

**HIT Policy Committee  
Certification and Adoption Workgroup  
ONC EHR Certification for Behavioral Health  
Virtual Hearing  
Transcript  
January 28, 2014**

**Attendance**

**Members present**

1. Joan Ash
2. Maureen Boyle
3. John F. Derr
4. Jennie Harvell
5. George Hripcsak
6. Stanley M. Huff
7. Mike Lardieri
8. Marc Probst
9. Paul Tang
10. Larry Wolf

**Members absent**

11. Carl Dvorak
12. Paul Egerman
13. Joseph Heyman
14. Elizabeth Johnson
15. Martin Rice
16. Donald Rucker
17. Micky Tripathi

**Presentation**

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee Certification and Adoption Workgroup. This is a hearing on ONC Certification for Behavioral Health. This is a public meeting and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Marc Probst?

**Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Larry Wolf?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Mike Lardieri?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Joan Ash?

**Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – Oregon Health & Science University**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

John Derr?

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Carl Dvorak? Paul Egberman? Joe Heyman? George Hripcsak?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University NYC**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Stan Huff? Hi George. Stan Huff? Liz Johnson? Donald Rucker? Paul Tang?

**Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi Paul. Micky Tripathi? Maureen Boyle?

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Jennie Harvell?

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any ONC staff members on the line?

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Elise Anthony here, hi Michelle.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi Elise.

**Daniel Fisher, MD, PhD – Psychiatrist – Mental Health America**

Daniel Fisher.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

No, I'm sorry, any ONC staff members on the line?

**Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology**

Liz Palena-Hall.

**Jennifer Frazier, MPH – Office of the National Coordinator for Health Information Technology**

Jennifer Frazier.

**Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology**

Hey, Michelle it's Elise here, oops, sorry, Elise Anthony here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi Elise, yes, thank you. As a reminder if you could please mute your lines if you are not the one speaking we'd greatly appreciate it and I will turn it back to you Larry for some opening remarks.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I'd like to welcome everybody we have a very full day for a hearing today. We're going to be hearing from a wide variety of behavioral health both providers and vendors, and some folks involved with policy. So, I think it should be a pretty informative day.

I want to comment, sort of an interesting statement of the transition time that we're in. We've gone through several patient and caregiver potential presenters only to have people back out feeling like they didn't really know enough at this point or hadn't had enough experience yet at this point. So, it speaks to how young some of this is.

But I think we should actually have a pretty interesting presentation from Daniel Fisher. So, perhaps that will compensate for our lack of a broad number of patients to kick this off. But we felt it was really important to have that perspective and actually wanted it to set the hearing and we we're hoping to have a much broader panel for that first one than we've been able to round up.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Just a reminder if you could mute your lines if you're not the one speaking we'd greatly appreciate it.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, with that Marc anything you'd like to say before we get started?

**Marc Probst – Vice President & Chief Information Officer – Intermountain Healthcare**

No, I think we ought to get into this so thanks Larry.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay let's take it on.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, thank you very much Larry, and a reminder to all of the speakers your testimony is limited to 5 minutes. Each panelist on the panel will be given 5 minutes to present and then we will turn it over to the Workgroup for questions.

I will have a timer and I will have to ask you to stop if you've exceeded your 5 minutes. We'll try and give you a 30 second warning sometimes that can be little bit more of an interference but we'll see how it goes with the first few panelist and take it from there. So, for our first panel, as Larry mentioned, we have Daniel Fisher. So, Daniel when you're ready if you want to begin speaking.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Okay, thank you very much. My name is Daniel Fisher and I'm a person who lived the experience of recovery from schizophrenia. I'm Director of the National Empowerment Center and also work as a Psychiatrist.

First of all I want to say thank you very much for this opportunity and as a backdrop I wanted to mention that I have been a member of the Behavioral Health Integration Taskforce here in Massachusetts over the last year and we came out with our recommendations in July of last year.

And the most heated topic that we considered I'd say really was this issue of balancing the need for medical information for people with psychiatric and substance issues to balance the need for that information by health care workers against the need for privacy.

And this wouldn't be as big an issue if there were not stigma and discrimination but it's really well established that people with psychiatric diagnoses are treated with more discrimination and stigma than people with other medical conditions and so that the sharing of that information has to be very carefully considered.

In one study it was shown that almost 46% of people with a psychiatric diagnosis remained undiagnosed by a medical physician. And I also have done a survey recently amongst other people with experience and uniformly, over 20 about responses, across the country people said that they had experienced discrimination and stigma in seeing the medical doctor when it was known that they had a psychiatric diagnosis.

So, the question is how can this information – how can the necessary information about a person's psychiatric condition and substance abuse condition be shared? And there is a mechanism and that is segmentation and increasing the granularity of records.

And I must say I don't feel as though I'm an expert on this, but I have talked with consultants working with the CDC, Jonathan Coleman, and at some length. What he said is that the technology is there. The technology is possible so that only information that the patient has really given authorization for release can be shared with the specific healthcare providers and that's what they call segmentation of the record and that is beyond HIPAA.

HIPAA actually has decreased the confidentiality over the previous system which is where you had to sign a release for every individual health care worker and you knew as a patient, you knew where that information was going, you knew how long it was going to that particular healthcare worker and it had to be renewed.

Under HIPAA one signature pretty much opens the door for all healthcare workers and it's very hard to know once you do open the door with an electronic record just how many people are going to see it, it's estimated that in the order of 150 people may see your record just routinely when it's released. So, how could we do this?

In this taskforce we struggled with the idea that, well medication is one piece of information that the medical doctor, psychiatric medication is a piece of information that a medical doctor should have, although even the release of medication reveals whether the person has a psychiatric stability or not.

So, there is however a computer system where you can put medication information into a sort of black box database and when it's put into that database you say that can be shared with your medical doctor, however the sharing of it does not reveal to the medical doctor the exact nature of the medication but it does say that if the medical doctor wants to write a prescription for a specific medicine and there is an interaction between the medications –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Okay, that interaction will reveal itself. So, the rest – according to the CDC consultant the segmentation is possible but it probably wouldn't be put in place until 2017. My recommendation is that until that is possible, until that occurs that only medication and lab tests be shared, we call that Tier 1 in our recommendation and that other information should remain just in the paper record until they successfully can segment the information that is beyond that.

So, issues such as diagnosis, such as – certainly psychiatric process notes, summary of hospitalizations, symptoms, all these should be kept in the private record, in the paper record and should be released maybe by fax but not released blanketly when they go into the electronic world you have no control really. There also is a need for patient education.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I'm sorry, Daniel, your time is up.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Okay, thank you very much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, but because you were the only one on this panel I'm sure that we can have a little more time for questions or perhaps if you wanted to finish up I'm sure we could allow that just because you're the only person on this panel.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Well, the only part I wanted to finish on was another issue that we raised in this taskforce and that is the ability to review your record. So, all too often there are omissions and commissions. There are omissions of information and there is incorrect information and this can happen as much as 50% of the time. There can be incorrect medications even listed.

My neighbor, just two days ago, she had a broken wrist, she got her electronic records from Massachusetts General and it was missing one of her medications and had a medication on it that she wasn't taking. I told her "quickly correct that."

So what we need though is the ability – we need to be sure that any state laws that restrict the ability of patients to review and correct information in their medical record should be changed and modified to allow appropriate review and correction. This is one of our recommendations to the State of Massachusetts. And this will add an additional level of security.

And I wanted to mention another thing and that is not only is it important in terms of getting the correct information through and not only has stigma and discrimination changed the doctor's behavior, but also if you have electronic records that are revealing too much – more information than the patient is comfortable with to a medical personnel it will severely inhibit people's wish and willingness to see a medical doctor.

So, this is going to put a chill on medical treatment. Also psychiatric treatment, people will not want to seek psychiatric treatment nearly as much if their psychiatric records are going to be released beyond their control to people that they don't know and the consequences I might mention are beyond just the medical consequences of this electronic information.

You still in many states can lose custody of your children. I personally have had at times difficulty with life insurance, with disability insurance even though in my case my last hospitalization was over 30 years ago. It becomes a permanent part of your record. So, I feel very strongly and passionately about this and I certainly hope that HHS will be very cautious about their recommendations.

And I also would like to say that I represent a coalition of people across the country, National Coalition of Mental Health Recovery, and we represent 30 different states, state-wide groups in 30 different states and we would like to work closely with HHS to come up with a real Meaningful Use. Meaningful Use not only from the stand-point of the provider but Meaningful Use from the stand-point of the patient, because I think too often Meaningful Use is really around the issue of what's convenient for the provider, but it has to also take into account adequately the person who lived the experience and that will require, by the way, information, education of people who with experience.

I managed to shake the trees enough in the last couple of day to get some of this information. I was on the state-wide taskforce so I was already oriented, but my colleagues are not, my other people with experience across the country there is very little knowledge still about this field as evidenced by the fact that I'm the only one that is actually presenting here. Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, Daniel. As a reminder to the Workgroup members we're going to use the "raise the hand" feature if you have questions, if you raise your hand that will put you in the queue and then I will call on you to speak. We've used up most of the time for this panel, but if there is a question – Larry Wolf has a question so I'll defer to you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so actually I think this is a great opportunity, thank you Daniel for your comments.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

You're welcome.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I wonder if you could speak a little bit more to that patient point-of-view? You brought up some very interesting technical possibilities but I'd like to get your thoughts on how patients might specify what it was they felt comfortable exchanging and the scope of that release of information? What your thoughts are on what's a reasonable approach to ask for that the system might at some point have as its goal to deliver?

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Yeah, I – first of all, first and foremost, the relationship is essential. You have to build trust, a trusting relationship and unfortunately when you have even less time with a medical doctor than you have with a psychiatrist, if it's maybe 6 or 7 minutes that's pretty good, the trust level is going to be very low.

So, I think that the – I can see the information unfolding as the level of trust increases. And by and large, although medication does have a certain signature associated with it, medication and lab results people feel, you know, a little bit more confident in that and can share that. And its trust also with – trust both with your psychiatrist and your mental health personnel and trust with your medical personnel. So, both relationships are essential.

I think having a record that is in a person's own words is very important and this is around person centered planning, which is becoming much more – attention is paid to. So, the issue of medical records goes hand in hand with having a maximal involvement in your psychiatric records as well as in your medical records.

And I could see the person for instance with their mental health personnel, with their mental health provider having two, perhaps two areas of the record. So they'd say "now this part of the record, you know, maybe this summary I'm willing to share" and it might be – and it should be in the person's own words.

And that each provider you will say then to the mental health personnel “oh, you’ve had a request from so and so, I’m willing to share this information with that provider.” But if it’s another provider who is new to you, another healthcare provider maybe it’s a consultant “I’m not willing to share as much information.”

The other part of the record – there should be a part of the record that the patient says “okay, if it’s an emergency I’m willing to have an override for this portion right here” and specify what the emergency means, you know, it’s life-threatening or if it’s, you know, I’m semiconscious and this also gets into the area of advance directives and the health care proxy that you really – this is going to force, and it should already force people to think ahead of time, who knows what their wishes are? Who knows what their consent would be? So that they’re involving this other personnel in their decision-making. Does that make sense?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes, so it does. So you actually are raising an interesting sort of question here about two models of information sharing, right? So, one model is – and you were talking about this when you’re establishing trust with the general medical community as opposed to the psychiatric community, right? That you were choosing to reveal information during your time with those physicians and those other providers and so that suggests that perhaps the consent in some ways might be on the receiving side that you would give them permission to go get the information.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

As opposed to permission from the psychiatric caregiver to send it. It seems like you’d need to have both ends would need to be cleared, right?

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

That’s right, yeah, both ends will be important and both relationships are important. So from the psychiatrist side of it what information, will you be willing, under which conditions to have release to a healthcare professional?

And on the other side of it, yes how your health care, who the health care professional would seek information from and to go through with them how they would get that information. So, there are consents that are needed on both sides, yes.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, in the taskforce and in your own thinking about this have you thought about – it sounds like some of this information tiering might be the answer to where I’m going but have you thought about –

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Well –

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

More general exchanges where you are sending information out there so that things like the medication and the labs become part of a broader medical record?

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Well we – you have to realize that were 19 of us on the taskforce and the biggest issue really, we had three Tiers. Okay, so Tier 1 was minimal necessary information, that’s what we considered this is really – and it’s around mostly either emergencies or serious medical problems especially and we called that Tier 1.

And under Tier 1 there was myself, representing patients, there was a lawyer, Susan Fendell, who was representing as an advocate also. Two of us really were trying to hold out for even under that Tier 1 that it be an opt out and not a – that it be an opt in and not an opt out. We wanted – in other words we wanted it to be withheld unless the person specifically said I will release this information.

The other – many of the other people on the taskforce, most of the majority, said “no” for Tier 1 medication and lab results, lab tests it should be opt out. And the problem with the opting out is that you have to have a very informed group of patients to know that they have the right and they have the capacity and they have the voice to say “no, I don’t want that information shared.” So, patient education is very important.

Our Tier 2 was more or less agreed that be an opt in, so that was more protected information, treatment plan, risk status and diagnosis. And everyone agreed that Tier 3 would be highly confidential that’s process notes and psychotherapy and actually substance abuse was held to even a higher standard than the mental health notes.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Always the bottom line is patient consent.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Thank you, we’re pretty over our time here. Any other comments from the rest of the Workgroup?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, thank you very much Dan, I’m sorry, Larry. Unfortunately, there are a couple of questions but unfortunately we need to move on to the next panel because we are a little bit over. So, thank you very much Daniel we appreciate you sharing your feedback with us. And so we’re going to move onto Panel Two.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

I’ll send in comments also, thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. So, Panel 2 is behavioral health from a provider perspective. We’re going to actually have two panels with provider perspectives, we broke it up because there were a number of different people that we wanted to hear from.

So, we will start with Dr. Lori Simon. As a reminder your Bios were shared with the group so please don’t take time telling us who you are just get right into your testimony if you can and also as a reminder, if anyone was not on, you have 5 minutes and I will give you a 30 second warning and then you will be cut off and we’ll move to the next presenter. So, we’ll start with Lori if you’re ready.

**Lori Simon, MD – American Psychiatric Association**

Yes, I am. Good morning and in the interest of time I’m actually going to go through my slides very quickly. So, if we could have the first slide and go to the next slide please.

Okay, so in the United States today there are approximately 44,000 psychiatrists, 55% are in Medicare, 43% are in Medicaid. Yet in 2012 with regard to Meaningful Use participation only 375 Medicare psychiatrists attested, only 292 Medicaid psychiatrists and I think that really speaks to the fact that among psychiatrists there is actually right now a very low use of EHRs in their practice. There are a number of reasons but one of the big ones is that there are just simply not enough EHRs that support the needs of psychiatrists. We can go to the next slide please.

So, this is basically a breakdown of the 2012 Meaningful Use participation by specialty and it’s a little bit hard to read there but if you can see psychiatry is way down at the bottom with only 7.1% participation. Next slide, please. So, the next few slides basically talk about some of the unique requirements to not only psychiatry but behavioral health, I’m just going to briefly highlight some of them if we could go to the next slide?

Okay, so with regard to clinical charting for example things such as the mental status examination, the use of DSM Diagnostic Criteria, very robust psychiatric and substance abuse history, group notes, even it was suggested a patient photo so if a patient is acutely ill, perhaps missing and the police need to be called in that would be helpful, guardian and capacity information, although not unique to behavioral health, certainly are encountered more so in the behavioral health field than in some other specialties. Next slide, please.

And so what I want to point out here are two things on this slide, one is that with regard to patient access, certainly having information from a patient's chart presented in an understandable way to the patient is absolutely important. But with regard to behavioral health there is another issue. Sometimes patients who are acutely ill who are perhaps psychotic may have a perception issue if they're disorganized or if they're paranoid for example in their perception of what's in their patient record not just understanding and so that has to be taken into account as well. Privacy and security, as mentioned earlier, are of particular importance both for stigma issues as well as laws that are currently on the books for example 42 CFR. Next slide, please.

