About the AMA’s Debunking Regulatory Myth series
Featured topic and speakers

In this episode of the AMA STEPS Forward® podcast, Kevin Hopkins, MD, primary care medical director at Cleveland Clinic and senior physician advisor for practice transformation at the AMA, and Lindsey Carlasare, the AMA’s research and policy manager, discuss common regulatory myths and share tools for eliminating guesswork and other administrative burdens.

The AMA’s Debunking Regulatory Myths series provides regulatory clarification to physicians and their care teams. Visit Debunking Regulatory Myths to read more or submit a myth for us to tackle next.

Speakers

- Kevin Hopkins, MD, primary care medical director, Cleveland Clinic; senior physician advisor for practice transformation, AMA
- Lindsey Carlasare, research and policy manager, AMA

Host

- Jennifer Mathews, communications manager of professional satisfaction and practice sustainability, AMA

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Transcript

Speaker: Hello and welcome to the AMA STEPS Forward® podcast series. We’ll hear from health care leaders nationwide about real world solutions to the challenges that practices are confronting today, solutions that help put the joy back into medicine. AMA STEPS Forward® program is open access and free to all at stepsforward.org.

Mathews: Hello and thanks for joining us today. My name is Jennifer Mathews. I'm going to be our podcast host and today we are discussing the AMA’s Debunking Regulatory Myth series. And today I'm being joined by guest Dr. Kevin Hopkins, who is primary care medical director at Cleveland Clinic, and a senior physician advisor for practice transformation here at the AMA, and Lindsey Carlasare, research and policy manager at the
AMA. Dr. Hopkins, Lindsey, thank you both so much for being with us today.

**Dr. Hopkins:** It's a pleasure. Thanks, Jen.

**Carlasare:** Thank you so much for having us. We appreciate the opportunity to talk with you about this work.

**Mathews:** I'm excited to discuss it, too. I think it's a really great series that can help a lot of people and I really want to make sure people know about it. So, with that in mind, I guess, why don't we just start there. If you could let the listeners know exactly what the Debunking Regulatory Myths series is and what the impetus behind it was.

**Carlasare:** Sure. So, I'll take this one. As you know, health care is one of the most heavily regulated industries in the United States. And with that said, while regulations are well intended and serve many purposes, they often create confusion and sometimes even create excess work and administrative burdens for physicians in practice leadership. So as the AMA began its work years ago to identify and address the drivers of burnout and the contributors to professional dissatisfaction, we identified several themes. And one was that it was common for there to be confusion or misinterpretation around certain processes that originated out of regulations and standards. Sometimes the interpretation of these regulations, for example, in particular those managed by compliance officers, they lead to overly conservative internal policies and procedures. Which, as we know—and which became the impetus for the DRM series, or Debunking Regulatory Myth series—these can inadvertently create extra and unnecessary work for the care team. So, the AMA established the Debunking Regulatory Myth series to help reduce confusion and clarify these common misunderstandings about how regulations and policies should be translated and put into practice.

**Mathews:** Where is the disconnect, Dr. Hopkins? Do you know what exactly is causing the confusion in the first place between the intent behind the regulation and then the execution of it?

**Dr. Hopkins:** I think there's several factors included in that, Jen. One is determining whether something that we've been told or accepted as a regulatory requirement is truly in fact a regulatory requirement or not. There are many things that in our everyday functions within our health care organizations that we’re told or communicated that, well, we need to do it this way because this is a regulatory requirement. So, I always encourage people when they're told that or when they hear that type of statement or phrase to ask some specifics about it. Which agency is this from? What's the intent of it?

And then also working with our compliance folks as far as what their interpretation of it is. As Lindsey mentioned, there's oftentimes then associated organizational policies which are developed to augment or to keep us distanced from crossing a line as far as a regulatory requirement. And they're meant with good intent, but we oftentimes put handcuffs on ourselves and limit workflows within our organizations with those good intentions. So, asking questions to help us understand why this is a policy or a regulatory requirement can help us better understand the difference between sort of the letter of the law and the spirit of the law. I always think starting with asking why can help to remove some of that disconnect and confusion, and yet we're all so busy that I think we don't often enough take time to do that.

**Mathews:** Yeah, that makes a lot of sense. In terms of building this series, how did you guys decide where and how to start this series and which myths to tackle first?

