January 29, 2016

The Honorable Lamar Alexander
Chairman of the Health, Education, Labor and Pensions
455 Dirksen Senate Office Building
Washington, DC 20510
Submitted via email to: HealthIT@help.senate.gov

RE: Feedback on Draft Bill BAI16031

Dear Senator Alexander:

Our thanks to you and your colleagues on the Senate Committee on Health, Education, Labor, and Pensions (HELP) for allowing feedback on Draft Bill BAI16031 related to improving the functionality and interoperability of electronic health record (EHR) systems, and to ease patient access to healthcare data.

The Association for Healthcare Documentation Integrity (AHDI) has been on the front lines of healthcare documentation since 1978, representing a community of 100,000-plus medical transcriptionists (now known as healthcare documentation specialists), serving as the primary means by which our nation's clinical documentation was generated.

Our long-standing, close working relationship with physicians engaged in the clinical documentation workflow has given us a unique vantage point from which to observe and comment on how the EHR workflow might be improved upon. For that reason, we are grateful for your invitation to provide feedback.

As an association committed to patient advocacy, we recognize the important role EHRs can have in helping move our nation to evidence-based medicine. At the same time, we are constantly being made aware—through research studies, Congressional and professional committee reports, media coverage, and other sources—that some aspects of EHR functionality remain a serious concern among a significant number of healthcare professionals.

Specifically, 30% of physicians who described themselves as "extremely dissatisfied" with EHR usage cite documentation workflow as the primary concern. Recent studies by RAND Corporation[1], The American College of Physicians[2], Medscape[3] and others have repeatedly shown that the two chief complaints most often cited by physicians with regard to EHR usage are both related to documentation: 1) EHR-based documentation modalities contribute to lost productivity; and 2) EHR-based documentation modalities have a negative impact on the physician-patient exam room dynamic.

We are extremely grateful to you and other members of the Senate HELP Committee for your tireless work in untangling the technology-related challenges in healthcare today. At the same time, we are concerned that Draft Bill BAI16031 does not adequately address the inefficiencies in EHR-based clinical documentation modalities, which are at the center of the storm in EHR dissatisfaction among physicians.

We would like to see the language of the Bill expanded to provide explanation of, and remedies for, these shortcomings of EHR usability.

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[1] Hirsch, Marla Durben. "RAND: EHRs 'Significantly Worsened' Doc Satisfaction." *FierceEMR.* 18 March 2014. 15 June 2014. <http://www.fierceemr.com/story/rand-ehrs-significantly-worsened-doc-satisfaction/2014-03-18>.

[2] American College of Physicians and AmericanEHR Partners. "Survey of Clinicians: User satisfaction with electronic health records has decreased since 2010." 5 March 2013. 25 January 2016. *American College of Physicians.* <http://www.acponline.org/pressroom/ehrs_survey.htm>.

[3] Medscape. "EHR Report 2012: Physicians Rank Top EHRs." *Medscape.* 23 August 2012. 25 January 2016. <http://www.medscape.com/features/slideshow/EHR2012>.

As clinical documentation experts, we see a number of contributing factors that help explain the underlying causes of the dissatisfaction physicians experience related to EHR-based documentation workflows:

1. **Over-emphasis on structured data**. We affirm the importance of structured data in evidence-based medicine but disagree that the structuring of all—or even the majority of—data resulting from the patient encounter constitutes the best practice for clinical documentation. In complicated medical cases, free-form narrative plays a critical role in providing comprehensive documentation of the patient's treatment.

In a 2015 position paper, the Medical Informatics Committee of the American College of Physicians recommended that "The clinical record should include the patient's story in as much detail as is required to retell the story."[4] The paper went on to state, "The ideal note would facilitate hybrid documentation by allowing physicians to efficiently capture the patient narrative and supplement it with context-sensitive, template-driven data that enhance, rather than detract from, the clinical record's relevance as a communication tool."

Furthermore, a chief complaint among patients is the erosion of the physician-patient exam room experience since the adoption of EHRs. This negative impact to patient satisfaction is an unfortunate unintended consequence of physicians' attention being diverted to handle data entry within the EHR.

Another common complaint among patients accessing their medical records via online healthcare portals is the high level of nonsensical content present as a result of EHR-based

[4] Basch, P; Barr, M; Kuhn, T; 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." 17 February 2015. 22 January 2016. *Annals of Internal Medicine.* <http://annals.org/article.aspx?articleid=2089368>.

templates and poor documentation habits.[5] This concern is likewise shared by physicians and was well articulated in a recent *Huffington Post* blog by Dike Drummond, M.D., in which he complained that "template-based notes degrade the quality of clinical documentation."[6]

We respectfully submit that the inclusion of qualitative information can provide important assistance in improving outcomes, including bringing about better continuity of care—especially when patients are treated by a team of healthcare providers.