With regard to Meaningful Use I've actually attested now three times and what I have found is that although most of the core functions and many of the menu functions are relevant to psychiatry most of the quality measures are not. You see the three that are but there are many that are not. If we could go to the next slide.

With regard to interoperability there have been many studies to show that the majority of visits to primary care providers involve a mental-health issue and actually a major source of referrals to psychiatrist are from primary care and so the ability to share information is very important. Patients in the behavioral health – patients who have mental illness can be found in a multitude of settings as you see. Next slide.

And also quite often a team approach is used, but unfortunately the health information exchanges today are very reluctant to store mental health information due to privacy and security concerns. Next slide.

Now I wanted to very briefly make you aware of two projects that have been going on and are going on to help better define behavioral health requirements. First the APA's EHR Committee of which I'm a member has developed a set of function requirement documents and the purpose is to both provide vendors with specific requirements and also a checklist for providers to identify their own requirements. Next slide.

Now this slide and the next slide, we can even go to the next slide, basically just shows the format of that document and as you can see it's very detailed it gets down to a field level and there is also a column for settings, that settings prompt can be easily expandable to include other areas of behavioral health besides psychiatry. And for each setting, for each requirement there is a priority.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Lori Simon, MD – American Psychiatric Association**

Okay. There is also – I just came back from the HL7 meeting, we are in the process of working on a behavioral health functional profile that will be all encompassing. And so in closing I would like to say that it's very important to have an EHR certified program for behavioral health, it's going to just help us do a better job because the information is going to be more easily available. Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Lori perfect timing. If Stacey Larson is ready?

**Stacey Larson, MD – Director, Legal & Regulatory Affairs Department – American Psychological Association**

Yes I am.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, whenever you're ready go ahead.

**Stacey Larson, MD – Director, Legal & Regulatory Affairs Department – American Psychological Association**

Good morning and thank you for inviting us to speak to you to do. The American Psychological Association believes that a voluntary ONC led Health IT Certification for behavioral health has the potential to improve care and care delivery within the practice setting for a variety of stakeholders including providers, patients and more.

Presently there is no guidance on which current available EHR products have features that would make them well-suited for behavioral health. While these products are available in the marketplace and are being purchased by behavioral health providers the systems appropriateness for behavioral health settings are unclear to policymakers and the public.

Guidance by ONC through a certification process could serve to demonstrate these products suitability for our members. However, if the ONC were to go ahead with a voluntary certification process for behavioral health IT this may lead to two separate certification processes for EHRs one tailored to primary care and one to behavioral health which could result in further disconnect between the two entities.

Given that the Affordable Care Act and other policy-driven initiatives are geared towards fostering increased integrated care within the US, for example the patient centered medical home model, this would be undesirable.

Therefore when considering whether such a certification process would be appropriate it is important to examine current health information technology that exists for psychologists and behavioral health providers in practice.

Presently psychologists are using a patchwork of Health IT resources in order to deliver care to their patients. Part of the reason as to why there is not widespread adoption of fully interoperable EHRs is because psychologists are not eligible for the Meaningful Use incentive payments under HITECH.

Because of this exclusion adoption of this technology is not cost-effective for solo practitioners or small groups and this has proven to be a formidable barrier in ushering psychologists across the threshold and into the HIT landscape.

On the other hand there are some psychologists who do use fully certified EHRs and these psychologists have identified two primary concerns, patient privacy and overall security of Health IT. Seeking mental health services is still stigmatized which leads to an increased sensitivity among psychologists to protect the confidentiality of the patient record.

Therefore, if the ONC were to lead a voluntary certification process for behavioral health EHRs APA would recommend that additional guidance related to the inherent security, confidentiality and privacy concerns of HIT functionality be provided as part of the certification process.

For example, vendors would have to include a training module on privacy and security issues related to their product as a part of their client training process. This could then be used to indicate to providers that the product meets all of the requisite standards for privacy and security as determined by HIPAA and 42 CFR Part 2.

Additionally, voluntary certification could also serve to educate more behavioral health practitioners who are either confused or uninformed about the various levels and types of EHR functionality. Specifically, many current EHR vendors tout products that claim to be specifically designed to meet the needs of behavioral health professionals but there is presently no specific guidance that helps practitioners in their decision-making.

This raises the issue of how would existing EHR programs align with the voluntary certification process? APA believes that the answer to this question would depend upon the certification process itself. For example, if the certification process is too rigorous we are concerned that EHR developers will decide that the cost of certification outweigh the benefits.

Alternatively, if developers pass the cost of rigorous certification onto consumers, the higher prices will discourage psychologists, especially those in solo or small group practices from using those products. Voluntary certification could serve to align existing federal and state programs but only if it is seen to work in conjunction with current certification programs rather than an additional expectation above and beyond what is already required.

Indeed part of the part of the challenge in aligning existing EHR standards with potentially new behavioral Health IT systems is that presently there is little behavioral health information exchanged between psychologists operating solo and small group practices and other healthcare providers because there is a lack of true interoperability between various EHR systems.

Hence, psychologists practicing outside of large health care networks often have little guidance in selecting an EHR that is truly interoperable with those used by other healthcare providers. A voluntary certification process might serve to allow psychologists to collaborate more effectively with primary care by selecting a system that is truly interoperable.

In conclusion, APA believes that a voluntary certification process for behavioral health IT could benefit psychologists in professional practices. Certification that both includes additional guidance about security and confidentiality and dovetails with existing expectations so as to promote greater collaborative care is most needed.

With the above considerations APA has confidence that the ONC could successfully lead this initiative by leveraging the current technology pipeline in conjunction with maintaining a meaningful dialogue with input from the provider, vendor and IT communities. Thank you again for inviting us to participate in the panel and we are eager to see how ONC moves forward on this initiative. That's it.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Stacey and we will now turn it over to Roger.

**Roger D. Smith, JD – Chief Legal Counsel – American Association for Marriage & Family Therapy**

Thank you very much, thank you for inviting us to participate in this panel. The American Association for Marriage and Family Therapy is a national professional association that represents the interests of license marriage and family therapists in the United States. MFTs are licensed in all 50 states. MFTs conduct individual psychotherapy as well as family and group psychotherapy. According to a recent SAMSHA report there are 62,000 marriage and family therapist practicing in the United States.

AAMFT supports the goal of ensuring that MFTs and other behavioral health providers can fully participate in the adoption and effective use of Health IT. We believe that Health IT certification for behavioral health could improve care. We also see the value to behavioral health providers and a voluntary certification program.

As discussed by other panelists and commentators there are some issues that will need to be addressed. As you know most behavioral health providers are ineligible for incentive payments under the HITECH Act. The lack of incentive payments is the most significant barrier to the adoption in Meaningful Use of Health IT by most behavioral health providers.

Many behavioral health providers operate as solo practitioners or in small group practice settings. Without financial assistance these providers do not have the money to pay for such a large financial investment.

Unfortunately, the lack of incentive funding in this Act could even call into question whether congress truly believes in encouraging the behavioral health community to adopt and use certified EHR technologies as a national priority.

The privacy and security of behavioral health information is another major issue. Other commentators and staff have done a good job in addressing this topic. I just wanted to briefly address one potential issue that relates to family and group therapy.

In family and group therapy the client can include more than one person. For example, if a therapist is treating two individuals and both individuals are the therapist's client the therapist owes a duty of confidentiality to both parties. Since there is only one client in this situation there is normally only one client record. If two or more clients are on one record there are issues with transferring protected health information to other providers without the consent of all parties.

Although MFTs have specific training in family therapy this issue impacts the behavioral health fields as a whole because many other licensed behavioral health providers also provide family and group therapy.

In terms of any considerations for structure of voluntary certification program for behavioral health without more information AAMFT does not have a strong preference at this time on whether the structure of a voluntary certification program for behavioral health should be modular or focused on core needs.

We would note that behavioral health providers are all required to comply with the same federal confidentiality laws and share core functionality. Instead of distinctions between the professions perhaps the structure should have distinctions between solo and small providers versus large providers or a distinction based on client volume. I would like to thank you for providing AAMFT with the opportunity to participate in this panel discussion. We do appreciate it. Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much. Michael Alonso?

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

Thanks everyone, good morning thanks for giving me the opportunity to present. I'm the Director of IT for Seneca Family of Agencies we're a California Agency that provides a variety of behavioral health services for children, youth and families and I do support the idea of this behavioral health certification but I do want to point out three things that really need to be taken into account so that we can create a program that's actually useful.

The first thing is that it has to be positioned as a well-accepted alternative certification. For example, as we know there will soon be Medicare penalties if you're not using a certified EHR, even though these penalties don't currently affect behavioral health, this does give those of us on the provider community reason to think that at some point there may be penalties for not using a certified EHR.

This expectation alone is enough to actually motivate a lot of providers to go after our certification even though the "our" criteria aren't totally applicable to them. But having the ability to pursue a behavioral health alternative certification would be so much more meaningful to these providers. And we have to think past just the federal level and into state and local levels as well.

For example, in California the state and counties have been concerned with electronic signature integrity and so they've been either requiring or considering requiring EHR certification of some kind. But a behavioral health certification from ONC would be great if it would be able to satisfy these local requirements that we face as well.

The second point that I want to make is that the criteria set for behavioral health certification has to be significantly simpler and completely relevant to behavioral health. The main motivation for seeking behavioral health certification is the promise of lower cost to get a product certified and this lowering of costs comes by eliminating criteria that are essential to behavioral health domain.

And if we don't enable lower cost of certification versus say ARRA it won't be a useful program because for one any organization that's already decided against ARRA certification because of the cost is going to ignore the behavioral health certification due to the same reason and this is the main reason a lot of behavioral health providers aren't pursuing an ARRA certified product.

Second, any organization that has decided to pursue ARRA, in spite of the higher cost, isn't going to bother with the behavioral health because after all why pursue a lesser-known certification if it isn't going to save any money?

The third thing that a behavioral health certification should do is encourage the completion of a continuity of care document for behavioral health. Here at Seneca actually a large majority of our services are provided in collaboration with the public mental health system and that system is administered through the individual counties. This means that the overall responsibility for a client's treatment is shared between both Seneca and a particular county mental health department and this creates a huge need for our EHR to be interoperable with the EHRs of the counties that we partner with.

Interoperability with primary care is certainly useful but in all honesty it's not as useful as sharing behavioral health information with behavioral health partners in the system of care. Of course the challenge here is that a CCD for behavioral health isn't at a point where we can start using it and I'm not deliberating suggesting that it needs to be "complete."

No standard is ever complete they always keep evolving but it needs to reach a point where we feel it's good enough to begin using and I think that if ONC was to endorse a particular behavioral health CCD standard it would encourage along the work that's being done. Because the CCD isn't complete yet, ONC perhaps could just publicize that it will be required in a Stage 2 behavioral health certification or something along those lines.

And finally, I just want to end by pointing out that the act of creating a certification process will not in and of itself create an increase in the amount of actual working interoperability in behavioral health and that's because the purchase of a certified product isn't the same thing as the provider actually using those interoperability features.

There is always an additional significant cost beyond the cost of purchase involved in actually setting up meaningful interoperability involving working with the vendor, etcetera. Without offering an additional incentive only the providers who already have a business need for interoperability are going to bother spending money to set it up.

So, in summary I do believe that the idea of a behavioral health certification is a good one but only if these things I've pointed out are included in the final product. Thanks for letting me testify.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much to all of our panel 2 speakers. We'll now open it up to questions from the Workgroup members and Joan Ash has a question.

**Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – Oregon Health & Science University**

Yes, hi, can you hear me?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We can hear you.

**Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – Oregon Health & Science University**

Oh, great, okay. I wanted to ask Lori, because she mentioned the work being done by HL7 and I'm hoping she can give us a progress report and tell us a little bit more about that?

**Lori Simon, MD – American Psychiatric Association**

Sure, there has been – the CBCC Workgroup which basically has a number of SAMHSA members on it, and as you know SAMHSA is involved a lot in the HIT world, they had already developed a behavioral health functional profile based on – there is an EHR functional model from HL7. It was based on release one.

And so, we've decided, and I'm a member of the CBCC Workgroup, that it's really now the time to start to develop release 2, that behavioral health functional profile. What we're going to do is basically start with the – encompass CCHIT's work that was done several years ago. The EHRs functional or the APA's EHR Committee's functional requirement documents, of which I was the primary developer, and also encompass what was done in release 1 of the behavioral health model, the profile.

And our aim is to develop a model that's usable that can be used by vendors so that they truly understand what the needs of behavioral health field are in terms of EHRs, and also for providers so that they could use it as a checklist so to speak to look and say "okay, let me see which requirements I need" and then see which vendors support those requirements.

I mean, I can envision a tool, an online tool that would be available. But the goal is to make it as all-encompassing as possible. We're just getting started on that, but we're going to try to work really hard and diligently to get that done. Hello?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, are there any questions from the Workgroup? Oh, I'm sorry, Mike Lardieri?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, thank you, yeah I had a question this is for Michael Alonso. Thanks for your comments. I know California has some challenges when it comes to reporting to the different counties because each county manages their own behavioral health system and so I'm wondering if you could speak a little bit about the certification or how, if there was a certification process, that might help with an organization that spans a number of different counties with their reporting requirements?

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

That's a good question. Right off of the top of my head I don't think that the certification process or what's being proposed for really addresses the things that the individual counties are looking for.

You know to be honest, I don't know right off the top of my head all of the details of what each county requires of us. I unfortunately don't have the right in front of me.

My instinct is to say that a certification program may not address that issue and yes that is a significant issue for California providers the fact that public programs are administered through the counties and that each county has different requirements. And that many providers span multiple counties.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

And just a follow-up. So when they span multiple counties do you then have multiple reporting processes and double entry and things like that?

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

Yes, to be honest it can become, to put it simply "a little bit of chaos." Some counties implement, actually all counties implement their own electronic health record, some of them try to insist that our clinicians use the county EHR system and that would involve double entry into both ours and the counties. Some counties are more loose about it and they'll allow us to use ours. At this point no county has gone down the road of electronic transfer of clinical information into something we've been really interested in.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay, thank you, thanks a lot.

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

Yes.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I don't see any other Workgroup questions but I'll just make sure.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Hi, this is Jennie Harvell I was wondering if I could ask a question?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Go for it.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

One of the panelists, I think it was Mr. Smith, described both individual and group therapy as being important parts of the clinical practice in behavioral health and in that line talked about the importance of being able to keep private and confidential group therapy notes for all participants in the group. I was wondering if any of the panelists could talk about the availability of standards to support the privacy and confidentiality of group therapy information?

**Lori Simon, MD – American Psychiatric Association**

This is Lori; I do know that there are laws out there that specifically name psychotherapy notes as being distinct from other types of progress notes and in practice typically the way progress notes are done now, and this is partly due to some of the standards that have been set up in terms of what progress notes are supposed to look like, there has been a separation where progress notes typically are closer now to what any other medical provider would be keeping. So, for example the medications the patients are on, diagnostic information just sort of the basics.

And those notes are potentially accessible by insurance companies for example or if they're subpoenaed by a court. But psychotherapy notes, and it's recommended that they do be kept separate, which basically talk more about some of the personal issues going on with the patient, the more confidential issues, those are kept separate and those are not – do not need to be made available to anyone without the patient's permission.

**Roger D. Smith, JD – Chief Legal Counsel – American Association for Marriage & Family Therapy**

This is Roger Smith, AAMFT, I would agree with what Dr. Simon said and that's sort of another issue I didn't mention in my presentation but our psychotherapy notes are normally treated and they are generally kept separate or supposed to be and how the data segmentation in the EHR handles that will be an issue as well.