**Carlasare:** So, I would say most of the current myths that we have published stem from conversations with collaborators, some of our research partners, AMA members, some of our physician advisors. So, it's been fairly grassroots to this point. We actually do have a simple email mechanism on the website for readers to submit ideas to us that can be found on the Debunking Regulatory Myths website, on the homepage. We know that the best source of information on these is the physicians and the practitioners that actually deal with the issues in
practice. So, I think that to this date the bulk of content development has been from conversations with physicians and people actually in the action. Some of the decisions made around how we publish, or which ones we publish, we go through a series of questions and we ask ourselves, is there actually a myth here? Is it a common misunderstanding or is this one person who was confused about something?

And then we also think about can this be answered clearly and concisely? Because sometimes we go down a discussion path of, well, yes, this is true, but if your organization has X, Y, Z payer, then it's not true. Or if your physicians are treating this kind of patient, then no, they don't have to follow that. If there's all these if-then statements in the development of our debunking, then we have to pause and think about whether or not we can really clarify this as well as we want without just creating more confusion for people. So that's really been a deciding point for us is whether we can actually truly debunk something concisely for people instead of making a bunch of if-then statements to make it more clear for people.

So, Dr. Hopkins, you might want to add a little bit to that part too, about the decision process on what we publish.

Dr. Hopkins: Well, Lindsey, first of all, I was going to say I really appreciate what you just said about the confusion that can be added just by the nature of the fact that we're dealing with regulatory requirements. And your answer actually might have been a better answer than the one I delivered for the previous question, as far as what contributes to the confusion and misunderstanding.

If you've ever tried to read CMS standards and regulations or Joint Commission standards, it's complex medical legal jargon. So it's very easy to get lost in the statements—after reading a couple of paragraphs my eyes tend to glaze over and I get lost in it. And this is something Lindsey and I are working with on a regular basis. So, your average physician or health care worker out there is just not going to probably engage in going to the CMS website and looking up the regulations. We're going to take it based on faith from our compliance office, but Lindsey's right, most of our topics have come from things that have been raised by physicians in practice, whether that's through our website or through speaking engagements that we do or coaching sessions and mentoring with health care systems across the country that are all struggling with very similar challenges. I think now of some of the workforce challenges that we're having and needing to be more efficient in our daily work. So if we can remove some things from our day-to-day task list that may not be required any longer because of updates or changes to regulations, then that benefits everybody, including the patient.

So we try to prioritize this list and we keep an ongoing list of things in the pipeline, but we're always looking for new topics. Some of the ones that we've worked on recently or are currently working on are things that honestly have come from my own clinical team and clinical experience, those things where you think, goodness, why do I have to do this this way? And every time I sign this form, I think about it and yet I don't ever have time to do anything about it. Those are the types of issues, topics we'd love to hear from listeners and AMA members about. And then we'll take the time to do the research and find out if that's something that can be resolved.

Mathews: I think that's a great service to offer, and we will link to the particular website page in the description of this podcast, so people know exactly where to go. So if they have a myth that they want to submit for consideration.

Carlasare: I also was just thinking about something else that I should have mentioned that we've had a couple of topics come up through policies adopted by our House of Delegates. And we've had delegations submit obviously hundreds of resolutions over the years that highlight topics and points of contention or confusion as they go through trying to maximize their practices. So recently we've had a couple come through policy, the policy avenue. So I wanted to just mention that we're always looking for ways, non-traditional ways to have these ideas, and the policy's been an important one.
Dr. Hopkins: We also work closely with the AMA advocacy group because as you might imagine when it comes to policy and regulation, there's a lot of need for advocacy for our providers, our caregivers and our patients. And some things aren't myths. And I would say if people have topics or subjects they would like us to take a look at, you don't necessarily have to know if it's a myth or not. That's something we will try to figure out. Some of the things that we research, we find out, yep, actually this is a regulatory requirement, but it doesn't make sense from this perspective, and this is something that we ought to advocate for change with the advocacy arm of the AMA.

Mathews: So, what are examples of some of the myths that have already been tackled in the series?

Dr. Hopkins: Some examples that come to mind easily for me are those related to documentation burden. The EHR is a complex and often challenging tool for us to use in our daily work. There are hundreds and thousands of clicks to be made in order to accomplish anything in the EHR. So anything that can be done to help us work smarter, not harder, more efficiently, I find to be incredibly valuable.

