January 24, 2019

Don Rucker, MD, National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
US Department of Health and Human Services
330 C Street, 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,

The American Psychiatric Association (APA), the national medical specialty society representing more than 38,500 psychiatrists who treat mental health disorders, including substance use disorders, appreciates the opportunity to submit feedback to the Office of the National Coordinator's "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. The APA is fully supportive of the overall structure geared toward reducing burden within the draft Strategy, with the goals of enhancing the patient experience, improving population health, and reducing costs by addressing the burdens surrounding clinical documentation, health IT usability and the user experience, EHR reporting, and public health reporting.

The APA would like to use this opportunity to highlight some psychiatric-specific burdens frequently endured by our member-psychiatrists as they relate to the four aforementioned domains ("Issues and Challenges") and offer recommendations on how the ONC can incorporate them into the final iteration of the Strategy.

## Clinical Documentation

The APA is supportive of the ONC's strategies to reduce clinical documentation burden associated with use of health IT in clinical care. Reducing regulatory burden around documentation requirements for patient visits; continuing to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements, and leveraging health IT to standardize data and process around ordering services and related prior authorization processes are all strategies that could help to mitigate the many burdens around clinical documentation that psychiatrists experience in daily practice. Some specific examples of these burdens are:

    1. *Documentation in the EHR*: EHRs possess features that potentially can make the practice of medicine easier (e.g., electronic prescribing, electronically sending patients messages and educational materials) and help physicians to measure the patient encounter at the point of care. Unfortunately, physicians are spending more time documenting the encounter in the EHR relative to the amount of time spent face-to-face with patients. According to a recent article in the *New England Journal of Medicine*, summarizing several studies, "for every hour physicians spend with patients, they spend one to two more hours finishing notes, documenting phone calls, ordering tests, reviewing results, responding to patient requests, prescribing medication,

and communicating with staff." This is at least one factor in "burnout rates…twice as high in medicine as in other fields."

These burdens are certainly applicable to psychiatrists. Here are some examples highlighted by our membership as particularly burdensome:

a. *The CMS Documentation Guidelines for Evaluation and Management (E/M) services*: Adhering to CMS' E/M Documentation Guidelines require a significant amount of physician time in the documentation of the patient encounter. Prior to the adoption of E/M Guidelines, a succinct progress note summarizing all pertinent clinical information and decision-making would have been sufficient documentation for record-keeping and billing purposes. Under the E/M structure, however, psychiatrists must now document specific numbers of clinical elements under the Guidelines in order to bill and be reimbursed at a certain level. ***Thus, under the E/M coding system, documentation becomes arbitrarily complex and litters the note with superfluous information without improving patient care in any useful or measurable respect.* The APA supports the ONC's recommendation to "partner with clinical stakeholders to promote clinical documentation best practices" and offers assistance in identifying psychiatrist-experts should the ONC convene a panel of consensus-forming stakeholders on this issue.**

Similarly, the requirement that attending physicians working with nurse practitioners must also rewrite most elements of the note to conform to CMS requirements (especially the history of illness and mental status exam) represents an additional burden. This redundancy in documentation makes working with Nurse Practitioners more time-consuming than is necessary and does not improve patient care. This issue is highly relevant in an era where more psychiatrists are working within integrated care settings. **The APA supports the ONC's recommendation to "leverage data already present in the EHR to reduce re-documentation in the clinical note," as well as partner with CMS on its documentation requirements, in order to mitigate this burden.**

b. *Prior Authorization:* According to a recent report by the American Medical Association, 92 percent of physicians report that "prior authorization programs have a negative impact on patient clinical outcomes." Indeed, the AMA study revealed that "every week a medical practice completes an average of 29.1 prior authorization requirements per physician, which takes an average of 14.6 hours to process—the equivalent of nearly two business days." The APA echoes these results, noting that prior authorization requirements to insurers generally result in an extensive amount of required paperwork to be submitted, multiple phone calls back-and-forth to insurance companies, and significant wait times for prior authorization, resulting in delayed or disrupted medical care for patients.