And what in terms of group therapy or family therapy I suppose that theoretically all clients could – who were in the client circle, if you will, who were receiving therapy could wave or allow the provider to provide the whole group notes to any provider, any other provider who is working with anyone in that client circle although that's probably not the best way or maybe the ideal way to handle that.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

And so this is Jennie again, just to clarify that as part of the clinical workflow in terms of group a clinician keeps notes naming all the individuals in the group for the group or they keep them separate for each individual?

**Roger D. Smith, JD – Chief Legal Counsel – American Association for Marriage & Family Therapy**

This is Roger Smith, that's an excellent question. Generally how, and it depend on the perspective of the provider, but generally I would say a majority of our marriage and family therapist do and many other providers is that the clinical record would be one record for all the group clients.

Some therapists may photocopy the record and make individual files, but still you have the same problem of confidentiality, because essentially you're just taking one record and replicating it. But generally they're all kept in one file if it's truly a group or family therapy and the names of all of the clients of course will be listed.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Thank you.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

And this is Mike Lardieri, I just want to follow-up on that question. Now is that situation you're describing, is that a private practice situation or in a clinical setting like an organization, community mental health center setting?

**Stacey Larson, MD – Director, Legal & Regulatory Affairs Department – American Psychological Association**

This is Stacey Larson, with the American Psychological Association, are you asking the way of keeping notes, is that what you're asking like in private practice or a group setting or I mean community mental health setting?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

No, I was specifically addressing Roger with his –

**Stacey Larson, MD – Director, Legal & Regulatory Affairs Department – American Psychological Association**

Okay.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Identifying that the group note would be a shared note, was he referring to that happening in an individual private practice setting or more of a public health system, community mental health center setting?

**Stacey Larson, MD – Director, Legal & Regulatory Affairs Department – American Psychological Association**

Well, I can address that briefly, for psychologists – I mean, because many psychologists are in private settings and I'll reiterate what Roger had already said is that it really is dependent upon the provider.

We have a lot of individual private practice practitioners who will keep one file for a whole group because the expectation of privacy with a group therapy setting is slightly different than individual.

We also have members that work in community mental health and hospitals, etcetera that might do it separately it generally depends on the guidelines for the facility that they are in.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay, thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Larry Wolf you had a question but did you change your mind?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, my question was about this notion of notes for the whole group. I certainly understand where, you know, part of the note is about group interaction that clearly is about the whole group. So, there is an aspect here that's very different from the records we typically look at that are focused around a single individual. Thanks. It's already been discussed plenty.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, if there aren't any other questions we'll move onto panel 3. I'll just pause to see if there are any other questions? Okay, so the next panel is also a provider panel and Paul if you are ready?

**Paul McLaughlin, MA – Executive Director – Hartford Dispensary**

Well, thank you. I'd like to thank you for inviting AATOD to participate in this conversation. It's the first time that I've been involved in a conversation on the certification process and Meaningful Use.

We believe in supporting Mike Lardieri's statement that the behavioral health providers need to be incorporated into the healthcare system on par with the medical providers and counterparts.

In our efforts to achieve the goals of the Affordable Care Act in terms of coordination of care with the physical health and mental health and addiction services we think the electronic medical record is critical in order to achieve the goals.

I find it interesting in one of the slides that was presented in the December 4<sup>th</sup> document that was sent out that the results of a survey that the National Council did indicated that only 2% of behavioral health at this time could achieve Meaningful Use.

I haven't had the opportunity to speak to any of my colleagues at AATOD since I recently got appointed to represent AATOD but I suspect that most of the opiate treatment programs – and AATOD represents 900 out of the 1200 OTPs in the country, that most of them have developed fairly sophisticated electronic capabilities and that a number of them would be interested and willing to move towards a volunteer certification process provided that it's not too burdensome and that the cost get offset by federal support.

We think that there are some benefits to Meaningful Use and to the voluntary certification process. But once again, it's an issue of cost and we're in a position right now as an agency, the Hartford Dispensary, in trying to make an informed decision as to what software package we want to purchase to help get us to certification and Meaningful Use.

So I think the vendors should develop the software that will satisfy all of these certification requirements. Now this is a decision that we were hoping to make it within the next 6-12 months, but I'm not sure how soon the certification requirements and specifications will be developed for behavioral health and I'm not sure if there will be any specific type of certification specific to OTPs which are kind of a unique modality.

One of the uniqueness of our modality of course relates to what Daniel said at the very beginning that if we were to transfer information regarding medication as soon as the word "methadone" is transferred that would be an automatic disclosure. So the security issues regarding CF 42 part 2 is a major concern to many of the OTP providers.

So, with that I'll just say, once again we are interested in learning as much as we can as soon as we can regarding the Meaningful Use and certification but it is going to require a significant amount of education for OTPs to be brought up to speed on where you are already.

There is – work has been done on these concepts for the last 4 or 5 years it seems yet this is the first time that we've been invited to participate in the conversation and I hope we continue to participate in the conversation. Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much. Our next speaker is Richard Rosenthal.

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

Yes, hi, the American Academy of Addiction Psychiatry is an academic professional membership organization founded in 1985 with about 1100 members in the United States and around the world. Membership consists of psychiatrists who specialize in treating addiction in their practices, faculty at various academic institutions, medical students, residents and fellows and non-psychiatry healthcare professionals who are making a contribution to the field of addiction psychiatry.

AAAP supports the National Quality Strategy aims of better care, healthy people, healthy communities and affordable care and as such supports the development of voluntary certification of behavioral health EHRs to further these aims.

Given the well documented high prevalence of co-occurring mental disorders and/or medical illness with substance use disorders, addiction treatment must have collaboration and/or integration with the rest of medicine including mental health treatment.

Reliable and standardized EHR is necessary but not alone sufficient for the health reform priority of clinical integration. Addressing these co-occurring disorders concurrently and with voluntarily certified EHR supported care coordination will begin to mitigate the disproportionate cost of these clinical populations through altered illness trajectories and reduced use of emergency and inpatient care advancing a National Quality Strategy priority.

But addiction treatment is separate not equal. In the evolving digital health system the very protections that were constructed in the era of paper records through 42 CFR Part 2 to keep addiction treatment data discrete for patient protection and to reduce stigma tend to maintain the isolation of addiction treatment from appropriate mainstream medical providers.

This is in part because the current state of mainstream EHR and HIE development does not typically include the ability to segment addictions treatment related data and to make it individually available to authorized recipients.

We believe the proper use of patient data and linkage to care coordination information either directly or through HIE will improve non-addiction specialist's clinician's perception of patients with substance use disorders and other mental disorders especially as they recognize through patient and care collaboration interactions over time that they are important and effective stakeholders in patient's recovery. EHRs might control this redisclosure of protected clinical information through development of standards that promote use of metadata tagging to auto cohort and restrict data on the receiving end.

Although the time required to accomplish regulatory change will be lengthy AAAP supports regarding 42 CFR Part 2 regulatory changes that facilitate lowered barriers in the HIE for appropriate caregivers while strengthening protections against and penalties for all unauthorized reception or redisclosure.

In order to foster systems change there also much be proper incentives to purchase and implement behavioral health EHR and the treatment programs that frequently operate within very narrow financial margins especially the freestanding ones. Without these incentives these programs are likely to continue to lag behind the rest of medicine.

As such AAAP supports the passage of the Behavioral Health Information Technology Act of 2013, that's HR 2957 incented 1517, which would create eligibility for Meaningful Use incentives to be applied to certain behavioral health providers. Other federal opportunities to offer incentives to practitioners and programs would accelerate the much-needed adoption of the EHR in addiction and mental health treatment.

So, certification standards should be supported for addiction treated related modules in mainstream EHR systems which would promote SAMHSA's Health IT goal of quality integrated behavioral care.

Agonist, antagonist and other pharmacotherapies for substance dependence are efficacious yet greatly underutilized interventions a quality concern due in part to the addiction treatment community's traditional distance from the scientific evidence-base, philosophy and practice of mainstream medicine.

In order to address this isolation which has created barriers to access to treatment we must promote the use of EHR for addiction treatment providers and programs. However, creating a new non-meaningful use-based core certification standard for behavioral health may propagate systems with idiosyncratic and potentially expensive interfaces that concretize it in its currently soloed state and without direct access to the medical functionality such as prescribing labs and imaging render it less capable of necessary clinical evolution.

Specialty behavioral health –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

Will offer basic functionality in the short-term but may not be able to keep up with the rate of change in mainstream systems over time and is increasingly likely to be divergent.

AAAP proposed that a flexible modular program structure can meet the content standard needs of diverse provider types provided there is a minimum data set for any clinical encounter that encapsulates core interoperability, privacy and security functionality for all providers aligned with Meaningful Use.

Rather presenting a flexible program will push the field towards the development of unified integrated EHR systems that have capacity for both current MU certification as well as the modular components for clinicians who are not currently eligible for Meaningful Use.

This will support care coordination and the generation of exportable standard care plans if not the ultimate goal of clinical integration.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, Dr. Rosenthal, your time is up.

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Dr. Gastfriend?

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

Yes, thank you very much I'm representing ASAM, the American Society of Addiction Medicine, which is the largest professional society in addiction medicine with about 3000 physician members and associate members from other disciplines as well.

First, I want to endorse everything that Dr. Rosenthal just said from the American Academy of Addiction Psychiatry, which is a colleague and partner organization with ASAM. Addiction is unique because it's a disease that reinforces the organism to become more ill. It hijacks the drive system and unconsciously produces the urge to consume substances and create more dependence.

So, it's a longitudinal disease with both acute and chronic episodes, highly multi-factorial causes, highly diverse and temporal varying presentations in the healthcare environment that ends up very fragmented cobbled by privacy obstacles and the treatment is disrupted frequently by the behavioral manifestations of the disease itself.

As a result the behavioral health EHR certification could be transformative for the field and the delivery of care. It could help physicians in addiction medicine and specialty work to provide more comprehensive assessment, share data better across specialty provider types and across the different levels of care that patient's transition through. It could help specialists to interact productively with general healthcare providers, which currently is not usually the case.

And another advantage that I don't think has been mentioned yet is that the rigorous quantification of data along the trajectory of the patient's illness can be shared with patients more easily when it is standardized and that process of sharing what is in the electronic health record, for behavioral health, is itself a motivational enhancement strategy for patient care.

So, I think this has the potential to balance some of the perceived risks of confidentiality and privacy because patients actually need and deserve to see what is in their electronic health record regarding behavioral health, it helps them to decide what is to be shared and isn't but it's more importantly a motivational tool.

Now current behavioral health IT functionality is terrible as we've been hearing. Although, many of the 15,000 or so US treatment programs have modest management information system reporting obligations because of the federal funding, ASAM has spent 20 years of expert consensus effort publishing an intricate set of decision rules, called the ASAM criteria, to rigorously determine how to place a patient in the optimal level of care.

And these ASAM criteria are endorsed by over 30 states, the DoD and the VA but there is no standardized implementation until now when with SAMHSA's help a computerized clinical decision support system has been created for routine clinical use and is about to go into national demonstration testing after alpha and beta testing and 10 years of research.

The ASAM criteria software is a hybrid model, the decision rule engine is closed and overseen by ASAM and a diverse coalition of stakeholders, but the hooks for input and output linkage to EHRs are open sourced and being made available to the behavioral health vendor industry and other large systems.

It's now in the process of pursuing Meaningful Use certification with assistance from SAMHSA and it's basically a structured interview exquisitely branched and it structures the counselor to assess all of the requisite fields for then running the data through a decision rule engine that calculates the recommendations for optimal level of care. The demonstration will involve 30 treatment systems, counties and states across the country.

So, the most needed functionality that we perceive for addiction behavioral health in IT is one linking this clinical decision support software to the –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

Thanks, to the medical EHR standards and securing Meaningful Use certification for it. Linking this to managed care, their utilization protocols for instant authorization to overcome the telephone tag that's currently the process. The third is to create a subset of this for emergency room and primary care use. Thanks very much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much. So, for our next speaker, Mohini was scheduled to present but he is ill. He did send in written testimony but he's also from the same organization as Mike Lardieri who I know worked with him on his testimony. So, Mike if you feel comfortable would you be able to speak on his behalf.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yes, thank you very much and Mohini a "she" so I just want to clarify that.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Oh, sorry.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

That's okay and we apologize but there is a flu bug going around and she got it. So, the National Council for Behavioral Health is a membership organization that represents over 2100 members across the country and our members are the health care system of community mental health centers and they treat – most of their clients are seriously and persistently mentally ill. You've heard some of the specifics about those people and they're dying earlier than the rest of the population. There are more than 8 million adults and children living with serious mental illness.

Our mission is really to advance our members ability to deliver integrated healthcare. Fundamentally we believe and advocate strongly that behavioral health providers need and should be incorporated into the health care system on par with their medical providers.

We know that a certification process in and of itself won't make sharing information happen. We do believe that there is a need for some financial assistance to do this and there are two bills that were already mentioned, one in the House and one in the Senate, to help support this.

As we move forward unless behavioral health is included in the health care system and able to share information, accountable care, health homes, coordinated care organizations they just won't work because behavioral health is so integral to that integrated care.

So, we also understand the cost associated with a certification process so our recommendations are that there be a modular approach to certification and at three levels and starting with the first priority being interoperability. If a system has certified its interoperability a provider could select that system and know that they'd be able to share information with their health home, accountable care organizations, the health information exchange, which would be very important.

We know that in itself gets to really the guts of the system and they would then be able to produce a continuity of care document or as the industry moves to a consolidated clinical architecture they will need to conform to the section's entries and coding systems that are currently in place and under development in the ONC standards and interoperability framework and HL7 Initiatives.

And we also need to recognize that the minimal dataset may not include everything that medical providers provide in that for instance vital signs, if an organization is made up of social workers they are not going to be able to provide that.

The next level would be clinical quality measures and then the next level would be clinical decision support. All of these recommendations can be carried in current certification programs without having to implement a new or burdensome set of requirements.

There is also the issue of 42 CFR Part 2 and that's been mentioned. And there is a need for some sub-regulatory guidance allowing a patient to identify current and future providers in the HIE involved in my care as an appropriate title for the release of information to that provider.

We were in a program with five state HIEs and this "to whom" section is the one stumbling block that right now prevents information from being shared. The current interpretation is that if a patient signed a release today all the clients in the – all the providers in the HIE they could share information with them.

However, if a provider joined 2 or 3 weeks from now and was also a provider that the patient was involved in care with that provider that provider would not have access to that treatment information even though from the patient focus groups at the five state HIEs we worked with had – patients do want to have integrated care with providers who are involved in their care and with that I'll –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, with that I'll close and thank you very much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much and I will now open it up to the Workgroup for any questions. I don't see anyone with their hand raised, so please feel to speak if you do have a question. Oh, Larry Wolf has a question?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Hi, I have a question and I had to get off mute, so, thank you to the panelists. I feel like you're presenting us an interesting conundrum so I will give it back to you. So, I've been hearing all morning really about the importance of information exchange but I've also been hearing about the barriers to doing that exchange.

So, I wonder if any of the panelists have some thoughts about ways in which we could address moving forward, steps we could take without the kind of robust data segmentation that has been talked about that would still be of value and would encourage adoption of standards-based systems?

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

That's a tough one.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I'll give you one inkling of a thought that maybe gets us moving in a direction. So, there are no constraints on your receiving information, right?

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

That's correct.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yes, that's correct.

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

It's actually not known that that's the case, but you are right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I wonder if that's perhaps a place to start?

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

Yes that would not require segmentation.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Correct.

**David R. Gastfriend, MD – Addiction Psychiatry Research, Education, Technology & Public Policy – American Society for Addiction Medicine**

But, this is David Gastfriend from ASAM speaking, I would actually encourage segmentation for, you know, the major categories of information starting with the default that no information from the specialty sector be shared and requiring a review process with the patient to consider what information can be shared.

Because when patients are given the option as part of the therapeutic process, to understand what's been gathered on them, where it's being protected and then the option of sharing it with their providers it will introduce a healthier perspective.

