Statement of

SAUL LEVIN, M.D., M.P.A.

CEO AND MEDICAL DIRECTOR

On Behalf of the

AMERICAN PSYCHIATRIC ASSOCIATION

For the

COMMITTEE ON WAYS AND MEANS
Subcommittee on Health

Exploring the Use of Technology and Innovation
To Create Efficiencies and Higher Quality in Health Care

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10:00 a.m.

On behalf of the American Psychiatric Association (APA), the national medical specialty society with over 36,500 psychiatric physicians nationwide, I write to submit into the record a statement with respect to the hearing on September 14, 2016, held by the Ways and Means Committee, Subcommittee on Health: *Exploring the Use of Technology and Innovation to Create Efficiencies and Higher Quality in Health Care*. The APA thanks Chairman Tiberi and Ranking Member McDermott for holding this hearing and facilitating a discussion on this important topic.

The APA believes that health information technology (HIT) systems can play a pivotal role in improving patient safety and quality of care. However, in order for that goal to be fully realized for psychiatric medicine, several barriers must be overcome, including a lack of true interoperability, the originating site restriction under Medicare, and lingering burdens unique to psychiatry in the Advancing Care Information (ACI) category – also under Medicare.

The lack of true interoperability between HIT systems arguably remains the largest challenge facing providers and policymakers today. Some barriers to achieving true interoperability are unique to psychiatry, while others are ubiquitous across the electronic health records (EHR) landscape. Interoperability is predicated on the idea that the patient's record should follow them wherever they go, geographically speaking, without restriction between health systems and providers. This idea has yet to become a reality primarily because larger EHR vendors view this as a direct threat to their business models, which often center on data collection and retention. Consequently, smaller EHR vendors, including those who focus on mental illness and substance use disorders, encounter challenges when designing systems since there is little to no incentive for larger vendors to cooperate with them. Thus, psychiatric patients' records are often kept separate from other health records, preventing the patient's full health history from being reviewed in one place.

The Office of the National Coordinator (ONC) for Health Information Technology has taken some steps to addressing the above issue, but both Congress and ONC could do more by developing a single performance standard for interoperability. Such an action, whether taken through legislative or regulatory means, could ensure that all vendors, large and small, have fewer reasons to compete and more incentive to share data, because a single performance standard could be based around payment reform. Such a standard would have to be designed in a way that does not place any undue burden on smaller vendors, especially those designing systems for mental health.

True interoperability would lead to increased quality of care for psychiatric patients who are at risk for continued readmissions due to poorly controlled symptoms of various disorders. Better HIT systems that share information across practices could find patterns to patients' readmissions (i.e., psychosocial reasons for decompensating; medication non-compliance; persistent suicidal ideation, etc.) and thus be able better to prevent repeated presentation at the emergency department.

Another barrier to HIT is the originating site restriction under Medicare, which restricts a patient setting to a clinical site, such as a doctor's office, outpatient facility, or hospital. Eliminating the restriction would be of particular benefit to psychiatry and the in-home treatment of mental illness and substance use disorders. This would especially benefit patients with

chronic/persistent diseases, as well as those with conditions that have demonstrated greater efficacy of treatment for telepsychiatry vs. in-person care. Furthermore, eliminating the originating site restriction would broaden access to psychiatric medicine for the treatment of mental illness in general by eliminating the stigma of going into the office for treatment.

Finally, the Advancing Care Information (ACI) category, which carries over many facets of the Meaningful Use program, still carries substantial administrative burdens unique to psychiatry compared to other specialties. Specifically, the objectives around engaging the patient within the EHR (e.g., View, Download, Transmit; Secure Patient Messaging, etc.) is a challenge for psychiatry due to the inherent symptoms in various psychopathologies that make this type of behavior difficult (e.g., major depressive disorder; schizophrenia and other cognitive disorders). Many psychiatrists practice within solo or small group settings and have slow to adopt EHRs, compared to the high level of adoption by large hospital systems, as reported by the ONC. The reasons behind this tend to be that the EHRs that are specifically designed for mental health are lacking in functionality that would allow the psychiatrist to use the system in a "meaningful" way, as defined by the ACI. EHR systems designed for larger practices tend to be expensive and require greater administrative support to bring online into practice and to integrate into existing workflows, which also is a reason as to why psychiatrists have been slow to adopt. Thus, not having an EHR results in a "zero" score on the ACI category, which will disproportionately, negatively affect small/solo providers, and may force some to decline Medicare patients.

The APA applauds the Subcommittee's attention to the important issue of health information technology, and we look forward to staying engaged with you moving forward. If you have any questions, please contact Ariel Gonzalez, Chief of Government Relations, at agonzalez@psych.org.