So, some of the things that come to mind in that realm include some myths about EHR documentation, who can document in the electronic health record as far as caregivers on the team? Does it all need to be done by the physician? What can ancillary staff or even patients document in their own electronic health record? What is actually required from governmental agencies and regulations around things like computerized provider order entry and verbal orders? We tackle those types of questions and myths that are things that people have understood to be true for a long while but may not really be true from a regulatory standpoint.

Such as statements like, well, no one except the physician can document in the EHR for the visit node of an ambulatory patient encounter. That's something that's just simply not true. And so, we give some guidelines and then link to other tools and resources through the AMA STEPS Forward® program to help folks understand more about who can do what part of the documentation.

Another segment of topics in the DRM series I'll mention are those relevant to coding and billing. So there have been changes that have been made by government regulatory agencies over the last couple of years to help simplify and make the process of billing and coding more efficient. And yet we tend to not always use the most up-to-date guidelines, whether it's from a clinical medical standpoint or it's from a documentation, coding and billing standpoint. So, it's in our best interests as physicians and in the best interests of the organizations for which we work, and our patients too, to make sure that we're billing and coding our visits accurately.

So things like, do commercial insurance companies need to accept updated E&M billing and coding requirements, meaning the 2021 updates, to bill on medical decision-making alone or on time spent alone, rather than including all the history and physical exam bullet points that we're used to from the 1995 and ‘97 billing and coding guidelines? Statements like, “You're not able to bill for both preventative and acute or chronic disease E&M services within the same ambulatory outpatient visit.” That's not true. And so we get into that when we debunk those myths and then again, link to other tools and resources from the AMA STEPS Forward® toolkits to help understand more.

Carlasare: We also had the opportunity to debunk a myth that was more relevant to the business side of running a practice which was unique among the rest of the myths. And that was actually one that resulted from a policy that was adopted regarding responding to online reviews from patients or members of the public. So, it was an interesting one to work on because there has been a myth perpetuated that physicians are prohibited outright from responding to patients or anyone that leaves a review, like a Google review or a Yelp review about their practice, which is not the case. And so we were able to dig in a little bit about what they are prohibited from doing and how they can still respond and protect their business but remain compliant with HIPAA and protect the patient's privacy while trying to do the best to mitigate effects of bad reviews online. So that one was an interesting one and one that I thought was unique in its perspective about the business side of running a practice.
Mathews: You've already touched upon this a little bit, but if you had to say what the overriding hope of this series is, what would it be?

Dr. Hopkins: I would say to provide a place that they can go to find out if something really and truly is a regulatory requirement or not. And if not, what can be done to alleviate the associated work burden that has come with being told that it is. So that's a lot of words to state what I think the main goal or purpose is. But so many of us are so busy throughout the day we think of these things, but we just never get around to taking the time to look it up. And if we do try to look it up, we don't know where to go and we don't understand necessarily the language that we find when we get there. So, avoiding physicians and other health care professionals from needing to spend hours digging through online regulatory legalese to find out an answer to their question. That's what I hope to provide.

Carlasare: And I would say that in fewer words would be just to make life easier for physicians. And I really think about it, how just to simplify things for them and the practice of medicine is complicated enough. And again, I go back to the heavy volume of regulations that are woven throughout health care and just to simplify those processes for physicians and make life easier in general, I think would be, if I could say it in layman terms, the goal of the DRM series.

Mathews: I believe layman terms are accepted. So correct me if I'm wrong here because I could be, but regulations sometimes evolve or change. How do you anticipate addressing that in this series with the myths that you've already debunked? Is that something that's on your radar to keep track of?

Carlasare: We do have to maintain these because they're not always evergreen. You're right that sometimes there are changes. The changes to the E&M coding requirements is a good example of something that we will probably have to continue to update as things progress. And it's important to us to make sure that as regulations change or as requirements change for standards that we keep these up-to-date. So, we do kind of a wellness check on the myths every year to make sure everything's still current.

Mathews: And do you have any myths coming up that haven't been published yet but are sort of in the queue that you think would be interesting for listeners to hear a little bit about?