There are patients who don't have as much fear of their confidentiality and want their general health providers to have access to everything about them. And only by requiring a process to evaluate the data sharing approval of the patient will we be able to open this up.

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

This Rick Rosenthal from AAAP and I agree with David on that and then you get sort of the process where patients who decline to sign the consent can be educated about the implications for the quality of the healthcare services they may receive and potential detriment to their own healthcare outcomes as a result and it gives them that power to, you know, divulge or not. So, I'm in accordance with that. I think it's a good strategy.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah and this is Mike Lardieri and yeah, I would, I guess third that and that's one of the reasons why we think that the certification for interoperability is important, because unless you give me interoperable you're not going to be able to segment and, you know, that's why we recommend that kind of approach.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, I'm hearing about the value of the conversation with the patient which I completely agree with, the value of segmentation, but I'm concerned that we don't have the ability to get started until we address the segmentation issue and that could turn out to be a lengthy process.

So, I was looking for places that could sort of demonstrate the value without requiring segmentation. So, let me ask a related question. One of the complexities around segmentation and sharing information comes from the SAMHSA requirement, you know, the Part 2 requirement to not have a second disclosure.

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

Yeah.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

That you only have permission for one hop of the information sharing. Does that apply generally in terms of people's understanding or if information was shared to another provider generally, separate from the substance abuse treatment centers, that that information is now in that provider's record and any consent needed would just be a general consent from that provider to share? Would that –

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

That's typically the case as long as it doesn't encapsulate, you know, the stuff under 42 CFR Part 2. I think redisclosure is standard as things get cut and pasted within the EHRs and doctors talk to doctors I think that's pretty routine.

So, I think that that's part of the problem in a sense of it's the responsibility of the divulger to prevent that redisclosure, to inform the, you know, the receiver that that disclosure is prohibited.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, many states on the mental health side follow HIPAA and so you don't have that issue, but it does occur with 42 CFR; that's why this sub-regulatory guidance from the General Council would be very helpful in moving some of this forward because it would open up the transfer of information for those patients who do want to share, which with the five states that we worked with and their patient focus groups, the patient focus groups they all agree if it's around integrating my care that should be allowed and some states that are already sharing this and have figured out a way about 95 or more percent of the patients in a behavioral health organization sign the consent for the HIE.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Thank you.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

This is Jennie Harvell and I wanted to ask a follow-up question to Larry's thinking. In addition to there not being any barriers to receiving information it doesn't sound like there would be a barrier to creating information?

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

You mean de novo?

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Correct, you know, so you'll – so here's the hypothetical and again I'm trying to think of a way, a strategy of moving forward. There are several existing EHR certification criteria in the Meaningful Use Program that for example require the creation of certain types of electronic information and so I'm wondering if in this behavioral health space if perhaps criteria for technologies in this behavioral health area should initially focus on the creation and/or the receipt of information but not advance requirements or criteria for the transmission of information until data segmentation becomes a more robust and usable standard?

**Richard N. Rosenthal, MD – Professor of Psychiatry, Icahn School of Medicine & Medical Director of Addiction Psychiatry – Mount Sinai Institute of Mental Health**

Well, I mean, clearly if you're – for example a physician or primary care doctor who doesn't fall under the provisions of 42 CFR Part 2 as being an addiction treatment provider he or she can certainly ask questions of the patient that inform him or her about certain, you know, information that would otherwise be prohibited without going through that process.

So, in other words if they independently find out someone is on methadone and the patient divulges that, that's not part or covered by 42 CFR Part 2. So that data can actually be created the problem is how do you without creating specific standards on the non-behavioral health provider side that gets those clinicians to get those data. I don't know how you otherwise inform them to create that new information?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah and Jennie, this is Mike. So, from where you're going, when it gets to the medical provider record the concern is that another provider might request it and they just shoot it off without some kind of flag that this is Part 2 data that's the concern people have. If you don't have this flag that the medical provider could then make sure that they don't send it off if the patient did not want them to, that's the problem that we're having.

So, there needs to maybe not be full segmentation but there to be some kind of flag that the systems could process to say "okay, stop patient didn't allow." That's why this re-phrasing or this sub-regulatory guidance would be so important because patients do know, for the most part, who is involved in their care and if they didn't want a provider to have that then they could get out of health information exchange and not share information that's the problem that we're having right now.

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

This is Michael Alonso from Seneca I'd also like to comment on the question that was posed about where could we get started without the segmentation quite done yet. There are a couple of situations, one is where anyplace, well not anyplace, but there are – there is a situation where Part 2 is not involved where an organization does not provide substance abuse treatment and that's the case with Seneca, we do not provide substance abuse treatment so Part 2 is not an issue.

And the other unique factor that we run into is that, as I mentioned, we work with counties in a shared responsibility for the client's treatment and it's perhaps a unique relationship where sharing of information is part of the normal process that we go through and so data segmentation wouldn't be as much of a necessity in that particular relationship.

So, there are already these unique relationships where information exchange using perhaps some of the available standards, even if the segmentation isn't complete could be very useful as a place to get started in testing things out.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Yeah, so thank you for that, but, so one of the things that I was trying to think through was I thought I heard earlier today, from Mr. Fisher I believe his name was, about the importance of maintaining the confidentiality and privacy/security of information even beyond substance abuse related information and so I'm trying to think through those issues in the field of behavioral health, absent a robust data segmentation standard.

**W**  
–

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

Oh, yeah, absolutely.

**W**

Sorry, go ahead.

**Michael Alonso – Director of Information Technology – Seneca Family of Agencies**

Sorry, I was going to say absolutely, I'm not suggesting that confidentiality isn't important when we're not talking about substance abuse it's just sometimes there are unique relationships between organizations that provide treatment that would – where information sharing is part of the norm and perhaps that could be a place to get started with information exchange. I'm not suggesting that either of those partners use this technology to re-release information to anybody outside of that relationship.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Right, yes, we certainly agree with that and maybe Jennie there is – maybe it's not at the EHR level that certification should happen or I think we'll hear later on during the day from Kansas HIE that has a particular way of processing the data.

The data does go to the HIE, however, the provider that the patient is in front of, when they go into the HIE if it's a behavioral health information, mental health or substance use they just get a flag, you know, the patient has opted out, you don't have access, it doesn't tell them why because in that state patients can opt out for any reason.

The provider then says to the patient would you like to share information? The patient then gives consent and then the provider basically breaks-the-glass, they have access to the information and the HIE audits that. So, it's really not at the EHR level it's at the HIE level that that's happening.

**Maureen Boyle, PhD – Health IT Lead, Center for Substance Abuse Treatment – Substance Abuse & Mental Health Services Administration**

And this is Maureen from SAMHSA I just wanted to make it really clear that compliance with 42 CFR Part 2 and the similar mental health regulations that exist in some states doesn't require data segmentation. I think the standards that it would require are, like we talked about on Friday, consent management standards and, you know, standards for controlling the redisclosure of information.

**Lori Simon, MD – American Psychiatric Association**

This is Lori Simon, if you talk to patients I think one of the biggest concerns is not so much the sharing of their mental health related information amongst clinicians that are treating them it's when – the concern is going outside of that environment.

So if you're trying to implement something that's short of data segmentation you might want to start with limiting the sharing of that data to only clinicians that are directly treating the patient that would be an easier thing to implement before you get to data segmentation which actually obviously is optimal but it would be a workable way. Not to say that there isn't some bias within the clinical world but it's certainly less than outside.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, do you speak more about the kinds of allowed versus disallowed uses you're thinking of? This is Larry.

**Lori Simon, MD – American Psychiatric Association**

I'm not sure what you're referring to?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, you said sharing among treating clinicians.

**Lori Simon, MD – American Psychiatric Association**

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, if EHR is, you know, health information there are hands-on users of that information who are various level of clinical provider but there is also use of that information towards operations and payment, and potentially other uses. So, I'm trying to understand when you say treating clinicians how your – who you're including in that and who you're excluding.

**Lori Simon, MD – American Psychiatric Association**

Right, I think, you know, first of all as was mentioned earlier I think it's extremely important to talk with the patient, that's critical and I think if you come up with different levels instead of trying to get it down to a data segmentation level as I said, which I agree is absolutely optimal, if you said to the patient let's do different levels.

So, for example, only patient – only clinicians directly involved with your care that would be one level. If you then said to them, yes, well, what about the need to talk – provide insurance that would be a second level and give them options on a level basis like that for starters and that would be way of getting away from the all or nothing approach which is, you know, unfortunately what we have, all too often have nowadays.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, if you will, being the segmentation if – you know, or the control has to do with the use of the information rather than the content of the information?

**Lori Simon, MD – American Psychiatric Association**

For starters only for starters, yes.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Right. Yeah, the real concern is that some of that information whether it's mental health or substance use will go past the treatment provider realm and get into the hands of law enforcement or child welfare services that in some states might jump in and take a child away from a mother even though it's really not necessary just because they saw that.

**Lori Simon, MD – American Psychiatric Association**

Right and that's why the EHRs have to have enough sophistication to recognize that "oh, this is a law enforcement officer" does that – you know, for example if they patient said "I only want information directly provided to clinicians directly treating me." Well clearly a law enforcement officer is not and so the EHRs would have to have sophistication to recognize that that's the level of person or organization that is not entitled to that information.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Let me jump in with one other question not exactly related to this but kind of related to this. It was mentioned in the earlier comments about whether you provide a list of specific individuals that you can share or organizations to share information with or a class of organizations.

So for example, it sounds like today the general interpretation is I have to say it's okay to share my information with these two, three, four, ten providers, but I can't broadly say you have my permission to share it with anyone I will in the future have a treatment relationship with. Is that correct?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Right.

**Lori Simon, MD – American Psychiatric Association**

Yes.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Right now, yes.

**W**

The office – the way the current 42 CFR Part 2 regulations are is that you have to give the name of the provider or the organization with whom you want to share your health information. So it could be, you could say, you know, share it with Kaiser.

So, it doesn't have to be the individual named providers, but, you know, some organizations have asked for it to be more broad, you know, any treating provider, but our Office of the General Council has already looked at this and determined that the regulations don't support that.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah and this is also something that – I was following the Accountable Care Organization Workgroup and they're struggling with as well, and, you know, they've also asked for, you know, that to be looked at again.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, thanks.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other questions from Workgroup members? Okay then I think we'll move onto our next panel. Panel 4 is a vendor's perspective and so Melinda Wagner if you are ready?

**Melinda Wagner – General Manager Behavioral Health & Rehabilitation – Cerner Corporation**

Okay, thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thanks.

**Melinda Wagner – General Manager Behavioral Health & Rehabilitation – Cerner Corporation**

Good morning and thanks for the opportunity to participate in this hearing. The effective use of information technology to support the delivery of healthcare drives better outcomes, safer care and lower costs. The term effective I think is important because whether you like it or hate it Meaningful Use has certainly helped with that effectiveness. We're not there yet but we're making progress.

We've established a great deal of consistency that wasn't there in the past and we're improving our ability to support public policy. Meaningful Use has set some base expectations for today's solution as well as some vision for where we need to go the future.

At the same time it's allowed the market to drive some innovation or the need for innovation without impeding that opportunity. We have to continue to challenge the standards in a way that we've always thought so that we can really drive outcomes.

Certification has also provided a framework for buyers to assess HIT vendors and also a driving force through the funding. Certification requirements have also eliminated some providers. This is really hard work and it requires persistence. If you think about the 2011 edition of the certified Health IT product list there were close to 4900 different products in contrast to the 2014 list there are only 664 products.

The Health IT Committee has done a great job of summarizing the needs, the value, the risk and the options for behavioral health certifications. From Cerner's perspective the primary focus and objective for HIT certification must answer to what's good for the consumer or the patient.

We need the right information at the right time with the right guidance to support the best decisions and interventions. Data driven healthcare has to include behavioral health and medical health. Information has to be accurate, complete and not limited by the boundaries of a given provider.

The right information must also be available to the consumer in a way that the consumer can engage in their healthcare to the extent they're capable.

Any certification has to support integrated care. We know that truly integrated care and coordinated care programs that are across the country are demonstrating tremendous results in better outcomes and lower total cost.

Cerner strongly believes that a consumer health information program or certification has to allow for the information to follow the individual across the continuum of care that some degree of consistency is necessary for all vendors regardless of the specialty.

Behavioral health is unique and we need to encourage that uniqueness to live within an environment where we can collaborate not just as behavioral health providers but as healthcare providers. We know historically medical and behavioral health worlds have collaborated well, but health information technology offers an opportunity to bridge that gap and the understanding that information brings.

We agree with SAMHSA's statement that behavioral health providers should be encouraged to adopt EHRs that are interoperable with those being adopted by broader healthcare systems. We also agree that behavioral health providers or any other specialty or technology vendors should not have to commit resources to develop functionality that is not required for their scope of practice.

I would add that we should not be looking at things just within the scope of practice, but more importantly, that which is of benefit to the patient's care. Scope of practice is changing. We see mental health providers incorporating medical services and vice versa. We have to be careful that we don't fragment the focus and thus the benefits of HIT.

Cerner is also supportive of behavioral health providers and other excluded providers who can attest to that which is determined to be core to all consumers and those aspects that are part of their practice scope to receive federal funding.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Melinda Wagner – General Manager Behavioral Health & Rehabilitation – Cerner Corporation**

Okay. Let's see, HIT certification should primarily focus on the needs for all the consumers but allow the flexibility within the current system to address the unique specialty requirements. We believe modular certification has great value and the challenge will be not impeding the capacity to manage the consumers care within context.

I can't stress enough that you can't simply say it's a mental health patient or a medical patient that discriminating approach has historically hurt the consumer and we have to think in terms of the whole person. The opportunity –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, Melinda.

**Melinda Wagner – General Manager Behavioral Health & Rehabilitation – Cerner Corporation**

Okay, thanks.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Kevin Scalia are you available?

**Kevin Scalia, MSEE – Executive Vice President – Corporate Development for Netsmart Technologies, Inc.**

Yes, I'm here. Good morning I'm Kevin Scalia Executive Vice President of Netsmart Technologies. I appreciate having the opportunity to address you on how we see certification integration and privacy affecting the behavioral health community.

I'll speak from the perspective of the largest provider of technology to behavioral health organizations. We serve more the 20,000 private behavioral health practices, 40 in the state operated hospital systems and approximately 1/3 of all the community mental health centers in the country.

We have been participating in the creation of care coordination systems and the associated health information exchange as needed to connect behavioral health to physical health for some of the largest health homes in the country.

The behavioral health and human services market is complex, as a provider of technology to these settings we understand that and have developed a continuum of EHRs to meet the needs from the smallest private practice to the largest behavioral health, social service, IDD and child welfare organizations.

Our approach was a market-driven response to the diverse needs and price points of these communities. Our EHRs have received the existing complete Meaningful Use 2014 certification. If there was a behavioral health certification we would still need to have complete Meaningful Use certification as it is required by our clients who are integrated with health systems and is a criteria in many buying decisions made through formal RFPs.

Adding another certification will only add more confusion and cost to the process. Prior speakers have addressed the low adoption rate of Health IT among behavioral health providers. I would make the case that nearly all providers have some level of IT in use. I believe the lower adoption of clinical systems is driven by a lack of capital resources and the fact that behavioral health providers are not eligible for Meaningful Use funding.

I do not believe that the rate of adoption would increase with a new certification system without commensurate incentives to help justify the investment. Although there has been reference made to the hundreds of vendors that provide EHRs to behavioral health community less than 10 account for nearly 100% of the total number of installed systems. All of these vendors have passed the Meaningful Use Stage 1 certification. Netsmart has already passed the Meaningful Use Stage 2 testing for all our EHRs and I would assume our competitors are right behind us.

In addition, our systems are sold on a modular basis so that a provider who does not prescribe, who wants to buy an EHR does not need to buy the ePrescribing system yet they could still have all the interoperability capabilities that the full system has.

