May 3-4, 2016

# Improving Health Information Technology

**Senators should include in the Improving Health Information Technology Act (S. 2511) additional reforms to reduce the burdens associated with the Electronic Health Records (EHR) meaningful use program and clinical documentation requirements and to enhance usability and interoperability, as described below in the "What's ACP's view" section. House members should include these elements in comparable legislation, as developed by the Energy & Commerce Committee.**

## What's it all about?

Health information technology (health IT), including EHRs, can be instrumental in improving patient care and reducing costs. Unfortunately, much of the potential value of health IT is being lost due to the myriad of federal regulatory and administrative requirements placed on the clinicians and others who must operate this technology. It may seem intuitive that an EHR would be more efficient in improving workflow, enable more face time with patients, and otherwise improve the delivery of care. However, in reality, EHRs lack standards that are needed for systems to be able to talk to each other in a way that is meaningful. In many instances, clinicians are required to input data into these records that have little to no clinical value. The costs associated with the systems that support EHRs can be exorbitant. And, there is a need for EHR developers and vendors to do more to improve the usability, functionality, and interoperability of their products. All of this has a chilling effect on patient care because clinicians now often have their heads buried in a laptop, having to contend with onerous reporting requirements and dysfunctional EHR systems rather than spending time with patients.

## What's the current status and why should Congress address it?

Medicare Access & CHIP Reauthorization Act (MACRA): There is an urgent need for Congress to do more to address the continuing problems with the Medicare EHR Incentive program, known as meaningful use (MU), as it transitions to the new Merit-Based Incentive Payment System (MIPS) created by MACRA. MU has resulted in mass adoption of EHRs and, to some extent for some clinicians, has led to positive changes to workflow and patient engagement. However, these initial positive changes have now given way to most physicians expressing deep dissatisfaction with the program and its impact on making their EHRs less useful and functional. In fact, the current approach to measuring attainment of MU is not only unnecessarily burdensome, but fundamentally flawed. See ACP's comment letter on the stage three final rule. Under MACRA, the current MU program will end and be incorporated into the new MIPS program. MIPS combines and streamlines the three distinct current-law incentive programs, the Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and MU, into one reporting program. Physicians who participate in MIPS will receive positive or negative adjustments to their Medicare Part B fee-for-service payments starting in 2019 (although it is expected that 2017 will be the reporting period for determining their 2019 MIPS payments). MU must be completely re-designed as it becomes integrated into the MIPS program.

Interoperability: ACP strongly supports the improvement of interoperability between clinical IT systems in order to ensure that health care is truly person-centered, with the right care provided at the right time, to the right person. To date, the term interoperability has been defined as the ability to securely exchange and use electronic health information, with a focus being on the idea that sharing more data is the best approach—rather than ensuring that the data shared are actually meaningful, usable, and actionable. The Senate Health, Education, Labor & Pensions (HELP) Committee introduced and approved bipartisan legislation in February, the Improving Health Information Technology Act (S. 2511) to improve Federal requirements relating to the development and use of EHR technology. Original sponsors include: Sens. Alexander, Cassidy, Murray, Whitehouse, Hatch and Bennett. ACP submitted detailed recommendations to the committee in February on the legislation, prior to its introduction, including outlining the need for truly meaningful and carefully implemented interoperability that:

- Ensures direct input from practicing clinicians into the development of national EHR interoperability standards that incorporate the necessary data elements for care delivery and quality improvement.
- Effectively prohibits information blocking, typically defined as interfering with the ability to share patient data whenever permitted by law, in a way that protects clinicians, particularly those in small/medium-sized practices, from any unreasonable costs associated with facilitating the transmission of health data. These EHR interfaces can be expensive and do not always provide clinical value.

Usability:  The ability of EHRs to collect, display, and share usable information among clinicians and with patients and families is directly impacted by coding and other regulatory requirements.  Template driven documentation originated as a consequence of the 1995 and 1997 Evaluation and Management (E/M) Documentation Guidelines—which redefined the cognitive office visit by what was *documented*, rather than what service is actually provided.  EHRs then digitized these templates and created software to make sure that what was required for a particular E/M CPT code was addressed within the patient record, losing the patient's story along the way.  Further, this approach to documentation makes it easier to generate large amounts of repetitive and sometimes inaccurate information, rather than a cogent and concise patient history.  ACP views this as problematic, as the purpose of clinical documentation should return to supporting excellence in patient care.

## What's ACP's view?

ACP supports the HELP committee's ongoing efforts to develop and advance such comprehensive health IT reforms. As the full Senate prepares to consider and vote on S. 2511, ACP recommends that (at a minimum) the following improvements be added and that the House develop similar companion legislation:

**Redesign the EHR Meaningful Use program so as to integrate it into MACRA's new Merit-Based Incentive Payment System (MIPs).**  ACP supports the Further Flexibility in HIT Reporting and Advancing Interoperability Act (FLEX-IT 2 Act, HR 3309), which was introduced by Rep. Renee Ellmers (R-NC) on July 29, 2015. ACP's support letter for the FLEX-IT 2 bill can be viewed here.  S. 2511 only requires HHS to work with stakeholders to develop a *strategy* to address MU burdens, so incorporating the reforms in HR 3309 is a good first step.

**Require the Office of the National Coordinator (ONC) to develop and implement national EHR interoperability standards *with direct input from practicing clinicians* on the necessary data elements for care delivery, quality improvement and reporting, including the need for a narrative that provides the context of the care needed; Require EHR vendors to adopt said standards.** While S. 2511 charts a path for a voluntary framework to national interoperability standards, it should also include direct participation from clinicians on what data elements are most critical for efficient care delivery.

**In the context of efforts to prohibit "information blocking," exempt clinicians in small/medium-sized practices from any unnecessary and unreasonable costs associated with the purchase of any health IT software, services or infrastructure that support data exchanges with little or no clinical value, as determined by the Secretary with input from practicing physician stakeholders.**  S. 2511 is problematic in that practices could be found to be engaging in information blocking (and punished) simply by refusing to purchase expensive interfaces that might be used rarely, if at all, and it provides for no exemptions from unreasonable costs.

**Establish a process to require that CMS and other relevant federal agencies reform or replace the existing E/M documentation guidelines with input from practicing clinicians and in collaboration with their professional organizations.**  ACP supports the provision in S. 2511 that requires development of a strategy to reduce regulatory or administrative burdens, including activities related to reporting clinical data for administrative purposes. ACP also urges House members to adopt this provision in companion legislation.

## Who can I contact to learn more?

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