American College of Physicians
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Karen DeSalvo, MD, MPH, MSc
National Coordinator for Health Information Technology
Acting Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Dr. DeSalvo,

We applaud you and ONC for this exceedingly thoughtful strategic plan for Federal Health IT for 2015 - 2020. This strategic plan makes it clear that ONC has carefully considered, and in many instances modified their approach, based on comments and criticisms on the earlier draft plan. We particularly appreciate that this plan has abandoned the draft plan's unwavering focus on data, data exchange and systems, and instead re-focuses health IT more appropriately as a means to an end – essentially as evolving infrastructure that supports the health and healthcare of people.

Secondly, this new plan clearly calls out what it is, and what it is not. Namely, it is not meant to be the sole author for national health IT strategy in support of better care; it is only addressing what the federal government can and should do. This is a very welcome shift in focus, as for the last five years, other stakeholder groups have been relegated to reacting to proposed regulations, rather than being able to participate as full partners - jointly responsible for the ultimate success of health IT's insertion into healthcare delivery.

Third, this plan highlights nontechnical barriers toward health IT's opportunity to help support better care; barriers which transcend data, data standards, and health information exchange. Specifically, we appreciate this plan's acknowledgement that the current focus on achieving better interoperability can go only so far. Other factors, such as workflow and technology innovations – enabled by payment reform (or at least not impeded by current payment policy) are also necessary.

Fourth, this plan adds necessary nuance to the case for standards and technical interoperability, acknowledging the importance of narrative to both patients and clinicians. Patients expect and deserve to be heard, and being heard can be circumvented by a

requirement for all information to be structured. And from a clinician's perspective, the last several years has provided us a rather disquieting preview of the world of structured documentation – scribble may have been replaced by legible notations, but what is legible reads more like a receipt from a grocery store – and communicates nothing. It is clear that clinicians need to continue to produce and transmit cogent narrative – and health IT must support and not stand in the way of this clinical imperative.

Fifth, this plan re-casts health IT's role in the learning health and healthcare system from what was previously positioned as a data input system that supplied data to researchers, to one that is meant to foster collaboration and continuous learning, innovation, and improvement.

The ACP accepts Dr. DeSalvo's offer of stakeholder partnership and will work with our members and others in the healthcare provider community on advancing health IT and its use to make care better - particularly in areas that are specialty specific, and thus outside of what federal policy can address. That said, as a stakeholder partner committed to seeing health IT achieve its potential, we wish to call out three shortcomings in the federal strategic plan that may impact our ability to be successful with our companion plan. We further point out one area of disagreement with the federal plan that we believe may place expedience over patient safety.

The first shortcoming we would like to note is that this new plan refers to the need to have an "efficient" health IT infrastructure, and one that promises to free clinicians (in particular) of unnecessary administrative burden. We have previously discussed how even mediocre health IT would be better received if it actually was useful in helping to reduce day-to-day practice operational burdens – what some estimate to take approximately 43 minutes out of each clinician's day . And yet the only place where the plan specifically addresses the potential for federal policy to influence private payers lays out the converse – that private payers could adopt the same rules of participation in their plans that Medicare and Medicaid use – essentially creating what may be additional burden, and with no promise of working toward reducing administrative burden. Every minute spent on resolution of unnecessary administrative burden is a minute taken away from caring for patients, as well as distracting clinicians from what they should focus on – which is delivering on the promise of health IT to help to make care better, safer, and more value laden. It is disappointing and indeed a lost opportunity that this plan does not make the use of health IT to reduce unnecessary administrative burden a key priority - as we as clinicians cannot do this on our own.

The second shortcoming also is in the realm of efficiency – that of documentation burden. ONC is rightfully concerned about electronic health record (EHR) usability, as even years after adopting EHRs, many clinicians still struggle with inefficient system operation during encounters and the need to spend more time on post-visit documentation. A major contributor to this inefficiency, a legacy provider payment system that all but requires verbosity – adding time and effort to the documenting clinician, and reading burden to the next clinician of record.

While ONC cannot change what CMS and other payers require to support billing purposes, it could at least acknowledge the problem and perhaps even work with other stakeholders in our effort to make health IT better serve the needs of patients and families – and not what it has largely become today – a vehicle for legible but unnecessarily verbose notes with much noise and little meaningful signal.

The third shortcoming is that this new plan describes the learning health and healthcare system in ways that should make clinicians want to participate, given that the learning health and healthcare system is now framed as a collaboration between clinicians and researchers. Further, this plan "envisions the establishment of a responsive health IT infrastructure." While we believe this is exactly the right stance and the right conclusion – we cannot easily reconcile what it suggests with the reality of what is described for Stage 3 of Meaningful Use – which as currently proposed, utilizes prescriptive process measures forever – essentially describing a fixed infrastructure that is impervious to the future findings of the learning health and healthcare system.

Finally, we feel obliged to comment on the opening headline to this plan, "…the only way for health IT to achieve its full potential is when it unobtrusively supports individuals as they strive to reach their full potential for health." While we appreciate ONC's sensitivity to a common criticism of health IT usability – essentially that health IT gets in the way where is should be working in the background; we believe there are times, particularly where patient safety is at stake, where it is absolutely essential that health IT indeed be very obtrusive. For example, if a patient has a life threatening allergy to penicillin and the clinician forgot this and ordered it anyway, we would expect the health IT system to make this potentially fatal error obvious to the patient and clinician.

In a post-MU world, specialty and professional societies must step forward to lead and to own the plan that gets clinicians and patients beyond the basics of having tools and making data liquid. We are proposing a positive, incremental path toward a new healthcare environment, where health IT stands the greatest chance of achieving its full potential – helping to make care better, safer, and more value laden.

Sincerely,

Peter Basch, MD, MACP
Chair, Medical Informatics Committee
American College of Physicians