The key to bending the cost curve in the United States is the integration and coordination of care. However, the current Meaningful Use requirements and CCDs do not include the ability to transmit many of the behavioral health specific data required to coordinate care.

I would stress that the focus needs to be on how we adapt the existing certification requirements to ensure that physical health systems and certifications mandate the incorporation and the ability to transmit and receive behavioral health data as well as physical health data.

At a minimum all EHR certifications should include the capacity to send and receive standardized data elements to support transitions of care and care coordination across all care settings. CMS should add behavioral health, child welfare, IDD and substance abuse quality measures into the existing certifications so that domain specific quality measures can be used. If CMS adopted a standard requiring the electronic exchange of these data elements that standard alone would create the business case for the adoption of EHRs.

Innovations designed to transform healthcare are being developed and implemented now. Health homes and ACOs will not succeed until behavioral health organizations are able to share data with their physical health partners and care coordination programs. However, due to SAMHSA's interpretation of the privacy laws behavioral health and substance use providers are all but eliminated from participating in health information exchanges. I'll illustrate this with an example.

If an adult with Alzheimer's and diabetes consents to records being shared on an HIE they can do that and they can receive the superior care that can be delivered by coordinating care and reducing the risk of medication interactions associated with their multiple medications.

A single person, a second person, one with diabetes and substance abuse issues who has part of her treatment is provided by a substance use provider cannot consent to share their records on an HIE without enormous administrative burden on themselves and their provider and in most HIEs in the country it's impossible due to technical limitations. This is unintended consequence is a result of SAMHSA's interpretation of informed consent. On the face of it this would appear to be discriminatory to a consumer with substance abuse issues and against the intent of the mental health – and affordable care reservations. HHS –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Kevin Scalia, MSEE – Executive Vice President – Corporate Development for Netsmart Technologies, Inc.**

HHS and SAMHSA needs to issue sub-regulatory guidance allowing the patient to identify current and future providers in the HIE involved in my care as an appropriate title under the two – requirements for part 2 consent.

The consumer should have the ability to opt out if they don't want to participate, but we can't discriminate and not let them have the choice if they so want to. Thank you for the opportunity to submit our recommendations and comments.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Kevin. Paul LeBeau?

**Paul LeBeau, MBA – Vice President, Product & Technology – SMART Management, Inc.**

LeBeau, yes, I'm here. Okay, good morning everyone we'd like to thank the Workgroup for the opportunity to contribute to this important effort. SMART Management started out organically to improve operations of our own substance abuse facilities by automating our information systems, 22 years later SMART manages and operates Discovery House a national system of 18 fully accredited facilities as well as provides a fully certified virtually paperless EHR to more than 120 installations internationally.

Our unique vendor and provider perspective allows SMART to understand both the demand and impact that national certification initiatives place on the end-user and the vendor. We recognize the benefit and value to a widely adopted certification standard for healthcare which is why we chose to certify our EHR not only from the software provider's perspective but also to ensure business continuity in this changing healthcare environment.

In the substance abuse treatment sector specifically IT functionality has been fragmented at best. I think other speakers have said something similar to this. Even today with many EHR solutions available there is a wide range of implementations from nothing at all to several disparate systems that have little or no interoperability.

Our solution is singular, comprehensive and ONC certified. Yet many of our customers are not pursuing Meaningful Use incentives as it would require them to adopt workflows to demonstrate Meaningful Use but they're not useful or meaningful to them in their treatment environments.

While acknowledging the benefits of utilizing a certified EHR the cost to implement one are substantial and I think we've heard that also from other speakers. From a provider's perspective overall cost of healthcare provision is increasing while revenue is decreasing.

Without some form of incentive providers who are motivated by improved care and transitions of care would simply have difficulty covering the cost. For this reason we feel that the potential for widespread adoption of a voluntary certification is low without broad adoption the degree to which information exchange improves care is really limited.

For information exchange between primary care and behavioral health to be meaningful and useful a certification program must be based upon a holistic redefinition of healthcare. That is, treat the whole person body and mind.

Primary care should have more of an interest in substance abuse treatment and substance abuse treatment needs closer involvement with primary care. The health homes initiative and state health information exchanges are helping to bring this together.

From the substance abuse perspective certification would help to improve information exchange but from a patient perspective information exchange could be perceived as compromising privacy and confidentiality. This perception is more about the potential redisclosure rather than with the process of sharing the information with the HIE in the first place.

Confidentiality requirements in substance abuse treatment pose significant challenges to the provider's ability to participate in data exchange. For example, uploading patient substance abuse data to an HIE is problematic because 42 CFR Part 2 requires signed consent to list all individuals who may access that data. This is difficult at best initially and impossible to maintain over time as membership in the HIE changes.

There are efforts underway, and I'm sure you'll hear something from Charlie Hewitt at Rhode Island CurrentCare, to establish the process that complies with the 42 CFR Part 2 but without revision to those regulations it seems that those efforts will remain hindered.

Beyond the benefits of information exchange for clinical quality measures to be useful they have to be specific to the healthcare sector. Uniform data assessment and measurement criteria in behavioral health would be needed to benefit the diverse community of providers.

In closing, while SMART is fully in favor of establishing an ONC certification program specifically oriented toward behavioral health we would encourage that this program be incentivized to maximize its potential for success at the same time broadening the eligible provider pool to include clinicians, that it be based upon measures specifically oriented to behavioral health and that 42 CFR Part 2 be amended to support this program removing a major barrier to its adoption in the substance abuse treatment center.

We thank you for allowing us the opportunity to offer this testimony and look forward to continued participation.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Katherine Peres are you available?

**Katherine Peres, PhD – Vice President & Co-Owner – Synergistic Office Solutions, Inc.**

Yes, I'm here. Thanks for the opportunity to address the committee today. My name is Katherine Peres I'm Co-Owner and Vice President of Synergistic Office Solutions, also known as SOS Software. I'm also a licensed Psychologist in Florida.

My company is a very small organization driven by the mission to provide software of the highest quality at the best possible price for the behavioral health and addictions community. Since 1985 we have provided practice management software and since 1989 a clinical record product. Currently, our customers are primarily private practice psychologists, psychiatrists, social workers and mental-health counselors in practices ranging from solo to large groups.

Approximately 10% of our customers are small to midsized family service of community mental-health organizations, 30% employ or are owned by a provider eligible to receive stimulus funds for Meaningful Use of a certified EHR.

In spite of our early interest in clinical record products, including my participation in 2006 and 2007 on the behavioral health profile working group cited by Dr. Boyle in Friday's meeting and by Dr. Lori Simon this morning, a few years ago we made the decision not to pursue ONC certification of our clinical product.

We chose not to certify for three primary reasons. First, as a small company our resources are quite limited and we could not increase our prices to cover the cost of certification. Second we determined that 70% of our customers are not eligible providers and do not meet ONC certified products.

Finally, our primary product is our practice management software while 25% of our customers own a license for clinical record software just 7% use only that product. The conclusion for was that most of our customers are not interested nor do they need a certified EHR.

Having made the decision not to pursue ONC certification being presented with this new voluntary certification brings up old and new questions for us as a company. First, is this really a voluntary certification or is it an elaboration and expansion of the certification for stimulus dollars?

It seems ironic that providers and organizations who are not eligible for stimulus funds might find themselves needing to purchase ever more highly certified EHR products. Would a product that does not have basic ONC certification even be allowed to pursue voluntary certification if their product does not meet the base EHR standards.

Will products without certification be allowed to send a Consolidated CDA? Will additional certification increase competition among software vendors or will it merely drive further consolidation gradually removing small vendors and ultimately small providers from the marketplace?

Is there a need for certification in areas where there are clear standards and testing methodologies and platforms? Is it possible to use the NIST testing platform to accomplish some of these goals in a less formal fashion? Are there other ways to accomplish the goals of an additional behavioral health certification without the significant cost that would be involved in yet another certification program?

Is it possible that certification is the tool that you're using to advance the goals of data sharing and clinical quality measures because it's the only tool you have? A screwdriver is not the best tool for placing a nail in a wall but if it's the only tool at hand it's the one that will be used.

Perhaps there are answers to my questions that clarify that reasons that only certification can accomplish the goals of ONC. While I would certainly be interested in such answers I don't believe that they would move our company toward pursuing this voluntary certification. My primary reason for this is one of cost.

The organizations we serve can be small in a way that some of you seem not to recognize. For the National Council a small member maybe a community mental health center with a \$1 million dollar annual budget. For us small is more likely to mean an organization that grosses well under \$100,000 annually.

Our clinical product begins at just over \$500.00 for a single computer license yet the most frequent objection to purchase that we hear is that it is too expensive. Most of our customers could not consider purchasing the ONC certified products of one of my SATVA colleagues because of their cost.

In fact, professionals of my generation trained in the 1970s and 1980s who have worked in freestanding psychotherapy practices are not in my experience prepared or willing to jump on the EHR bandwagon.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Katherine Peres, PhD – Vice President & Co-Owner – Synergistic Office Solutions, Inc.**

Some even see the use of an EHR as potentially unethical. I believe it's the responsibility of the ONC to recognize the extent of the losses in professional experience and knowledge that are occurring as providers remove themselves from the marketplace to avoid EHRs. Perhaps the consideration of ways to move HIT forward while making those losses more gradual would be worthwhile. Thanks for this opportunity this morning.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Joe Viger?

**Joe Viger – Vice President of Business Development – The Echo Group**

Good morning, this is Joe Viger, how are you? I'm Joe Viger and I'm the Vice President of Business Development for The Echo Group and I'm the President of the Board of Directors of the Software and Technology Vendors Association or SATVA and that is who I represent this morning.

Founded in 1999 SATVA includes 11 member companies representing a diverse collection of technology. Our members deliver solutions to behavioral health and social service organizations across the continuum of care. From our founding we believe strongly in the value of data and information technology standards to reduce the unnecessary overhead our customer's experience.

We've also been enthusiastic about the value of interoperability, investing a lot of time and energy in workgroup activity on that topic and the potential for technology to enhance quality of care. This has driven our ongoing activities as an association and our ongoing desire to engage in dialogue with organizations like the National Council, Mental Health Corporations of America, SAMHSA and the ONC.

We've advocated that standards definition is vital. We believe they're a useful tool for vendors that allow us to build our products to guidelines that make development more efficient and they allow our customer base to better understand the future sets we're building into our products.

We're recommending a continued focus on the alignment of certification standards with existing federal and state programs as part of the framework engaged. Electronic health record certification has been introduced on top of existing standards that customers are already required to comply with be that Medicaid, CARF, JACHO, etcetera. Stage 2 introduces further complexity to that process.

Meanwhile, more standards initiatives are being introduced and taking shape as time goes by. This has included state forms-based projects like in New York or Massachusetts, the possibility of behavioral health certification and the possibility of voluntary certification programs.

We're encouraging the coordination of standards to truly achieve the goals of better integrated care and other speakers have spoken to that already and I appreciate those comments.

A lack of standards coordination is increasing the difficulty for success within EHRs for both providers and vendors as well as increasing cost. I observe what I'll call standard's fatigue where the providers I speak with don't really seem to understand the requirements that are presented to them and how they integrate with each other or the challenges and opportunities they face in adopting those standards.

Many guidelines they are confronted with don't contribute to their ability to implement a quality Meaningful Use certified record that can enhance their care, coordinate care and reduce costs. For vendors and providers the cost and complexity introduced is creating a significant barrier to adoption of the electronic health record.

In many ways certification is aligning technology with exciting new developments in behavioral health care, primary care integration is an excellent example where certification standards promoting interoperability and introducing medical data requirements into the behavioral health record have benefited provider organizations who adopt this approach.

But in other ways we observe certification requirements creating a tension between what our customers want and what certification is driving the vendor to deliver in a certified application. One example is the way behavioral health providers define their client is generally different than what we've seen develop in the certification process.

Another example is that behavioral health providers focus on treatment planning and the concept of the golden thread that isn't really reflected in certification. Most providers bristle at the problem list being equivalent to the elements of a behavioral health treatment plan.

As a result we advocate for standards accommodating the specialty of behavioral health while balancing the challenge of integrating the data to treat the individual as a whole. We encourage that standards speak to behavioral health requirements are developed in the context of core certification standards already in place.

We are concerned about how increasing specialization in these standards could impact the behavioral health provider's ability to integrate into the larger healthcare ecosystem and treat their clients as part of that larger healthcare ecosystem.

One example of how this can be accomplished relates to interoperability. Our belief is the existing standards are sufficient to support systems interoperability but we welcome the sub-regulatory guidance already suggested today to address the requirements of 42 CFR Part 2.

In closing we thank you for the opportunity to address the committee today. We look forward to participating in continued standards definition in our industry, to enhance health care, the consumer experience and reduce cost. Thank you very much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you very much and thank you to all of our panelists. If there are any Workgroup member questions please go ahead, as of now I don't see anybody with their hand raised. Joan Ash has a question.

**Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – Oregon Health & Science University**

Yes I'm somewhat confused about how many of the issues we've been discussing are policy issues or regulatory, or legal issues versus the technical issues and it sounds like there are products out there already addressing the segmentation issue we've been talking about which seems to be technical.

I wonder if those on the panel could tell us how they're dealing with that segmentation issue with all of the permissions and consents that are needed?

**Kevin Scalia, MSEE – Executive Vice President – Corporate Development for Netsmart Technologies, Inc.**

**Sure, this is Kevin Scalia and I wanted to comment on even some of the discussions from the last panel. I think there are some misconceptions about what we are looking to exchange or what most providers who are looking to coordinate care be it with an ACO or a health home, or just with a local FQHC, or private practice, there are some misconceptions that when you participate in health information exchange I'm taking the client's entire clinical record and posting it on the Internet, you know, to be trite about it.**

What I'm seeing in most of the interoperability cases we're working with, especially in health homes or integration with primary care where we're dealing with people with multiple chronic diseases, the primary care side of the world really has no interest in the psych notes or the group therapy notes, or progress notes what they're interested in are what's the medications that the client is on, what is the diagnosis and if you have lab results what are the current lab results so I don't have to redo a test.

And what we're seeing, I think it was Dr. Gastfriend said, for those clinicians who sit down and explain the benefits of coordinating care with their consumers were getting nearly 100% of the consumers agreeing to consent to coordinate care because they see their clinical benefits.

Having said that and understanding the sensitivity to some of the stigma you have to be able to give the consumers the ability to opt out or not opt in depending on the structure of the health information exchange. We can do this today, the problem is – and the HIE panel that's coming after us I think will address some of this, other than one or two of them there is virtually not one single HIE in the country that can handle the 42 CFR requirements as the way it's been interpreted by Health and Human Services and SAMHSA.

So, what we're being forced to do is go out and climb every single mountain individually. We have to partner – in our case we're partnering with Epic and we're partnering with Cerner to do point-to-point connections because all of these new care coordination bodies are being built today and we can't wait for the – if we wait for the regulations to be developed all the behavioral health and substance abuse will effectively be left behind in this integrated healthcare world.

You have to do it with informed consent with the consumer but you have to be able to let those consumers choose to participate if they want to and not discriminate against them.

So, I don't see anybody today asking to share psych notes or, you know, progress notes it's the medications that they want to coordinate care so we don't prescribe drugs that would cause an interaction and would potentially kill the consumer.

**Paul LeBeau, MBA – Vice President, Product & Technology – SMART Management, Inc.**

This is Paul from SMART Management; I think I'd like to extend what Kevin just said in terms of the medications. We are certified like I said before and we chose to partner with DrFirst for ePrescribing and discovered very quickly that in the process of integrating with something like that you end up violating 42 CFR as soon as the medication list gets sent up.

So we've been working very closely with DrFirst to try to come up with some mechanism to get by that but we don't believe that we have something solid in terms of the way that HHS and SAMHSA interpret those regulations.

