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**STATEMENT OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CMS-ONC Listening Session: EHRs and Documentation Challenges**

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My name is Ivy Baer. I am Senior Director, Regulatory and Policy Group at the Association of American Medical Colleges. The AAMC represents all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans' Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians.

Today I will talk about documentation challenges posed by the use of EHRs combined with a health care system that is moving from fee for service and individual provider reimbursement to payment for team-based care that meets quality metrics and reduces cost. I will focus on the special complexities that confront institutions when they use the EHR while simultaneously caring for patients; teaching residents, medical students and other learners; and conducting research. For example, in an academic medical center the number of individuals who touch a medical record—whether it be paper or electronic—is large, both because care is more likely to be delivered by a team and because of the presence of learners who need to become competent in the use of EHRs.

Teaching hospitals have been early adopters in the national commitment to electronic health records (EHRs), which many consider essential for high quality, safe, and coordinated care. According to the latest available data, in 2011, 99 percent of Council of Teaching Hospitals and Health Systems (COTH) members and 96 percent of non-COTH teaching hospitals have EHRs.

Academic medical centers ~~have~~ are at the forefront of many innovations in care delivery that often are dependent on the use of electronic health records. While AAMC member institutions account for less than 6 percent of all hospitals, they constitute a much larger percentage of participants in reforms sponsored by the Centers for Medicare and Medicaid Services (CMS). For example, AAMC members make up:

- 44 percent of Health Care Innovation Award grantees;
- 34 percent of the Innovation Advisors Program;
- 18 percent of all CMS ACOs;
- 38 percent of Pioneer ACOs; and
- 17 percent of Medicare Shared Savings Program participants.

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These and other efforts are in support of what we all are familiar with as the triple aims: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. As leaders in EHR adoption and use, academic medical centers also have had the opportunity to identify ways in which the current Medicare rules, and the movement toward new ways of care delivery, are inconsistent with the goals of better care, teaching future generations of physicians, and conducting research, especially for population health and comparative effectiveness.

Let me start with the EHR and patient care and provide some background. In the latest-1990's, with the growing focus on compliance, the purpose of the medical record shifted from its original purpose-- a document that was necessary to communicate patient care delivery -- to an encounter document that had to support any service billed, justify medical necessity (even when events took place months ago and by another provider) and support Joint Commission and conditions of participation (CoPs). At the time, this was consistent with a payment system designed for fee-for-service, per provider, payment. As the medical record was viewed as the source for billing that role seemed to overshadow the role of the medical record as the source for good patient care. Today we are at yet another juncture, where the electronic health record is being envisioned as a tool for managing care across providers and across settings; as a teaching tool; and as a powerful source for meta data in the research arena for managing population health and conducting clinical effectiveness research.

Understanding the challenges posed by electronic health records, the AAMC's Compliance Officers Forum began a multi-year project of developing advisories to help guide members as they implement and use EHRs with a focus on the challenges of ensuring compliance with Medicare's rules—all developed when paper was the only medium available-- in an electronic environment. The development of the advisories involved many hours of discussions that lead to the conclusion that there is no single way to achieve what one of the Advisories describes as “appropriate clinical documentation to support quality patient care, facilitate the optimal and efficient use of available documentation, and simultaneously provides controls to ensure compliant data usage in support of billing.” As a result, they look at a myriad of strategies that combine the need for appropriate EHR design, adoption and implementation of institutional policies, provider education, and monitoring. One of the advisories states that “much of the mitigation of risk rests on policy and training directed at the judicious use of tools [that are available in the EHR].” For example, it may be easy to cut and paste a portion of a note written during another visit that is pertinent and accurate for today's encounter. Re-use of previously documented EHR information should not be categorically impugned as fraud, but should be viewed as a time-saving tool that allows the physician to spend additional time with the patient, such as past medical history or family history. How the documentation guidelines for coding contributes to “note bloat” will be commented upon later in my testimony.

The AAMC was very pleased when the ONC Meaningful Use and Certification Adoption Workgroups recommended the use of a feature similar to track changes to “help the reader assess accuracy and find relevant changes by making the originating source of sections of clinical documents transparent.”¹ The committee saw this as a tool to combat fraud and abuse. What was not noted is that seeing this

¹ Clinical Documentation Hearing Recommendations Meaningful Use and Certification and Adoption Workgroups, Office of the National Coordinator for Health Information Technology, March 26, 2013

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merely as a tool to combat fraud and abuse diminishes the potential of the EHR as providing value to patient care, teaching, and research.

As physicians and other health care professionals expand the use of electronic health records, perhaps the optimal time for them to learn how best to use them is while they are students. Thus, the EHR has the potential to be an important teaching tool. Medical students and other clinical students must learn to use the health record to document succinctly their observations and findings, become comfortable with its importance in providing high quality health care, and understand that the data in it supports patient care, communication with the care delivery team and may be a tool for researchers.

