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Improving Electronic Health Record Adoption in Psychiatric Care: A Cornerstone for Healthcare Transformation

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Psychiatric illnesses—mental health and substance use disorders—are prevalent, disabling, and costly to patients, their families, our communities, and healthcare system. By age 29, over half of Americans will have experienced impairing and clinically significant psychiatric illness.¹ The Interdepartmental Serious Mental Illness Coordinating Committee, the new federal inter-agency committee authorized by the 21st Century Cures Act, delivered additional staggering statistics to Congress this past December.² For example, one in 4 adults with psychiatric illness has a co-occurring substance use disorder and 1 in 6 has misused opioids in the past year. Also, individuals with psychiatric illness have much higher rates of medical comorbidity—resulting in lower life expectancies and 2–3 times higher healthcare costs.

The report provides a clarion call and blueprint for how to improve the healthcare and lives of individuals with psychiatric illness—which includes promulgating evidence-based integrated healthcare, performance measurement, and early identification. But a glaring omission in the report threatens to impact many of the goals of the Committee, the 21st Century Cures Act, and healthcare reform more broadly. Specifically, how will the federal government form a coordinated response to improve electronic health record (EHR) adoption in psychiatric care?

EHRs represent a key component of healthcare redesign. However, their adoption in psychiatric care lags far behind the rest of medicine.^{3, 4} Therefore, psychiatric providers (e.g., psychiatrists, psychologists, licensed clinical social workers and counselors) often lack

access to patient healthcare information, assistance with drug-drug interactions, and other clinical decision support. New models of healthcare coordination and integration are hampered because they demand electronic health information exchange between psychiatric and medical providers. Furthermore, patients with psychiatric illnesses are disproportionately unable to benefit from a learning healthcare system that will use EHR data to discover etiologies and early warning signs of psychiatric illness, and determine how best to improve outcomes. We believe three prominent barriers to adoption in psychiatric care must be addressed: inadequate financial incentives/assistance for psychiatric providers; complex privacy law and regulation; and misalignment between unique psychiatric clinical workflows and EHR design.

Meaningful Use (MU) financial incentives accelerated adoption in medical settings by helping to defray costs. However, psychiatric hospitals were ineligible; and while psychiatrist ambulatory providers were eligible (like other medical providers), psychiatrists are mostly in solo or small group practices,⁵ which makes affordability of EHRs more challenging. Additionally, psychologists, licensed clinical social workers, and counselors provide care to people with psychiatric illnesses, but like other non-physician healthcare providers, were not included in the MU incentive program. Increasingly, federal health policy focus is towards EHR interoperability to enable health information flow across providers—which is a very important goal. However, interoperability will have limited benefit for patients with psychiatric illness if adoption in psychiatric settings remains poor.

Also, psychiatric treatment has a much more complicated privacy regulatory environment than most of medicine. In other areas, providers must follow the Health Insurance Portability and Accountability Act (HIPAA) regulations, and notably, HIPAA does not require patient authorization to share information for treatment purposes. However, psychiatric providers are governed by more stringent and varied state and federal laws requiring patient authorization to share information, even for treatment (e.g., the federal 42 Code of Federal Regulations (CFR) Part 2, which governs information from substance use disorder programs). Despite these requirements, EHRs have limited ability to accommodate individual patient preferences (i.e., authorization) for information sharing. Federal efforts to address this have been focused on updating 42 CFR Part 2 to be more like HIPAA, and piloting EHR technology that allows patients to control who receives their Part 2 covered health information. However, the technology remains limited, and federal efforts towards Part 2 ignore the role of state privacy laws (which often are more restrictive than federal requirements). Additionally, removing patient authorization is controversial with patients concerned about discrimination and stigma experienced in healthcare and elsewhere related to their illnesses. The debate between those who would like privacy laws to align with HIPAA and those concerned about its effects on patient treatment-seeking behavior often fails to sufficiently acknowledge legitimate points and concerns on both sides.

Finally, psychiatric care has key elements not found elsewhere in medicine which are challenging to accomplish in EHRs and could be developed by vendors. For example, multidisciplinary treatments plans—a regulatory requirement in psychiatric care—largely have not yet been developed and the ones that do exist are unworkable. Also, residential and partial hospital are important levels of care unique to psychiatry that don't fit neatly into the

clinical, scheduling, or billing workflows of inpatient or ambulatory care, yet have received little vendor development attention to date.

These challenges would all be amenable to course corrections through national policy. We have three specific recommendations to address them.

First, federal attention should focus additional efforts on developing EHR capability to better delineate patient preferences for health information sharing. This would enable EHRs to meet federal and state psychiatric privacy law requirements and respect patient informed consent and autonomy in how their health information is used. Concern about how sensitive health information is shared is also relevant for other health issues, such as HIV or sexual assault. More robust EHR capability respecting patients' preferences would more broadly improve patient confidence in the privacy of their health information.

Second, Congress should enact an incentive program to facilitate EHR adoption in psychiatric care. This would foster competition among vendors for this largely untapped market, and spur innovation in EHR usability for psychiatric care. While there may be little appetite currently in Congress to allocate new funds for an incentive program, it should do so if it is serious about redesigning healthcare to improve quality and efficiency. Psychiatric care struggles with discriminatory financing practices and policies, and reimbursement rates lower than other health care services (and often lower than cost).² Expecting psychiatric providers to adopt EHRs without financial assistance, as was furnished to other healthcare providers, risks both an inability to provide higher quality and less costly healthcare and/or exacerbating the existing shortages of psychiatric providers if some providers are unable to stay solvent if required to adopt EHRs without financial assistance.

Third, the Department of Health and Human Services (HHS), through interagency collaboration between the Centers for Medicare and Medicaid Services and Office of the National Coordinator for Health Information Technology should provide a timeline for vendors to develop and implement robust EHR tools that enable patients to control the sharing of their health information as part of future HHS EHR certification criteria. Vendors could begin development *in advance of and in concert with* a psychiatric hospital/provider incentive program. This would create incentives for vendors to compete for the psychiatric market, and give psychiatric hospitals/providers options to purchase an EHR that meets their privacy and clinical needs.

To achieve the goals of the 21st Century Cures Act, and more broadly improve quality and reduce costs, healthcare must better address the complex needs of patients with psychiatric illnesses. We will not achieve these goals if EHR adoption in psychiatric care continues to lag far behind the rest of medicine.

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