Dr. Hopkins: So some of the things we've focused some work on right now is around reducing in-basket burden. So, one of them that is coming soon is a myth about the need or the requirement for health care organizations to share patient event notifications with physicians. For instance, each time one of my patients goes to an emergency department and/or gets admitted to the hospital or gets discharged from the emergency department or the hospital, I may receive a notification in my electronic health record in-basket. Some of those actually could be beneficial because they may be actionable. Others of those may just contribute to the noise, just the amount of stuff in our in-basket that doesn't actually bring value to caring for patients. So, we have one coming out about that, about the actual regulatory requirements for patient event notifications.

One also about home care plan of care re-certification. How often those patients who are receiving home care does the ordering physician need to sign off on the re-certification plan of care? And what are the requirements around that? And we're working on one about Joint Commission requirements for accreditation and the things that they review when they review an organization for accreditation. Those are a few I can think of off the top of my head that I've thought were interesting and will be interesting when we're able to publish them. Lindsey, any others that come to mind for you?

Carlasare: Top of mind for me was also The Joint Commission standards and like to just make a plug out there, if anyone is listening and has any points of confusion about Joint Commission standards or questions, and we'd love you to submit those through our website.
Also top of mind for me are HIPAA and telehealth being hot topics for I guess creating a multitude of confusing factors, especially as telehealth ramps up in its implementation and utilization.

So those would be the broader topics that I think of, and we'd obviously love for people to write in and let us know if there's anything they can think of under those topics or others to help us or to have us look in to.

Mathews: Dr. Hopkins, could you speak a little bit about exactly how these myths are presented on the website so that people have an idea of what they can expect when they visit and that they're not going to have to necessarily dig through a ton of information to get the answers that they need?

Dr. Hopkins: Sure. So when you get to the AMA Debunking Regulatory Myths landing page, there is a straightforward, simple numbered list of topics in the DRM series. You can click on that link and it will pull up the associated document. These are relatively short. We've done, I think, a reasonable job at distilling complex governmental regulatory text down into simple-to-understand, more straightforward documents. And most of these take on average three to five minutes to read. It actually says at the top of each one what the read time is. And so, it's not something that's going to take you 30 minutes and a dictionary to wade through. If you've got five minutes or four minutes and you want to look up one of these DRM topics during the middle of your day because something's come to mind and you want to look it up in the moment, these are built for that. So it's very accessible—it's short, concise to the point.

Mathews: There's a webpage for each myth. There's also a corresponding PDF if you'd like to have something that you could print out that you could share with your compliance department or your peers. That's correct?

Carlasare: Yep, that’s correct. Each one has a related PDF.

Dr. Hopkins: And each one has buttons across the top for easy sharing. And that could be to social media outlets, it could be by email, it could be just saving a downloaded copy of the PDF or printing the page if that's what you desire.

Mathews: That's great. This is an exciting series and I think it's probably, not probably, I think it is going to help a lot of people. Do you guys have any last thoughts? Anything I failed to ask about that you would want to share with your listeners before we wrap up our time today?

Carlasare: I would just say thanks for tuning in and our goal in our business unit and in the AMA is to make the practice of medicine more efficient and less burdensome and more enjoyable for physicians. So, this series is one of many efforts to make that happen. So we really appreciate anyone helping us continue this work.

Dr. Hopkins: We know from work done by the AMA and other organizations, surveying physicians and others about professional burnout, symptoms associated with it and the causes of it. One of the big ones, most significant ones is regulatory burden and documentation burden and burden of the in-basket and the electronic health record system. So, anything we can do to help alleviate some of that burden would be a welcome change in the medical community. And it really goes to our goals of continuous practice transformation and continuous improvement. How can we make the lives of our patients better and the lives of our physicians and caregiver teams better? How can we make your work more fulfilling, more engaging, more enjoyable? How can we help you focus on work that is actually value-added rather than value-detracting? And the Debunking Regulatory Myths is just one part of how the AMA is aiming to do that.

Mathews: Absolutely. And as I think we mentioned before, you can access the entire Debunking Regulatory Myths series on the AMA website, which we will link to in the description portion for this podcast episode. And we also encourage listeners to visit stepsforward.org where we have a wide variety of resources available to help address and combat professional burnout.
Speaker: Thank you for listening to this episode from the AMA STEPS Forward® podcast series. AMA's STEPS Forward® program is open access and free to all at stepsforward.org. STEPS Forward® can help put the joy back into medicine by offering real world solutions to the challenges that your practice is confronting today. We look forward to you joining us next time on the AMA's STEPS Forward® podcast series, stepsforward.org.

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