For instance, phone-based peer-to-peer reviews conducted are typically scheduled on short notice at the convenience of the payer and can require significant amounts of time to complete. Other utilization reviews are also time-consuming for administrative staff and require providing significant amounts of information on a frequent basis. ***The APA supports ONC's recommendations under its Clinical Documentation strategy, especially to "evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization," and "support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data***

*elements, and real-time standards-based electronic transactions between providers, suppliers, and payers." The APA recommends that CMS work with APA technical experts to spearhead development of a streamlined, asynchronous process for such reviews that could be done electronically, without frequent and lengthy phone conversations. The content of required information must be standardized amongst all payers to facilitate this content's integration into electronic workflows.*

Furthermore,  EHR certification criteria should include the ability to handle prior authorizations efficiently within the e-prescribing workflow. *Prescribers should be able to require that prescription-related information from payers and pharmacies be transmitted electronically rather than via mail or fax*, to reduce confusing (and potentially unsafe) duplications in communication.

*Electronic strategies around reducing burden in prior authorization determinations should include having them being made available to the prescribing physician rapidly and at the point of care — especially in the case of denials — with a clearly delineated process for real-time appeals.*

### EHR Reporting

The enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Federal Health IT Strategic Plan (2015 – 2020) has been successful in driving the adoption of basic Electronic Health Record (EHR) systems as well as certified EHR technology among acute care hospitals, academic centers and large group practices. Nevertheless, uptake among psychiatric hospitals and solo and small group providers continues to lag behind. The time associated with purchasing and integrating an EHR system as well as upfront and ongoing costs remain barriers to EHR adoption by psychiatrists. Many psychiatrists also have found that there are too few certified EHR solutions geared toward mental health practices. Specifically, the EHRs that are targeted to most small group and solo practitioners (i.e., primary care providers) do not mirror the workflows of psychiatric practices, whereas EHRs that are intended for smaller mental and behavioral health practices are not economically motivated to pursue ONC certification.

1.  *Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR Reporting* Programs. **The APA supports this strategy and recommends that the ONC continue to explore opportunities to partner with standards organizations (e.g., using HL7's FHIR), to facilitate this process. Using these industry-approved best practices for data mapping and adopting data standards that makes access to and extraction of data would make integration across and between health systems and small-group/solo providers less financially and administratively burdensome.**

2.  *Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.* Regardless of practice type and size, most EHR software designs do not facilitate efficient or effective psychiatric care, resulting in time-consuming, practical adaptations by psychiatrists and their support staff. In addition, EHRs generally do not possess clinical quality measures germane to psychiatric care.  These factors, among

others, have resulted in lower rates of EHR adoption by psychiatrists, which ultimately hamstrings their ability to be successful under the Merit-based Incentive Payment System (MIPS') Promoting Interoperability performance category. **The APA appreciates the reduction in patient-driven measures, as detailed in the 2019 PFS PI category, and supports the ONC's recommendation to "simplify the scoring model for Promoting Interoperability performance category" as a way to continue to reduce the burden associated with this program.**

3. *Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.* With respect to this strategy, APA would like to highlight three categories of clinician burden that could be mitigated through adoption of this strategy: Compliance, Administrative, Implementation.