So to address the question more specifically, technology costs money to implement, but it's technology, it can be achieved. With what we've run into is more administrative issues policy, regulatory issues than it has been technological.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other questions from Workgroup members?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Hi, it's Larry I'll jump in. So, those comments were very helpful about the types of exchange that you're pursuing with point-to-point because of the issues around the HIEs and the perceived value in exchanging medications and labs.

So one of the things that I didn't hear mentioned and maybe because it's a given or maybe because it's not well captured, is allergies. Presumably that's a relatively clean thing to share. Any comments about that?

**Kevin Scalia, MSEE – Executive Vice President – Corporate Development for Netsmart Technologies, Inc.**

Yes it is something we are sharing because there are components of the standard CCD and I'm pretty sure that that's in the standard CCD I'll check with – I have to check with the technical people, but I'm pretty sure that that's in there and yes because of the interaction with medication and food that is important.

Now the other part that is evolving as you look at health homes and, you know, ACOs and the like is the ability to share a care plan. So the issue as we've worked closely with Epic is that the primary care systems, the acute care systems don't have the capability to capture some of the data that for example 42 CFR, I'm sorry DSM IV or V Diagnoses that the behavioral health systems generate.

So, this is where I think some of your guidance in changing the certification requirements that we have to go through as vendors under the existing certification to require the physical health system to be able to capture and share this data, as well as to drive, I think it was Paul who mentioned, the ability to have domain specific quality measures, you know, doing a cancer registry for a methadone clinic doesn't make a whole lot of sense, but having outcomes measures that the substance abuse community has agreed upon that would make sense for a substance abuse provider to track and capture and report on would move the industry forward.

And I believe it would also help end the bulk and it would not end, but lead to breaking down the balkanization amongst the 50 states. Because the other complexity we have is that each state defines their own outcomes, measures and quality measures, and assessments that you have to use which means that we have to build those into our systems 50 times and it's probably some of the most complex components of the systems that our client have to deal with in terms of their regulation at the state level, because there is no unanimity among the 50 states. Having a federal standard would help to drive some continuity down that path I believe.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

This is Stan Huff—just a comment and I realize that this may not be in the scope of the committee per se but, you know, the challenges with 42 CFR, you know, are real in that, you know, the intent of keeping information private and secure and then also patient safety seem to be in conflict. In other words, as we've looked at it it's not a technical problem.

The problem that we have is that if we, you know, if we hide, you know, medications and lab work that would divulge the treatment or the diagnosis then we stand in danger of causing patient harm by not telling clinicians about potential allergies or drug interactions or other important considerations.

And so it almost seems like there is a need to think about the regulation, to re-examine that. I'm not sure that people thought through all of the electronic medical record implications of the regulation or the legislation.

We want to do the right thing and we can't determine the right thing based on the conflict between patient safety and the confidentiality and privacy issues.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other questions from our Workgroup members?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Let me jump in with a question it's sort of more to Stan but maybe the panelists would like to comment on this. So, earlier this morning we heard the comment about the notion of a black box database. So, some aspect of the computer system would know about the specific medications, the specific diagnoses, the specific sources of that information. But that information would not be directly available to the human beings but would be available to the decision-support logic.

So the system could flag a new drug as interacting with some other drug but it couldn't tell the clinician what that other drug was. Is that actually a valuable thing for us to be considering or is that going to cause way more unintended consequences than the value it might deliver?

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah, I think that's problematic. I mean, I guess we need clinicians to weigh in on this, but I – you know, the likely – if you tell me there's an interaction and you don't tell me what it is I wouldn't know what to do. I mean, you would just frustrate me.

**Melinda Wagner – General Manager Behavioral Health & Rehabilitation – Cerner Corporation**

I think there could also be legal liabilities too knowing there is an interaction but not knowing what it's supposed to do.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so an example of a solution that might be sort of technically, I hesitate to say "elegant" technically possible but not actually of any real value.

**M**

Correct.

**Stanley M. Huff, MD, FACMI – Chief Medical Informatics Officer – Intermountain Healthcare**

Yeah, I think that's exactly right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay.

**M**

And it goes to some of the issues with segmentation, we've heard the same comments from providers around segmentation. I think there is a whole list of other problems but there are clinicians that have told us, hey if you segment the data and I'm getting data from you that says, okay you're going to send me your medications for this patient but not for another patient or you'll send me the lab results for this patient but not for another patient I'm not going to believe anything that comes from you, because I'm going to assume that you're withholding something so I'm just not – I'm going to disregard everything that comes in.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, so the whole question about completeness gets worse rather than better?

**M**

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Sort of an interesting dilemma a little bit of information turns out to be worse than none.

**M**

Right.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

I had a question, Joe, you mentioned the notion that your definition of clients might be different from the physical medicine end of the world. What were you thinking about?

**Joe Viger – Vice President of Business Development – The Echo Group**

I was really referring to kind of the tradition of how the behavioral health providers quantify their clients. So, as we look at certification we're starting to incorporate SNOMED codes and different types of coding systems, different types of values that aren't typically part of what social workers are learning in school certainly, but how the practices engage today and what typically the clinical director in a software search is saying they want to see in our system.

So the diagnostic structure, Kevin mentioned earlier the DSM IV codes not really being part of the larger healthcare universe. Now that's really implicit in the base tradition of behavioral healthcare but isn't spoken to in the certification regulation.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay so it's more around the code sets?

**Joe Viger – Vice President of Business Development – The Echo Group**

That's one of the primary examples, yeah, certainly I would suspect behavioral health providers would expand on that talking about the nature of their clinical assessment versus that of a healthcare provider and again how that might be reflected in the certification standards but the code sets are the most ready example I think.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Okay, thanks.

**Joe Viger – Vice President of Business Development – The Echo Group**

Sure.

**Kevin Scalia, MSEE – Executive Vice President – Corporate Development for Netsmart Technologies, Inc.**

Yeah, I think it's also important to comment – there were a couple of comments made about – one I wrote down on my notes here was that if a law enforcement officer logs into the – or gets into the EHR and gets access to data – I mean, I'm not a lawyer, there are probably some on the phone who could comment, but I think that's illegal.

And if the person isn't involved in the care they're not allowed to access the record that would be a violation, I think of HIPAA, again I'm not a lawyer, but I think that we have to be careful with some of the generalities of who legally can access the health record and who, if they access the health record, would be violating current law.

And I would make the case in many ways having the electronic health record is more secure than some of the paper records, because by our certification requirements we have to log everybody who has had access to that data so we can track it. If there is a violation that person can be prosecuted.

And I think as we move down this path, especially as we educate consumers, as one of the speakers talked about informed consent, we have to educate them as to what the current legal, I think, felony requirements are for people who illegally accessed records under the current law.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah and this is Mike Lardieri and Kevin I just want to support that. I know we do leave out of this often times the whole patient education component and we need to do a lot of work with patient education and I think it's been shown that when you do that and they understand the benefits versus the risks of sharing their information then they're in a much better position to make the right decision for them.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any more Workgroup questions? I don't think that we have Wende from our next panel, but I just wanted to check and see if she has joined? So, why don't we start with the other two presenters and then hopefully Wende will have joined. So, the next panel is the health information exchange perspective. So, Dr. Laura McCrary are you available?

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

I am can you hear me?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We can hear you.

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

All right, super. Do you want to go ahead and put my PowerPoint slides? That's great thank you. Hi, my name is Laura McCrary and I appreciate taking this opportunity just to provide some input to you regarding what we are doing in Kansas as well as how we have been working with all of our behavioral health organizations. So, let's go to the next slide.

Just to give you an idea we are a health information exchange in Kansas. We do provide statewide health information exchange services. We do have well over 2 million unique patients in the exchange, you know, probably 630 different KHIN members and we do have quite a few of members that are in production meaning that they're actually sending their data to the exchange, it includes 45 hospitals over 180 clinics.

And then LACIE is our sister exchange in our state and so we are connected to our sister exchange and they have an additional 8 health systems that we can access through their exchange. We are helping all of our providers meet their MU2 requirements by doing their public health transmissions and we were the first in the nation to send data to the CDC from our health information exchange and we've sent well over 1 million transmissions now for the diseases that CDC tracks. So, let's go to the next slide please.

This is just a quick look at our participating providers and this map isn't complete, but I think the thing that I wanted to particularly point out to you is if you go down and look below the map you can see about halfway down on the left-hand corner is the community mental health centers.

So we have 27 community mental health centers that are KHIN members and if you go on down you'll see that there are five individual behavioral and mental health providers and then if you go over to the other side you see that there are three substance abuse treatment centers that are all KHIN members.

Because we've been very adamant that as we build this exchange behavioral health data and physical healthcare data should be together in the exchange to ensure that if a patient has an emergency that that information is available at the point of care. Next slide, please.

So we provide to all of our members that 630+ a number of products that are important just for you to be aware of. We provide Direct which is of course secure e-mail for healthcare providers and we have over 5000 different healthcare providers in our state using Direct.

We also have a provider portal for those members who don't have an electronic health record so that they can embed the exchange. And so we provide full health information exchange query functionality meaning that you can search for a patient across the exchange and really all you need in order to do that is just access to a computer and to Internet.

We do provide a personal health record, a statewide personal health record for free for all Kansas patients and this is a place where they can maintain all of their own health information. There is educational material available there and also it's a place where they can securely e-mail their providers.

We are responsible for helping our providers develop their state level interfaces for MU2 and you can see that listing there and we are just now beginning our work on the alerts and data extract. Next slide please.

So, one of the things that I was asked to speak about is how we have really moved forward to include behavioral health information in our exchange and so one of the key pieces of legislation that we passed in Kansas was in 2011 and basically we had a lot of outstanding consent laws around releasing behavioral health information.

So, in 2011 we normalized all of those consent laws with HIPAA and so the only then outstanding regulation was the 42 CFR Part 2 regulation which is a federal regulation around substance abuse treatment and we'll talk about that.

There were quite a few concerns from the behavior health community that the legislature had authorized this and so in 2012 the legislature reconfirmed again their intention of normalizing all of the consent laws with HIPAA.

And then the other thing that our state required is that our state required technology functionality that blocked data from being released at the health information exchange level and so that was critical to us being able to include behavioral health information in the exchanges that we could block it at the HIE level and don't have to worry about the EHR vendors blocking the data.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

**We have policies and procedures to include behavioral health information and you can find those there. Go to the next slide, please.**

And so one of the things I want to make sure I tell you is that it's very important to block the data at the HIE level and not at the EHR level and you can see because the data is not available in the event of an emergency and the data is not available when the patient gets consent. Last slide, please.

All right these are the issues that are associated with behavioral health EHR participation in KHIN. We really have found that the EHR vendors have difficulties with interoperability that other EHR vendors are now being able to address, they have difficulty with transitions of care because they don't have a direct product embedded, they have difficulties with patient engagement because there is not a patient portal and they have difficulties in managing how the 42 CFR Part 2 substance abuse data is included. And so thank you very much. I think I probably took my 5 minutes.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Charlie Hewitt are you available?

**Charlie Hewitt, MBA – Director, Health Information Exchange Products Delivery – Rhode Island Quality Institute**

Yes I am. Do you want me to –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Please go ahead.

**Charlie Hewitt, MBA – Director, Health Information Exchange Products Delivery – Rhode Island Quality Institute**

Okay, hang on just a second. Good morning, my name is Charles Hewitt I'm the Director of Health Information Exchange Product Delivery at the Rhode Island Quality Institute. RIQI implements and operates Rhode Island's Statewide Health Information Exchange called CurrentCare.

Rhode Island considers CurrentCare to be a key component in achieving the goal of a healthcare delivery system which integrates the treatment of behavioral health and physical health conditions. CurrentCare's function is to collect clinical information from many diverse sources and make the information available as a single normalized longitudinal patient record when and where needed for treatment and coordination of care.

The key requirement for the CurrentCare success is easy interoperability between CurrentCare and its partners. With regard to behavior health at this moment CurrentCare is receiving clinical information from two community mental health organizations and enabling this information to be used to treat and coordinate the care of patients. The information concerns treatment for alcohol and substance abuse and is subject to 42 CFR Part 2 regulations.

CurrentCare provides two kinds of service to healthcare providers with viewer and hospital alerts. The CurrentCare viewer enables authorized healthcare providers to find and view clinical information of the patients they are treating. The clinical information is collected from sources, data sharing partners which voluntarily send clinical transactions and documents to CurrentCare.

The types of information currently being collected include lab results, admission, discharge, transfers, diagnostic imaging reports, medication history and continuity of care documents. To use the viewer the provider only needs an Internet connection.

Hospital alerts enable providers to be notified when one of their patients is admitted to or discharged from an emergency department or a hospital. Providers are able to subscribe to individual patients and in this way an entire care team may be notified of an event.

The trigger point alert is an admission, discharge, transfer transaction from a hospital. CurrentCare associates the patient with the subscribing providers and sends the providers a Direct secure e-mail alert message with a CCD attachment.

CurrentCare is able to collect and disclose highly sensitive information such as treatment for substance abuse received at a program which must comply with 42 CFR Part 2 regulations.

Rhode Island's consent policy is opt in to send, that is CurrentCare may collect only the information of the persons who have voluntarily consented to share their information and disclose it only to healthcare providers who are treating them or coordinating their care. Persons who participate in CurrentCare also agree to allow the collection of all their information including sensitive information such as treatment for behavioral health conditions.

Interoperability of an EHR with CurrentCare is critically important. CurrentCare receives information from practice-based EHR systems such as those used by community mental health organizations in the form of the CCDs attached to Direct secure e-mail messages.

Typically at the completion of a patient encounter the EHR system automatically sends a Direct message with a CCD attachment to the CurrentCare participation Gateway. The Gateway checks for consent and if the patient is participating in CurrentCare the CCD is forwarded to CurrentCare, otherwise the message is blocked. Once in CurrentCare the CCD is consumed into the patient's record.

Hence, interoperability of an EHR with CurrentCare depends on the ability of the EHR to create automatically upon the occurrence of a trigger event a proper CCD and send it using the Direct messaging protocol. With regard to voluntary certification of the behavioral health EHRs RIQI strongly recommends that such EHRs meet the same standards for interoperability as are required of EHRs that are covered by Meaningful Use.

By using a system certified through interoperability the behavioral health provider will be on a path to share information effectively with other healthcare providers even those who only have an Internet connection via CurrentCare.

Moreover, as standards such as continuity of care documents evolve behavioral health providers with certified systems will be aligned with the progress of the healthcare delivery system in general moving towards the goal of integrated healthcare. I appreciate this opportunity to address the Workgroup and thank you very much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you. Has Wendie now joined?

**Wendie Baker, MEd – Executive Director – Electronic Behavioral Health Information Network (eBHIN)**

Yes I have, thank you very much, Jennifer.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

This is Michelle, actually, so Wendie I know you weren't on just a reminder that you have 5 minutes, so please go ahead.

**Wendie Baker, MEd – Executive Director – Electronic Behavioral Health Information Network (eBHIN)**

Okay, definitely. Thank you very much for the opportunity to participate in this discussion around the voluntary certification standards. The Electronic Behavior Health Information Network is a regional health information organization, we operate HIE and EMR applications for a network of behavioral health organizations in Southeast Nebraska.

In developing our system we knew from the very beginning that integration of care between behavioral health in medical settings was going to be an important factor in trying to address disparities suffered by behavioral health patients and interoperability between systems is a crucial piece in terms of trying to address those disparities.

As we work with the providers there is just a vast difference between the providers who are out in the field and serving rural Nebraska and the medical systems such as hospitals that are providing acute care in the more urban settings. And so the differences between these two systems creates a challenge in terms of trying to share that information that is so crucial to the care.

So one of the points here I think in terms of the certification process is that this standardization of various modules will help those entities to at least get a basic product and to know that that product meets certain standards.

Their IT resources are extremely limited among the groups that we serve and having a certified product that they know is going to deliver that operability is going to be very important to them and the use of what resources they have.

