AMERICAN PSYCHIATRIC ASSOCIATION

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October 15, 2018

Dr. Donald Rucker, National Coordinator for Health Information Technology
ATTN: EHR Reporting Program Request for Information
Mary E. Switzer Building, Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Dear National Coordinator Rucker:

The American Psychiatric Association (APA), the national medical specialty society representing more than 37,800 psychiatrists who treat mental health disorders, including substance use disorders, appreciates the opportunity to submit feedback to the Department of Health and Human Services' (HHS) Request for Information Regarding the 21st Century Cures Act Electronic Health Record Reporting Program. The APA is fully supportive of the myriad ways in which the Office of the National Coordinator (ONC) has endeavored in recent years to attain the "Triple Aim" of enhancing the patient experience, improving population health, and reducing costs. We also applaud ONC's commitment to improving the work life of health care providers (the "Quadruple Aim") among its priorities. Unfortunately, many psychiatrists are still experiencing significant burdens with respect to using electronic health record (EHR) systems meaningfully in practice.

The APA would like to use this opportunity to respond broadly to some facets of the Electronic Health Record Reporting Program specified in the Cures Act and underscored in this RFI. Namely, our letter will focus on **usability and user-center design** and how these may be improved upon in general, and specifically for psychiatry, by information collected by users and developers for the proposed EHR Reporting Program.

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 ONC Certified Electronic Health Record Systems geared toward mental health practices. Specifically, EHRs often do not accommodate specialized workflows across psychiatric settings (e.g, emergency, inpatient, partial hospital), subspecialties (e.g., child psychiatry, geriatric psychiatric, addiction psychiatric, consultation psychiatry), treatment modalities (e.g,. group psychotherapy, electroconvulsive therapy, transcranial magnetic stimulation), and practice models (e.g., integrated care, multidisciplinary team-based interventions).. Further, EHRs that are intended for smaller mental health and addiction practices are not economically motivated to pursue ONC certification, which sometimes disincentivizes providers who use these systems from participating in the Medicare program in order to avoid financial penalties to their practice.

To that end, the APA would like to highlight several ways in which the proposed EHR Reporting Program may help to illuminate areas of improvement among systems that are certified, with respect usability and user-centered design.

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, ubiquitous legibility of documentation, the inherent capacity to view documentation offsite) 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.

Some of this burden could be mitigated by the reduction of complicated—and often redundant—documentation requirements related to quality reporting programs (e.g., various requirements of both the Joint Commission and CMS conditions of participation), documentation specific for the Medicare program for different clinical roles within a practice, E/M coding requirements and inpatient multidisciplinary treatment plan requirements, the latter two of which are not well supported for psychiatry in most EHRs. **Requiring the EHR Reporting Program to have vendors work with clinician-expert partners to identify areas where the same level of data could be streamlined and/or easily imputed based on a minimal number documented entries/steps would be helpful in ameliorating the burden associated with these various reporting programs.**

Seamless Integration of Prescription Drug Monitoring Databases with EHRs: **As a cross-cutting issue between vendors and clinicians, the EHR Reporting Program should collect information on how well EHRs integrate with PDMP databases and how much time it takes for clinicians to complete this documentation in the patient record.** By collecting this information and making it transparent, the APA hopes that it might incentivize vendors to begin using a common standard and/or legislators to mandate a solution.

The APA acknowledges that 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. However, clinicians are currently burdened by having to 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. This is time-consuming and results in fragmented patient data.

The ONC should establish benchmarking for common clinical tasks in EHRs and these benchmarks should be reported through the EHR Reporting Program. When selecting an EHR, it would be helpful to have baseline data on how systems compare to each other with respect to the *time* and *subjective ease* it takes to complete common tasks, such as finding a patient, completing a chart review, messaging a patient, electronic prescribing, creating and documenting a progress note, and so on. Per this RFI, the ONC indicates that it will "engage a contractor to convene stakeholders and use the responses to this RFI to inform stakeholder discussion in order to formally develop…criteria" around the EHR reporting program. **The APA recommends that the ONC also contract with an entity to perform such benchmarking using sample workflows tested with sample participants.** Such benchmarking could be completed for a discrete set of clinical tasks within EHRs for specialties and would provide helpful information to specialty providers when selecting an EHR. Examples of such benchmarks

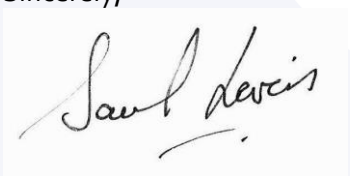
include the time and subjective ease required for "breaking the glass" for access to sensitive information, retrieving external health systems' charts (e.g., requesting, downloading, and viewing notes from other regional health systems), finding and contacting the primary care provider, tracking medication history longitudinally (including long-acting injectable or implanted medications).

Include information from providers and vendors on the privacy/security features of EHRs. While the APA generally advocates for providers to have access to all records (especially when it comes to patient substance use disorder information), there are scenarios where it would be useful to granularly mark/tag specific patient information as confidential, when appropriate. These are not unique to psychiatry, and apply, for example, to the care of adolescents, to reproductive health issues, and to the care of individuals who are known to health system employees (e.g., current relatives, ex-spouses, neighbors, locally prominent people, public figures, etc.). **The APA recommends that vendors and providers report on their EHR's capacity to perform such granularization of data.** For products that are not capable of performing these functions satisfactorily, these could be built around the Family Health History standard (170.315 (a) (12) 2015 CEHRT) or, the ONC could make required the DS4P sending and receiving standards (170.315 (b) (8); 170.315 (b)(8), 2015 CEHRT), rather than making them optional for vendors, in future iterations of the EHR Certification Program.

Please identify any sources of information that were not in the EHR Compare Report that would be helpful as potential reporting criteria are considered. In addition, please comment on whether any of the sources of health IT comparison information that were available at the time of the EHR Compare Report have changed notably or are no longer available. **The APA recommends including the Healthcare Information and Management Systems Society (HIMSS) EMR Usability Evaluation Toolkit in the type of information that should be included in the EHR Reporting Program[1]. The APA also recommends including our APA Mobile Application Evaluation Toolkit.** As many EHRs contain patient-facing portals, the App Evaluation Toolkit offers helpful information for both providers and patients on the type of information that should be considered before using a specific application to manage health data.[2]

Thank you for this opportunity to submit feedback to this Request for Information. The APA looks forward to continuing to engage in a robust dialogue with the ONC on behalf of its membership and their patients around the unique technological challenges and needs when providing quality psychiatric care.

Sincerely,



Saul Levin, MD, MPA

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[1] https://www.himss.org/himss-emr-usability-evaluation-toolkit

[2] https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model