- **Compliance burden**: *The responsibility of physicians to successfully submit voluminous amounts of quality measures into disjointed quality programs.* This burden is particularly high and poses additional difficulties for psychiatrists, as they <u>are often limited in the quality measure data they can report due to the limitations of EHRs that omit certain data elements included in psychiatric electronic-Clinical Quality Measures (e-CQMs).</u> One particular difficulty is that psychiatrists are responsible for reporting e-CQMs, but by virtue of their contractual work, they do not own the patient data, and therefore cannot report provider-level quality measures through the facility's EHR system, nor can they import the data into their own practice's EHR system.
    - o **The APA supports the ONC's recommendation to "explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives" in order to address the technological issues associated with the above burdens.**
- **Administrative burden**: *The imposition on clinical and personal time caused by the steadily increasing time commitment associated with quality measure data collection.* Not only are the voluminous amounts of quality programs and measures which psychiatrists and others are expected to participate in time exhaustive, but they increasingly impede on clinical encounter time. For instance, if <u>an EHR does not capture the necessary data elements required to report the e-CQM (as noted in the above section on burdens inherent to the PI category of MIPS), efforts are made to submit proxy data</u>. This takes additional time and effort and may unintentionally alter the level of quality demonstrated by the measure.
    - o **As mentioned above, we support the ONC's continued efforts toward increased interoperability between EHR technologies by employing universal standards, such as FHIR.** This would help to alleviate administrative burden by capturing data elements frequently included in cross-cutting eCQMs and thus would allow such elements to be used by psychiatrists in reporting. We recognize that data elements specific to mental health specialty measures may not be included for mainstream implementation in general medical facilities, but certain data elements are more frequently collected and assessed by eCQMs appropriate for mental health providers' utilization. By leveraging common standards such as FHIR to potentiate interoperability, and by reducing the need for proxy data, eCQM results will be more robust and informative of the quality of care administered as well as help to mitigate related costs.

- **Implementation burden**: *The ability for a practice to integrate data collection processes and data extraction into the clinical workflow.* Given that psychiatrists have been slow adopters of EHR systems in practice, as noted above, there has likely been a similarly slow uptake and pace of modifications made to psychiatrists' workflow for the inclusion of e-CQMs in practice. Further tied into the other types of burden is that many psychiatrists—especially solo or small group providers—have limited or no support staff, depending on each particular practice. This limitation in practice often prevents the e-CQM from being implemented at the point of care, which invalidates the very benefit of using e-CQMs and making them "meaningful" to the patient encounter. Likewise, many psychiatrists also may not have a plan for data extraction and use after the information is collected.
  - **As above, the APA remains supportive of the ONC's efforts to increase interoperability using existing standards. If successful, implementation burdens have the potential to be greatly reduced. For example, manual chart review is often still need to extract necessary information from progress notes or other sections of the chart. This task often falls to the clinician who lacks adequate support staff who might assist in this process. Better interoperability— including appropriate meta-data tagging of quality information within the progress note — and EHR usability would help to substantially alleviate this burden.**

## Public Health Reporting

1. *Federal agencies, in partnership with states, should improve interoperability between EHRs and PDMPs through the adoption of common industry standards, consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules.* Improving interoperability between these two systems is paramount; however, the integration of these two systems is a challenge due to the various legal hurdles between individual states sharing information as well as the lack of data standardization within the collaborative data network between state PDMPs. Thus, using PDMPs remains burdensome: clinicians must leave the screens of the EHR, log into the state PDMP web site, search for each patient's name, and then return to the EHR to complete their task. Therefore, **the APA supports this recommendation, particularly in light of the ongoing opioid crisis, as well as for its value to overall clinical care.**

2. *HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.* **The APA's position is that the regulation governing the transmission of substance use disorder information (42CFR Part 2) should be aligned with HIPAA privacy requirements for treatment, payment, and operations (TPO) purposes. The APA recommends that the ONC continues to work with HHS and the legislative branch of government to develop commensense, technological solutions based on standards (e.g., data segmentation; complete disclosures and record access audit trail transparency) in order to better align HIPAA with 42CFR Part 2.**

The APA appreciates the opportunity to offer feedback to the ONC from the perspective of the psychiatric physician community on the myriad burdens encountered every day during routine practice in using EHRs. The APA looks forward to working with ONC in helping ONC in reducing clinician burden in the use of EHRs, and also the "burden-to-burnout" phenomenon experienced among clinicians of all specialties. As you consider ways to reduce physician burden, please use the APA as a resource.

If you have any questions, please feel free to contact Nathan Tatro, Associate Director of Digital Health, at (202) 559-3680 or ntatro@psych.org.

Sincerely,

Saul M. Levin, MD, MPA
CEO and Medical Director
American Psychiatric Association