Our experience with NextGen Healthcare Information Systems is, you know, this is a very high quality product that offers deep, deep flexibility in the application and the only way that we have been able to get these products adopted among our lower resource partners is by going out and getting subsidies for the product, you know, we've seen people go to much less capable systems simply because they could not afford to get a higher end product.

It's also true that most of the medical EMR products are not configured for compliance with CFR 42 Part 2. We've spent a lot of time in resources in working with our vendor around accommodating the needs of CFR 42 Part 2 compliance.

Interoperability and the use of standards around interoperability will affect patient safety and quality. The information – you know, our behavior health patients and chronic mental illness is characterized by episodic need for acute care and in those instances when those patients need acute care having the correct information available when and where it is needed is absolutely crucial and interoperability is something that is really going to contribute towards that.

It's also true that behavioral health entities because they're new to the electronic market and there is variability in service delivery they don't have access to good comparative data around service delivery and so having the adoption of certified products that have these kinds of measures embedded is going to help them do the quality assurance and performance improvement activities in order to deliver their services more effectively and efficiently.

We also know that based on industry that Meaningful Use and the certification process has contributed significantly to the vendor adoption of those standards and although voluntary I believe that a certification process the vendors could offer would in fact be adopted, would spur adoption in the industry and would also spur adoption by the behavioral health community. So, that's the scope of my comments. I appreciate being able to contribute to the discussion today.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, Wende and thank you to all three panelists. If there are any Workgroup member questions please go ahead and ask them.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Yeah, this is Mike Lardieri, this is a question for Laura. I'm wondering if you could explain how your HIE has worked out the process? And I referred to it earlier but I just wanted to make sure it came from you as opposed to me to make sure it was correct.

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

Oh, thanks Mike. As I said earlier, you know, in Kansas we normalized all of our patient consent laws with HIPAA so that allowed behavioral health information to be shared in the exchange with the exception of the Part 2 data that was referenced earlier the substance abuse data.

So, we worked closely with our community mental health centers to determine that we were going to share two specific data and that data was the diagnosis codes for the patient as well as the medications that had been prescribed at either the substance abuse treatment facilities or the community mental health centers.

And then what we have done as we've started to integrate the data into the exchange is that we've made a conscious decision to opt out all patients that have been receiving care at a 42 CFR Part 2 substance abuse treatment facility. So, those patients are opted out of the exchange.

However, we have passed a policy for KHIN in our state that allows those patients to provide consent at the point of care for their data to be available. And then of course if there is medical emergency that information is also available.

So, all of the patients that their data is protected under 42 CFR Part 2 that data is lost except for in the period of time when the patient has given explicit consent for it to be shared or in the event of a medical emergency and there is a form that the patient signs and our health information exchange has a very robust auditing functionality that allows that information to be checked if someone has accessed the information to ensure that actually there was a treatment relationship and the patient had given consent.

So that's the way we worked through the process. We've been very pleased at the response from all of our mental health providers. They feel that we've met the requirements. We've also shared that information with SAMHSA and with the National Council. And I think that as we move forward with this we'll be able to have some good experiences to share with you on how this has worked out. Thanks, Mike.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay, thanks a lot.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Laura, this is Larry, I was getting some static on the line, you said that there were two sets of data that you were exchanging, I got diagnosis codes and what was the other one?

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

Medications.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And medications, Thanks.

**Laura McCrary, Ed.D – Executive Director – Kansas Health Information Network (KHIN)**

You know, as we worked with our providers, and I hear that static too, I apologize, as we worked with our providers we determined that those were the things that were most critical in the event of an emergency.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other questions from the group? Okay, I don't think we've ever run this early during a hearing so thank you very much to all of the health information exchange panelists. I just want to do a quick check to see how we're doing with panel six to see who is on the phone. Do we have David, Justin, Rick and Tim?

**Rick Harwood – Deputy Executive Director and Director of Research & Program Applications – National Association of State Alcohol & Drug Abuse Directors**

Rick Harwood here.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

David are you on? Justin Harding are you on? And Tim Knettlar are you on?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

What do you think if we do something radical and have a 5 minute break?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We can do that I just get concerned with getting everybody back together. So, let's go ahead and do that.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Don't leave, don't leave, this is John, don't leave the line just leave the line open.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Right, right don't hang up.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Right. So, because we need to get everyone from the last panel on the line, so why don't we plan to regroup at 11:46 so that we can get started back up again.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And it sounds like if nothing else we've got Tim, so we've got one that is ready to go, so please be back in 5 minutes.

**Justin Harding, JD – Senior Policy Associate – National Association of State Mental Health Program Directors**

Justin Harding is back.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yeah, Justin, okay.

**Rick Harwood – Deputy Executive Director and Director of Research & Program Applications – National Association of State Alcohol & Drug Abuse Directors**

And Rick Harwood is here, did you hear me?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

We hear you now.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, we hear you now.

**Rick Harwood – Deputy Executive Director and Director of Research & Program Applications – National Association of State Alcohol & Drug Abuse Directors**

Okay.

**Justin Harding, JD – Senior Policy Associate – National Association of State Mental Health Program Directors**

All right.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

All right, thank you, 11:46 everyone.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Too bad we can't play some music.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Hello?

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

Yeah we're on, we're on a 5 minute break.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Okay, great, good morning.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Oh, hey, David.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Hey, Mike, I appreciate your prompt it looks like you're running a little early I was going to join about quarter till, so –

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Oh, okay.

**M**

They were going to start us at 46, 11:46.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Very good.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Is this David Lloyd?

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Yes it is. How are you this morning?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Good, thank you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Hey, Michelle, are we ready?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We don't have Tim yet but I think we can get started. Latanya can you please take the music off? Thank you. So, welcome back everybody, hopefully we got everyone back. So, I think we are ready to move to our last panel. So, to provide a regulatory and quality improvement perspective.

So, I think that David Lloyd has now joined. So, David I know you weren't on earlier so just to give you a quick summary, you'll have 5 minutes at the 30 second mark I will let you know that you have 30 seconds remaining. So, with that if you want to begin your testimony.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Good morning, I appreciate this opportunity and very kind to invite me to share some thoughts. My name is David Lloyd and I'm Founder of MTM Services. We have been for 20 years providing behavior health management and database management consultation to over 1000 community providers in 48 states.

We have worked primarily through the National Council since 1997 when I wrote my first book on how to maximize service capacity. We have primarily worked in areas of EHR conversions and implementation support within these centers.

We also, what we call work in "post-EHR implementation recovery" because in so many cases, which is a point of my comments today, EHR implementation has been very difficult for our behavior health centers and in many cases what we find in our assessment is that they are not fully implemented even after years of attempts and I want to talk about some of the challenges that we see as causing that.

Secondly, we have worked with statewide clinical documentation data element development. We have standardized all behavior health including MH and SUD provided services for Medicaid providers in the State of Ohio, the State of Massachusetts, I think there are 171 there and the state of New York, and the State of Oregon.

But what we've done is gone into those states and developed basically a compliance grid that allows us to understand for all the prayers, all the contractual requirements, all the accreditors, we typically work with Joint Commission, COA, CARF as well as NCQA if we a managed care entity in the state.

But we basically say, "What data elements are required specifically for each of the clinical form processes?" This data development then becomes basically a data map which then allows the vendor, EHR vendor, to certify within the state of Massachusetts or the state of New York that they meet the specific documentation requirements for clinical documentation within their state.

This certification process is really on mini, mini scale is really what you are proposing which we wholeheartedly support because without it what we find example in our statewide documentation efforts in one state we had over 1800 different assessment form types when we started our work. The result was one assessment form type with 115 data elements.

But when we start with such diversity and each of the behavior health centers starts with its own version or its own process of how it wants to develop its clinical forms and that uniqueness has been almost, you know, embraced in the past has now come back to really haunt us. Because basically what we're finding is that when we try to convert and bring in EHRs the implementation challenges for the vendors is unbelievable because every single BH center is an island unto itself and the experience has to be duplicated and replicated over and over through a very grueling implementation and costly process.

Also we have had the privilege of working now with over 250 behavior health centers with all the behavior health centers in Arkansas, Colorado, Tennessee, Kansas and Georgia and we are just adding them in this spring.

But we measure through SPQM Services, which is data – a service encounter database, we measure about 10 million encounters a month now and what we provide to these centers and to these states is comparative service process and quality outcome data. So that's been another area that we've worked in.

In terms of our challenges and the reasons that I presented today and basically these challenges I think can certainly be met in the area of the ONC lead IT certification program in terms of improving care or care delivery as well as IT functionality that exists within our behavior health system which I've indicated some challenges.

But, you know, what we're finding within our measurement process, we do process measurement/process change, developing same day access models things of that nature over the past 20 years. But the average number of data elements that are collected in the average behavior health center that we work with and we've measured over 1000 is basically 1750 data elements or questions, if you will, from the initial –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thirty seconds.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

Okay, screening to the treatment plan up to 2100. So what we see with these multiple processes is we need some standard, we need some ability to say this is what is required therefore we recommend the Meaningful Use incentives because it would improve standardization of the data elements within the EHRs and enhanced interoperability but support more standardized access to treatment because the models we're seeing are varying and create tremendous challenges and enhance the comparability of service encounter data including the ability to measure process, process variance which will basically help us to identify why we had good outcomes and actually to replicate those good outcomes. Thank you so much.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you David. And Justin Harding are you ready?

**Justin Harding, JD – Senior Policy Associate – National Association of State Mental Health Program Directors**

I am ready. Can you hear me okay?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We can hear you.

**Justin Harding, JD – Senior Policy Associate – National Association of State Mental Health Program Directors**

Excellent. My name is Justin Harding I'm speaking on behalf of the National Association of State Mental Health Program Directors, which we represent the state level directors for all 50 states as well as the various territories.

We wanted to come at this problem from a very basic and overall systemic stand-point. Sometimes we forget about these basic underlying things but for us these things are what drives the conversation many ways.

Our consumers, our customers, however you want to phrase them as, they range from kids to older adults each population in many instances has their own sub-system and their own set of specialized requirements that need to be taken into account.

One thing that I cannot overstate enough is that people with a serious mental illness or a mental illness of any kind tend to die 25 years before anyone else in the rest of the population. So, for example, if the average life expectancy is 75 year olds for most of the population, someone with a mental illness will typically die around 50 years old. That is an enormous driver of pretty much everything that we want to look towards not in terms of electronic health records but just about everything and it needs to be seriously considered with whatever it is that anyone is trying to implement.

Our consumers often have trauma. They often have co-occurring disorders, at least 6.8 million according to the latest SAMHSA statistics. There is a lot of stigma involved and Dan Fisher adequately, more than adequately, discussed that at the beginning of today's conference, and they're often multiple system users.

Those systems vary quite widely. They can be CMHCs, they can be state hospitals, they can be substance abuse settings, they can be emergency rooms, all forms of medical and surgical settings from diabetes to cancer clinics, they can be prisons in many instances and in some instances they can be schools.

We are also concerned about what other data systems and what other burdens states and providers and everybody in between also has to deal with as they look to implement new tasks. There are a lot of new things coming out of CMS, things come out daily and each of these adds an additional burden and layer toward state authorities and the CMHCs, and the substance abuse authorities.

Private insurance including the exchanges is also a big driver of what's going on and I don't need to talk about that because that has been more than adequately discussed already. Joint Commission as well as all other forms of licensing requirements, these also require a burden on the state systems and the providers in terms of how they have to account for their business, what they have to do to provide and ensure that they can continue to be able to do business.

The Block Grant, not a month goes by that NASMHPD does not have to defend the Block Grant from either congress, the GAO, CBO or somebody else in terms of proving that we need to continue to have the Block Grant. At the same time the Block Grant increasingly has requirements upon the states and the authorities, and the providers in terms of what information we have to provide to the federal government. Those information requests increase on an annual basis.

Now why are all these barriers and burden so important? In this current era states have suffered enormous budget cuts and they are under a lot of difficulties in terms of trying to provide additional information or add additional layers of complexity to theirs systems.

NASMHPD is very much in favor of the certification and the process behind it but we need to keep in mind that adopting it could be very difficult for states as well as to providers within the states. Adding new bureaucracy at this time may not necessarily be good idea.

Connecting all of the dots. We want to see a new system that works well in all forms and settings. It has to work not only with CMHCs and substance abuse providers but it also has to be able to connect people to emergency rooms and state hospitals and all other forms of settings otherwise people will continue to die 25 years too early.

We do not want to create new silos we want to bash down those silos so that we can solve this overarching large public health problem. We want to see a new system that is on the same rolled up IT platform as the exchanges and many of the other things that are currently being implemented otherwise we just add another layer of complexity that will likely be ignored on the state and local level.

Third there are serious other hurdles that still remain. People have talked in depth about 42 CFR Part 2 and I expect that my colleagues from NRI might also talk about this, but there is also a large amount of state and local laws that prevent information sharing that would make adopting a nationwide system very difficult because each state and each community in many instances would have their own different requirements that are often higher than 42 CFR Part 2 as well as HIPAA.

We would like to see a certification process that is scalable in some ways so that it's perfectly fine if we start just with the providers right now but it needs to be able to ultimately include state hospitals and any other setting that our consumers are passing through. They are often in a state hospital one week, they might be seeing someone in a CMHC the next week as well as the day seeing someone in a substance abuse setting.

This doesn't also forget – we also can't forget, excuse me, any diabetes issues or other physical health problems they might have, again, dying 25 years too early usually because of physical health problems and not mental health problems.

So, ultimately what we'd like to see is a system that connects all these dots that puts all these systems together and decreases the amount of silos that we see but also at the same time, and this is where it gets extremely hard, not that it wasn't hard enough already, but doesn't add additional layers of bureaucracy that at this point might be unreachable under the current settings.

Overall we see this right now as a window of opportunity. Enormous changes are occurring within the health system and it is essential that the behavior health both mental health and substance abuse are included within this massive changes otherwise as other presenters have already said, we'll get left behind. At the same time –

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I'm sorry Justin your time is up. I'm sorry I didn't give you a 30 second warning.

**Justin Harding, JD – Senior Policy Associate – National Association of State Mental Health Program Directors**

Okay, I was pretty much done anyway, thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Sorry about that. Rick Harwood?

**Rick Harwood – Deputy Executive Director and Director of Research & Program Applications – National Association of State Alcohol & Drug Abuse Directors**

Good morning and thanks for the opportunity to address the committee. Data policy and data access is quite important to our members. The things that slap our members in the face every day are the fact that only about 20% of the people who need substance abuse treatment get it. Yet we know that so many of them are going and getting healthcare, primary care, emergency rooms, other places and we think that good EHR systems will be able to assist that.

We also have to stare at the fact that over 15,000 people a year are dying from overdoses from prescription drugs. We're looking at 50 people a day and this is making headlines. These are the things that EHRs, electronic health records, and HITs we think can really help and we appreciate very much what ONC has been doing and the private vendors in trying to develop good systems.

We're enormously encouraged when we hear you say this can be done that we can develop interoperability and we can do it in a way that is compliant with 42 CFR and other state protections of confidentiality.

Our members work very hard within those restrictions and SAMHSA does as well. There are a lot of SAMSHA initiatives that are going on that are trying to build upon electronic health records and use that data. I hope that you're tapping into them, common client level data collection will be done, SAPT Block Grant reporting, and our association spends a lot of our time and invests a lot of the time of the members to work on data policy not specifically EHR but accessing data so that we can manage our systems better.

I neglected to say, I do want to say, I'm representing NASADAD the Association of State Agencies responsible for receipt and management of the Federal Substance Abuse Block Grant. The Association has been around about 40 years and we are a dues-driven organization as well as having support from SAMHSA.

