually review and update this information, checking for issues such as allergies and drug-to-drug interactions that could complicate a patient's care. These processes are required by CMS surveyors, and in the Promoting Interoperability Program. However, due to health systems having more than one EHR platform and patients visiting a variety of pharmacies, medication lists often are inaccurate. This presents serious patient safety concerns, with providers unable to verify the medications that patients are currently or have previously taken, making it difficult to update and/or create new dosages and prescriptions. In light of these concerns, providers must spend hours repeatedly sorting through patients' medications and prescriptions and inputting that information into medical records, only to have the next provider repeat the task.

A more ideal system would utilize cloud-based computing to enable real-time input and updating of medication lists, including the medications that the patient has been prescribed and those he or she actually fills and takes. Such a system could empower pharmacists to own the reconciliation process, as their more regular and consistent contact with patients generally means they have the most up-to-date information about which prescriptions patients are taking. This could eliminate the need for facility-based providers to review a patient's prescriptions at every visit.

While CMS cannot create these technologies on its own, we strongly urge the agency to put in place incentives to encourage or require vendors to improve EHRs in this space. Our members stand ready to work with CMS to develop the technologies and capabilities that would improve the safety and usability of medication lists. We also encourage CMS to consider using its authority under the Center for Medicare and Medicaid Innovation (CMMI) to conduct a demonstration to test shifting authority for medication lists to pharmacists.

IMPROVE THE SECURITY, PORTABILITY, AND MANAGEMENT OF PATIENT DATA BY TESTING THE USABILITY OF BLOCK CHAIN

Block chain technology offers the potential to systemically and significantly improve the way patient data is shared among providers. Specifically, block chains could allow

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secure access to patient records by any provider with the necessary private key. Block chain technology also would enable all users of a medical record to see real-time, synced updates, producing a medical record that contains a patient's entire medical history and that is always up-to-date. This could address some of the issues described above, such as the time providers spend re-entering into medical records information previously entered by another provider and conflicting and outdated medication lists, among many others.

We therefore urge CMS to use its CMMI authority to test the use of block chain technology to address some of the factors that contribute to providers' documentation burden, which could be accomplished by including it as an aspect of other demonstrations.

We appreciate your consideration of these ideas. Please contact me if you have questions or feel free to have a member of your team contact Shira Hollander, senior associate director of policy, at shollander@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President