However, for billing purposes, current Medicare rules limit the use of a medical student's documentation to review of systems and past family and social history. Being alert to the potential compliance issues that may arise when medical students enter any additional information into the EHR, some AAMC members feel it is necessary to limit the information that medical students can enter into the EHR; others allow medical students to enter a full note but keep it in a separate part of the medical record so that it cannot be used for billing purposes. Anecdotally, there are reports from some medical students that the limitations on the use of their note makes them feel less of a team member, and this at a time when team-based care also is something that they must learn to provide. Some organizations have called for the adoption of medical student competencies in the use of electronic health records², a recommendation that would be hard to implement under current Medicare rules.

The answer about to how to treat student notes is not simple, but it is noteworthy that a Medicare rule, written in the time before electronic health records and team-based care, is now seen as a barrier to training our future healthcare workforce. If the ONC recommendation for a track changes function—or something similar that would make readily apparent which note was entered by a medical student—has the potential to open the EHR as the important learning tool that it should be. A medical student's ability to readily view changes made to his/her note by a resident or attending physician would be an important learning opportunity, especially when paired with a discussion about why the changes were made.

Moving beyond track changes could be a requirement that the EHR must identify the author of all entries. While I cannot comment on the technological feasibility of this, it would be wonderful to reach the point where there would be a certification criterion that would make every medical student note appear in red, or somehow be readily distinguishable from other entries, and that this feature could be extended to everyone who enters information into the medical record. This would free institutions from the fear of allowing medical students into the electronic health record and would help build the type of future workforce that is needed.

This one example underscores the issue that, our payment systems—both governmental and commercial—are moving from fee-for-service reimbursement to payment that is based on quality and other metrics, and optimal care is being delivered by teams of people. The documentation requirements must change from supporting billing that is based on individual level of effort (the

² Hammoud, Maya M., et al, Medical Student Documentation in Electronic Health Records: A Collaborative Statement from the Alliance for Clinical Education, *Teaching and Learning in Medicine*, 24(3), 257-266.

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current evaluation and management system) to supporting payment for care that is provided by a team and is expected to meet metrics related to quality and cost.

For example, one item that should be on the CMS agenda is an in-depth reassessment of the foundations of the evaluation and management (E/M) guidelines. Under the current coding requirements for evaluation and management services, developed in 1995 and 1997, each note must include information that is generally stagnant (or stable) and viewable/updateable elsewhere in the EHR. This clutters the note and detracts from the assessment/plan documentation which reflects the clinical judgment and treatment plan of the physician. CMS rules should recognize that EHRs store prior information, which can be marked as reviewed or updated as needed. To repeat this information in the body of the encounter note for the sole purpose of E/M documentation and billing renders the note less useful for quality patient care. As with many Medicare requirements, these two E/M Guidelines should be revised and modernized in recognition of EHR technology, reduce burden on providers, and increase the accuracy—and therefore the usefulness—of data entered in the electronic health record.

But no matter how good the technology, its uses are limited if all aspects of the payment system do not support care that is being provided and paid for in a new way. CMS has been undergoing reviews of the CoPs which are outdated and/or burdensome, and has been proposing revisions. This same process could be applied to documentation rules to determine which ones should be removed or revised. Physicians, in particular, have the choice of documenting to evaluation and management codes from 1995 or 1997. In the many years since those codes were developed, care has changed. I urge CMS to undertake a full review of these codes and to work with the physician community to ensure that they are current and reflect the care being provided in the 21st century.

Finally, I need to mention that the electronic health record has the potential to provide a wealth of information for researchers. However, when researchers think about the potential richness and vastness of data collected by an electronic medical record they are confronted by the issue that the quality of the data available is only as good as the quality of the data entered. Researchers need assurances that the data are correct if they are to use the electronic health record as a source for managing population health and doing comparative effectiveness research. This suggests that physicians and others who enter the data need to be educated about the importance of accurate data entry which can be seen as a way to help them manage patient populations and to help those who are engaged in comparative effectiveness research. For research, as for clinical care, interoperability is essential. Systems that are not able to talk to each other hinder research and may make data comparisons inaccurate. It also is important to remember that whenever patient information is used, the privacy and security of that data must be maintained. Above all, consistency in data is needed. CMS and ONC can provide this by working with stakeholder to develop standards that can be used locally and nationally to improve the health of our citizens.

The AAMC and our members are pleased that CMS and ONC are listening to those struggling with the current rules. Our hope is that listening will become action and that working together we can find avenues to move the health care system forward, with the electronic health record reaching its full potential as a key instrument for patient care, teaching, and research.

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AAMC Compliance Officers' Forum EHR Compliance Advisories are available at:

<https://www.aamc.org/download/253810/data/medicalstudentdocumentationinanehr.pdf>

<https://www.aamc.org/download/253810/data/medicalstudentdocumentationinanehr.pdf>

<https://www.aamc.org/download/316610/data/advisory3achallengefortheelectronichealthrecordsofacademicinsti.pdf>