Collectively our agencies have a budget of \$5 billion and they support a treatment network of 8000 providers, specialty providers that are very conscious of 42 CFR but even more conscious of the challenges of getting patients in the door, patients who are very, very concerned about stigma and so this has to be – it's at the forefront of what they do and the electronic health record systems that are offered to them they need to be something that they can work with, a tool that addresses the dual realities that they're confronting.

Our systems are providing care for 2.5 million individuals per year, this is the public sector and that's the majority of the people who are getting care. And as has already been said, few of these providers are actually eligible for subsidies, public support and so forth. But the technology will be incredibly important for us going forward.

Our members are really adamant that the systems need to address 42 CFR Part 2 and that it's possible. We hear from vendors and others here that there are strategies to do that. That you can get consent, you can do it in an appropriate way that is not off-putting to the patient and that you can get the data that you need.

In addition, the EHR will be extremely valuable to our members as they try and manage the system, manage resources and try and sustain quality by looking at the results that are being achieved by providers and our members already do that, they extensively compare the outcomes of providers because that's a part of what their data systems currently get.

Our members are already investing a lot of money in data and the electronic health records hopefully can be a more efficient vehicle to acquire that data and get even more refined data and better quality data.

So, I'm going to back up and say again thanks to ONC. Thank you very much to the providers of EHR and developers of services for struggling with this. This is a common problem that all of us are dealing with and sharing the technology or dealing with the resources from SAMHSA so that you don't have to reinvent the wheel is just an awfully good strategy and we do want to encourage that.

We're not saying that everything needs to be open source but to the extent that there is public information and SAMHSA and ONC can do that and make it more efficient for those who develop and provide electronic health records I know that our members would support that. So, again thanks and keep doing what you're doing.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you Rick. Tim?

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Yes, hi, thank you and thanks for the opportunity to present our information as well. With me is Azeb Berhane she is our Senior Data Manager and she'll be doing part of this presentation as well. Do we have the – I don't see the slides up that we had – yeah, there we go, thank you very much, if you go to the next one.

NRI is a non-for-profit organization that for the last 26 years has been devoted to helping public mental health systems collect, analyze and utilize data to improve behavioral health services.

One landmark research project that NRI coordinated was the first multistate study that looked at the premature mortality among consumers in the state the health systems. This study documented that persons in the state mental health system die up to 25 years prematurely compared to their peers without a mental illness.

This landmark work by NRI, SAMHSA and the states has led to an increased focus on the co-occurring physical health needs of persons with mental illness. Those findings, among many others, support the need for fully implemented and interoperable EHR system. Next slide please and the next slide, please.

These two slides are just more detail about the data systems that we have that we're able to produce some of the reports that we have. Next slide, please. And let me turn this over to Azeb.

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

Thank you. I'm just going to quickly provide you with an overview of where state mental health agencies are in implementing EHRs. As you can see from this map the majority of state mental health agencies have implemented EHRs in their state psychiatric hospitals while only 13 have not yet done so.

Similarly, if we go to the next slide, EHRs are implemented in community mental health centers, operated and/or funded by the state mental health agencies in 25 states while 11 additional states are currently in the process of installing EHRs.

And if we go to the next slide you will notice although state psychiatric hospitals are not eligible for the Meaningful Use incentive payments in 18 states all state psychiatric hospitals are using EHRs that are certified to meet the Meaningful Use requirements.

And on the next slide we have we're just showing you the most commonly implemented EHR functions in state psychiatric hospitals and those are patient admission, discharge and transfer records and billing, whereas progress case documentation, reporting and clinical assessments are most commonly implemented in CMHC.

And if we go to the next slide, state mental health agencies are devoting a substantial amount of money towards the implementation and operation of electronic health records in 2013, 26 states spent over \$85 billion on the implementation and operation of EHRs and averaged about \$2.6 million on EHR software, \$453,000 on annual maintenance fee and \$1.6 million on staff training to use the EHRs.

And if we go to the next slide, information sharing is critical in EHRs, as such states have put in place agreements that allow the sharing of EHR information between state psychiatric hospitals, between CMHCs and state hospitals and through information exchanges.

And if we go to the next slide, as our other colleagues have mentioned confidentiality and privacy protections are critical for mental health consumers and to ensure the confidentiality and privacy of mental health consumers 26 states have statutes or policies that provide increased privacy protection beyond the federal HIPAA privacy rule.

And the final slide we have is just to show you the perceived benefits of EHRs that we're hearing from the state mental health agencies which include enhanced quality assurance, improved data reporting, improved productivity, reduced billing errors and generating client outcome measures. And I'm just going to turn it over to Tim to close us out.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Okay, all right and to that last slide just the contact slide, just in conclusion, you know, the majority of the 7 million people served by the state mental health systems are adults with serious mental illness or children with serious emotional disturbance.

Our data shows that despite the inability of psychiatric hospitals and community mental health centers to draw upon the Meaningful Use incentive payments for implementation of EHRs state governments and providers are expending substantial amounts of their own funds to implement EHR systems as you saw in the previous slide.

Many mental health consumers receive service from multiple providers making the implementation and sharing of clinical information through EHRs critical. This also shows the importance of a fully implemented and interoperable EHR solution. Thank you for allowing us this time and we fully support all of what is going on here. Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you and thank you to all of our panelists. We'll now open it up to the Workgroup. I don't see any hands raised but if there are any questions from the Workgroup members please go ahead.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Hi, this is Jennie Harvell and I just wanted to say thank you to the panelists for this information and I'm just wondering from the last speaker if they could describe what – I guess it's a two-part question.

What policies have permitted the use of – permitted the EHRs implemented in the states that they've described as having implemented EHRs including admission, discharge, transfer functionality?

What policies have been implemented in those states to support information exchange from the hospitals to other providers and I assume, pardon me if it's wrong, that some of those patients are being treated for substance abuse disorders?

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

There were several questions in there I think. Azeb do you want to take a stab at that? Maybe repeat one of the questions?

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Well maybe let's – here's the first part, is it correct that some patients in the state psychiatric hospitals are being treated for substance abuse disorders?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

And a request to the panelists when you speak would you identify yourself so we can get your names on the transcript? Thanks.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

All right.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

I'm sorry, that was Jennie Harvell who was asking the question.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Could you repeat that please?

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

So, I'm wondering if patients being treated in state psychiatric hospitals are at least some of them are being treated for substance abuse disorders?

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

We do have – a lot of our clients do have co-occurring mental substance abuse disorders so they do receive treatment for substance abuse while they're also receiving treatment for mental health services.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Okay, thank you and this is Jennie Harvell again, and so for those patients in state psychiatric hospitals that have EHRs that include the functionality that you described in your presentation that support admission, discharge, transfer those psychiatric hospitals are creating – their EHRs are creating summary documents to support those transfers?

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

Yes.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

And in those states what policies have been established that enable those of psychiatric hospitals to use their EHR systems to create summary documents for transfer of patients?

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

That obviously would be a state-by-state answer. So we'd be happy to help look into that and provide you with some specific state information on a state-by-state basis. But wouldn't be able to answer that at this point without doing some further investigation.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Thank you and then I guess a last question. Do you know if there was any additional functionality in those EHRs at those state psychiatric hospitals that was necessary to support the exchange of information at times of transfer?

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

I think it's whatever agreements they have. If they have an information exchange agreement with another provider or whatever it is then that's the policy they use to transfer or discharge clients.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Thank you.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other Workgroup member comments or questions?

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

This is Mike Lardieri, and I guess this would be for Tim and Azeb as well, but in your slides, and I was a little lost earlier I thought more states were HIPAA in terms of mental health or mirrored HIPAA but I see you identified 27 states have more stringent mental health regulations than HIPAA. Could you just give the range?

I know you can't give state-by-state but how many of those regulations would be more leaning towards 42 CFR Par2 compliance and that requirement or how many are closer to HIPAA or what's that range or that extra requirement for confidentiality and sharing.

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

42 CFR basically applies to co-occurring clients, clients that also have substance abuse disorders but it doesn't really apply to the mental health consumers only. So the states, each state has decided to – of course everybody follows the HIPAA regulations but then in addition to HIPAA they have put in place additional requirements and to give you a range we're going to have to get with you after to give you specific info about each state.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay, okay, are some of them – are some of them based – do any of them say co-occurring disorders need this extra regulation?

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

No.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

That would be helpful.

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

Yeah, we could do that, but this is generally for anybody that's in their system co-occurring or not because the substance abuse only has the 42 CFR but then the mental health clients don't have it so it's whoever is in their system benefits from these added or more stringent confidentiality.

**Michael Lardieri, LCSW, MSW – Vice President Health Information Technology & Strategic Development – National Council for Behavioral Health**

Okay if you could get that to us I think that knowing that range might be helpful, thank you.

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

Okay.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Thanks Mike for your question.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

This is Jennie Harvell again and I wanted to ask the same presenters on one of your slides, there was a very helpful slide that described, at least to me, the functionality of these EHRs being implemented in these state psychiatric hospitals and one of the rows on that slide included external consultants or consulting reports. Can you describe what that functionality is?

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

We would have to get some more detail for you and get back with you. Who was that and we'll certainly get back with you.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

It's Jennie Harvell.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Okay.

**Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**

Thank you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

It would be useful to get that back to the committee as a whole. So, whoever was your contact, your specific contact.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, if you could share that information with Jennifer Frazier who probably worked with you and then we'll share it with the entire group.

**Azeb Berhane, MA – Senior Data Manager - National Association of State Mental Health Program Directors Research Institute**

Okay.

**Tim Knettler, MBA, CAE – Executive Director/CEO – National Association of State Mental Health Program Directors Research Institute**

Sure, you bet.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you.

**John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC**

This is John Derr, I just wanted to thank all of the presenters because this is a very complex subject because it's really a disease and not a specific provider and this behavior health has so many different shades. So this has been very interesting.

I used to be in charge of psychiatric products at Squibb 50 years ago and the marketplace and what you guys are doing has really progressed a lot and I appreciate you being on this virtual panel. Thank you.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Hi this is Larry Wolf I've got a question. We heard about some of the efforts that you were involved with, several of you were involved with it sounded like, to help within a state get some consolidation around the standard assessments and data elements and working that magic in more than one state. Do you have any thoughts or guidance for us as we look towards national efforts that might move that agenda further along?

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

This is David Lloyd and our efforts have been very, very interesting in that each one has presented a unique challenge not only from a quasi-political but also a quality or understanding of quality as well as a funding compliance requirement from the different funders and/or accreditors. So, when you put all of that together into, you know, kind of a matrix of what are we required to do and what must we do or want to do it becomes quite an interesting challenge.

I think in every case with all of the states we've worked in the understanding of what we are collecting now in our EMRs/EHRs and what we are asking through the intake process has been really candidly exacerbated by oral or what we call review, traditional review history where a reviewer might come out and say "we'd like to see it this way" another reviewer comes out from the state or the accreditor and says "well we prefer to see it this way."

So, over a period of 25 to 30 years we have accumulated quite a bit of information. As I said in my slides, you know, we're collecting as much as 1750 to 2100 data elements. We had one center collecting 2700 data elements and what it's resulting in is very significant delays in treatment.

So, what we're doing is starting with someone and by the time we get them into treatment, because of all the access grants we've managed the average number of days to treatment within like 15 behavioral health and SUD centers and the integrated health initiative last year was 30.5 days. So, what we're saying is thank you for calling us but by the time we ask you all of our questions and go through our intake process we will treat you in 30.5 days.

Now the outside on that was 182 days but when we start looking at the number of staff hours, the number of staff hours nationally, we're seeing is 5.8 hours of staff time with the client just to ask the questions we need the we definitely need some lead or leadership regarding what data elements are required to help our IT functionality. Because with this myriad of different data elements when we try to implement "standardized" or a vendor software it becomes quite a nightmare.

So I think, you know, if we could get any guidance and I think Meaningful Use and the incentives that could be provided can give both the vendors as well as the provider users some incentive to start looking at some of these processes and saying, hey maybe this isn't working the way that we've done it.

I know right now in one state we collect SPQM data from 17 behavior health centers, we had 2300 different service labels in their database. We had over 847 different payer labels and that was out of their EMR when we pulled that data extractions and at some point we've got to get real about having comparable data that's not apples, oranges and grapes, because our concern is that's what we're seeing from the EMRs and it's not again, anyone's fault, this is not saying someone's to blame here.

I think we just need some leadership, which I think you're providing and I congratulate, to help lead us into a process of what do we need to collect because what we're finding is about 900 data elements are needed not 2100.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Thank you.

**David R. Lloyd, M.Div. – Founder – Management, Training and Measurement (MTM)**

I hope that was hopeful.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Are there any other Workgroup member questions? Well, thank you to all of our panelists on panel six and thank you to all of our panelists who have presented today. I think we've set a record, we've finished early which never happens so we really appreciate everyone's efforts to stay close to the time that we've allowed and we can't thank you enough for participating.

All materials from today's meeting will be posted on the public website if you want to reference them for future use.

I will just defer to Larry Wolf to see if you have any closing remarks before we opened up to public comment.

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

So, thank you. I'd like to thank all of the panelists it's been a very full morning into the afternoon. A lot of diversity of information here, it seemed like some pretty consistent messages about on the one hand the value in sharing information and the desire to do that given appropriate patient consent, but also the severe challenges both at a policy level and a technology level of actually doing that. So it will give the Workgroup plenty to chew on over the next few weeks as we try and distill this down. So, again, thank you very much for your input and for your materials. It's been a very informative day.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

So with that Larry are we ready to open up for public comment?

**Larry Wolf – Senior Consulting Architect – Kindred Healthcare**

Yes let's do that. Let's open it up for public comment.

**Public Comment**

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay. Thank you. Operator can you please open the lines?

**Caitlin Collins – Project Coordinator – Altarum Institute**

If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-6006 and press \*1 to be placed in the comment queue. We do not have any comment at this time.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

Wait a minute –

**Susan Fendell, Esq. – Senior Attorney – Mental Health Legal Advisor Committee**

Actually, I'm on the same line Dan Fisher was on.

**Daniel Fisher, MD, PhD – Psychiatrist and Director – National Empowerment Center**

That's Susan Fendell speaking now. Go ahead, Susan.

**Susan Fendell, Esq. – Senior Attorney – Mental Health Legal Advisor Committee**

Would it be okay at this point in time to make a public comment?

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Sure go ahead, I'm sorry, can you please state your name?

**Susan Fendell, Esq. – Senior Attorney – Mental Health Legal Advisors Committee**

Sure, my name is Susan Fendell I'm a Senior Attorney with Mental Health Legal Advisors Committee we're a state agency under the Supreme Judicial Court of Massachusetts and we provide advice and information to people throughout the Commonwealth on mental health and legal matters.

There are two things I wanted to comment on one is the presumption that integration of behavioral health and physical health information will necessarily result in better care. We've already heard how persons with psychiatric diagnoses die much earlier than other persons.

Our agency has conducted research on the sharing of psychiatric information and what we found is that there is quite a bit of research out there showing that there is stigma within the healthcare profession, that persons with psychiatric illness receive less care than people without psychiatric diagnoses and that it is a function of being told basically that their illnesses are in their heads.

We have conducted public forums as part of the behavioral health taskforce and people came one after another talking about how their physical ailments were attributed to psychiatric causes which is why we are so concerned that the criteria for behavioral health certification and actually for physical, for all medical record EHR certification should include the ability of behavior health information to be segmented. We think this is very important because without the individual with the psychiatric illness having the ability to determine which healthcare providers know they have psychiatric diagnoses there is the potential for people not receive the physical healthcare that they need.

**Michelle Consolazio – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Thank you, public comment is limited to 3 minutes and you've hit your 3 minutes, thank you very much.

**Susan Fendell, Esq. – Senior Attorney – Mental Health Legal Advisors Committee**

Can I add one last thing? Just that it's the segmentation and consent management standards that allow people to release their information per provider not per healthcare system or health information exchange.

**Public Comment Received**

1. I think there are some misconceptions on what most providers are looking to exchange.