Recommendation: *We respectfully request the inclusion of wording in BAI16031 stating that a balanced combination of structured and unstructured data could improve productivity for some physicians, provide clinically-important detailed information to the healthcare delivery team, and restore a more patient-centric exam room experience.*

2. **When technology blocks physicians' options.** Physicians who continue using dictation and transcription often do so at a high cost. Transcribed documents require an interface to connect technology systems and import medical records into the EHR. Interface fees can range from a few hundred dollars to tens of thousands of dollars, depending on the EHR vendor.

Interface fees effectively function as a barrier to entry for many physicians, obstructing them from choosing the documentation modality they feel is best suited to their practice of medicine and delivering quality patient care. As documented in *Modern Healthcare*, EHR-based interface fees remain a significant barrier to achieving the national goal of an interconnected healthcare industry.[7]

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[5] Bobrow, Robert. "Your Electronic Medical Record is Filled with Gibberish." *Huffpost Healthy Living.* 19 January 2016. 27 January 2016. <http://www.huffingtonpost.com/robert-s-bobrow-md/your-electronic-medical-record-is-filled-with-gibberish_b_9017840.html>.

[6] Drummond, Dike M.D. "9 Reasons Doctors Hate Their EMR." *HuffPost Healthy Living.* 25 January 2014. <http://www.huffingtonpost.com/dike-drummond/electronic-medical-records_b_4319674.html>.

[7] Conn, Joseph. "Fee Frustrations: Connecting EHR systems too pricey, providers say." *Modern Healthcare.* 27 July 2013. 25 January 2016. <http://www.modernhealthcare.com/article/20130727/MAGAZINE/307279974>.

In addition, our concern is that some EHR vendors might charge interface fees as a *de facto* tool for information blocking, influencing the discontinuance of transcription as a documentation modality through its control of access to the patient record. A cursory review of EHR websites[8] (see footnote below) demonstrates how EHR companies have based their value proposition in part on the elimination or reduction of transcription costs.

A recent study showed that of the estimated 2.1 billion patient encounters documented in the United States in 2015, approximately 32%, or over 670 million documents, were generated by dictation and transcription.[9] We estimate that nearly a third of all U.S.-based physicians continue to use dictation and transcription for some percentage of their clinical documentation. Furthermore, HIMSS Analytics predicts a 200% growth of in-house medical transcription in 2016.[10] This figure clearly indicates that a significant number of physicians have definable workflow-related reasons to continue their use of dictation and transcription.

In short, some EHR vendors may have abused their role as gatekeeper to the patient record by creating barriers to limit the documentation options available to physicians, thereby hampering interoperability among healthcare technology vendors and potentially impacting patient safety.

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[8] for examples see:

Practice Fusion: http://www.practicefusion.com/health-informatics-practical-guide/

Cerner: http://www.cerner.com/uploadedfiles/md_powernote_dragon_casestudy.pdf

Allscripts: http://www.network-systems.com/products/ehr.php

Meditab: http://www.meditab.com/ehr-solutions/

[9] WebChartMD. "Transcription Market Share Analysis." *WebChartMD.* 2015. 25 January 2016. <http://webchartmd.com/resources/clinical_documentation_market_by_modality.pdf>.

[10] HIMSS Analytics. "17 Technologies Shaping Hospitals Buying Plans in 2016," slide 12 of 15. *HIMSS Analytics.* 25 January 2016. <http://www.himssanalytics.org/news/17-technologies-shaping-hospitals-buying-plans-2016>.

Recommendation: *We respectfully request the inclusion of wording in BAI16031 which acknowledges that interface fees may serve as a barrier by preventing physicians from choosing the documentation modality they feel is best suited to their patient care practices. Vendors of EHRs and other healthcare technology applications should be required to simplify and streamline a physician's ability to use dictation and transcription in conjunction with their other healthcare technology applications. Additionally, interface fees should be abolished in order to level the playing field, ensuring a physician's right to choose the documentation modality she or he feels is best suited to her or his practice of medicine.*

3. **When physicians handle data entry rather than delivering patient care.** Accurate, high-integrity documentation of patient care does not happen in a vacuum, nor can it be accomplished by placing that documentation burden solely on the shoulders of the physician. Ensuring the integrity of clinical documentation will continue to require a partnership between physicians and the documentation team—highly skilled, analytical healthcare documentation specialists who provide risk management support in capturing healthcare encounters and making sure they are documented and formatted in a way that promotes clinical clarity and coordinated care. A certified healthcare documentation specialist or certified medical transcriptionist can ensure accurate documentation of those care encounters and identify gaps, errors, and inconsistencies in the record that may compromise care or compromise compliance goals.

Certified healthcare documentation specialists and certified medical transcriptionists are a best-fit, ready-made solution to ease the documentation burden from physicians. It is AHDI's strong position that the existing healthcare documentation workforce should be deployed in any setting where clinical encounters are being documented to preserve the integrity of health information.

Recommendation: *We respectfully request the inclusion of wording in BAI16031, which expands the definition of "non-physician members of the care team," to include certified healthcare documentation specialists and certified medical transcriptionists.*

Proposed Amendments

We would like to propose the following changes to BAI16031 to address the above-mentioned concerns:

1. Change the existing language related to ‘‘SEC. 13103. ASSISTING DOCTORS AND HOSPITALS IN IMPROVING THE QUALITY OF CARE FOR PATIENTS, section 1(c) (Draft Bill Page 5) to include the phrase “or to a professional association offering credentialing in healthcare documentation,” to now read:

‘‘(c) APPLICATION OF CERTAIN REGULATORY REQUIREMENTS.—Notwithstanding any other provision of law, clinical documentation requirements that are imposed upon health care providers by Department of Health and Human Services regulations may be delegated to non-physician members of the care team as permitted by State licensure and State medical and health professional board regulations, or to a professional association offering credentialing in healthcare documentation.

2. That the proposed amendment to Sec. 13103 (2) Strategy (Draft Bill Page 4) be expanded to include: “(L) activities related to improving the clinical documentation experience;”

3. That new content be added to the bill focused specifically on improving the clinical documentation workflow. Since studies and physicians testimonies all point to the inefficiencies surrounding this one key area of the EHR, let’s focus on the problem and take steps to improve it. We propose an expansion of the current bill to include that content. We respectfully recommend that the responsibilities of the HIT Advisory Committee include reviewing and making recommendations on improvements needed to EHR-based clinical documentation workflows. (Draft Bill Page 33)

4. That the (D) Conditions of Certification section, item (iii) (Draft Bill Page 10) be expanded to add the phrase “at no or nominal cost” as follows:

"(iii) health information from such technology may be exchanged, accessed, and used through the use of application programming interfaces or successor technology/standard at no or nominal cost as provided for under applicable law."

5. That Section 3009A. Health Information Technology Rating Program, section (a) be expanded to include a representative from the AHDI, or, at least, be included as a stakeholder as defined in (C), (D), (I) and (J).

6. That Section 3022. Information Blocking (a) definition be expanded to include under (1) (IN GENERAL), (A)(ii) (Draft Bill Page 22) the addition of "or the use of non-EHR based workflow applications," as follows:

"(ii) the developer, exchange, or network knows, or should know, are likely to interfere with or prevent or materially discourage the access, exchange, or use of electronic health information, or the use of non-EHR-based workflow applications;"

7. That Section 3022. Information Blocking (a) definition be expanded under (2) (RULEMAKING) (Draft Bill Page 23) to include a new section:

"(C) identify actions that meet the definition of information blocking as it pertains to possible discrimination against workflow applications based outside of the EHR which are dependent on interfaces for inclusion in the EHR-based workflow."

8. That Section 3022. (b) INSPECTOR GENERAL AUTHORITY (Draft Bill Page 23) shall be expanded to include a new section:

"(iii) engaged in setting price levels for interfaces which act as a deterrent to a physicians' ability in selecting the most appropriate workflow applications which he or she deems most suitable for documenting patient care."

9. Under Section 5 Interoperability, that the definition provided in the new paragraph (10) be expanded to include the phrase "and do so at minimal or no cost." (Draft Bill Page 27)

   "(10) INTEROPERABILITY.—The term 'interoperability' with respect to health information technology means such health information technology that has the ability to securely exchange electronic health information with and use electronic health information from other health information technology without special effort on the part of the user, and do so at minimal or no cost."

10. That Section 3002 Health Information Technology Advisory Committee, paragraph b.1.B (Draft Bill Page 37) be expanded to add a new paragraph:

    "(IX) Technologies or applications that reside outside the EHR and that interface into the EHR, which enhance or augment the workflow already present within the EHR;"

11. That a representative of AHDI be given the opportunity to participate as a member of the HIT Advisory Committee. (Draft Bill Page 43)

Thank you, Senator Alexander, for the opportunity to share our perspective and recommendations with your committee. Please don't hesitate to contact us with any questions you might have. We look forward to an ongoing dialog regarding these very important issues.

Respectfully,

Jay Vance, CMT, CHP, AHDI-F
2015-2016 President
Association for Healthcare Documentation Integrity

Linda G. Brady, CAE
Chief Executive Officer
Association for Healthcare Documentation Integrity