

**HIT Policy Committee
Quality Measures Workgroup
Transcript
March 28, 2014**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPH – 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's Quality Measures Workgroup. This is a public call 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. Helen Burstin? Terry Cullen?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Here.

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

Hi Terry. Ahmed Calvo? Aldo Tinoco?

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

I'm here.

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

Hi Aldo. Alexander Turchin?

Alexander Turchin, MD, MS – Director of Informatics Research – Partners Healthcare

I'm here.

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

Hello. Cheryl Damberg?

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation

I'm here.

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

Hi Cheryl.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation

Hi.

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

Chris Boone? Daniel Green? David Kendrick? David Lansky? Eva Powell?

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Here.

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

Westley Clark?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

Here.

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

Hi Westley. Heather Johnson-Skrivanek?

Heather Johnson-Skrivanek, MS – Agency for Healthcare Research and Quality

Here.

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

Hi Heather.

Heather Johnson-Skrivanek, MS – Agency for Healthcare Research and Quality

Hi.

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

Marc Overhage? Jim Walker? Jon White? Kate Goodrich? Kathleen Blake? Letha Fisher? Mark Weiner? Michael Rapp? Norma Lang?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality & Informatics – University of Wisconsin

Here.

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

Hi Norma. Olivier Bodenreider?

Olivier Bodenreider, MD, PhD – Staff Scientist – National Library of Medicine

Here.

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

Paul Tang? Russ Branzell? Sarah Scholle?

Sarah Scholle, DPH, MPH – Vice President of Research & Analysis – National Committee for Quality Assurance

I'm here.

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

Saul Kravitz? Hi Sarah. Steve Brown? And Tripp Bradd? Are there any ONC staff members on the line?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Kevin Larsen.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Kim Wilson.

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

Hi Kevin and Kim. And with that I'll turn it back to you Terry.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Oh, great, thank you, thank you so much everyone for taking Friday afternoon, we seem to make you want to have a pleasant way to enter into your weekend by spending time with us prior to your weekend. Helen is not able to be on today so I will be chairing this Workgroup. You can go to the next slide, please.

We do have a very full agenda because we've asked many people to help us answer the questions that we are going to pose and we appreciate your time and commitment to helping us work through this issue. As you can see we have a clear objective today it's related specifically to behavioral health and whether there are quality measurements that should be adopted and through the certification and adoption process in this arena.

We did, on our last meeting, look at long-term care, we had a charge specifically to this and you can go to the next slide on that. We were asked to make recommendations for voluntary, I want to stress the word "voluntary" certification of EHR technology for behavioral health settings and we were asked to make recommendations on the quality measure issues that would confront that in this setting itself. Next slide.

What you see here is some recap of the hearing testimony, the ONC certification criteria and standards for support and proposed areas for behavioral health certification once again, voluntary, in this arena and our goal is to really look at the clinical quality measures and provide recommendations to the Workgroup on potential, in this case just behavioral health, the LTPAC stands for the long-term area, for clinical quality measure opportunities for EHR certification. Next slide.

We did ask federal agency representatives to participate in our discussion today. You can see the list of people here; they also have helped inform the questions that we are using as we go through your testimony today to help us.

So on the next slide let me just show you what the questions are that we have asked you to address. Our goal was really to structure this so that in your presentations you can share with us responses to this, we realize you might not get to all of them and then after your presentations to go back and hopefully facilitate a dialogue that at the end of it will allow us to develop recommendations.

I will point out that we have a very short time to do this; we have many people on the call who we are incredibly grateful for their participation. It may be that we get to recommendations and it maybe that we get to a sense that we need to gather that information together and send it out for you for review.

So, with that I think that you'll see these questions, what programs require quality measures reporting of behavioral health, are quality measures currently used and are they mapped to standard vocabularies, currently 14 clinical measures are these useful? How does the ONC certification program potentially be leveraged to support behavioral health? What gaps or barriers exist and what clinical questions related to behavioral health would you like answers to? For instance what would a specific quality performance measurement look like for you?

And with that I am going to move to the next slide which is Harold Pincus and Harold if you – I think you're on and if you just want to introduce yourself. For those of you who have gotten the invitation there is a lot of background information that we sent out with the invitation to this meeting that some of it is specific to what people will be talking about. And with that I'll turn it over to Harold.

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

Terry, before you turn it over to Harold can I ask a quick –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yes.

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

Logistical question.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Sure.

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

I think I've been told that we want to stay very close to the 5 minutes and just as we do when we have a hearing to notify people when they're 30 seconds are up do you want me to do that or do you want to just, you know, see how it goes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

I'd love to just see how it goes but sometimes that doesn't work. So, I think, you could do the 30 second.

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

Okay, okay.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Thanks.

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

So, just to warn everyone you have 5 minutes and I will give you a 30 second warning. So, thanks Terry and Harold off to you.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Okay, so I have five minutes to answer six questions. So, first I just want to say that I appreciate being asked to do this. I think my testimony from five years ago has been circulated and I just want to say that for the most part virtually all of the points I made in that testimony are still applicable today as are all of the recommendations from the 2006 Institute of Medicine Report on adapting and crossing the quality chasm strategy for mental health and substance abuse, and I would note, particularly chapters four and six, and five for that matter in this regard, actually all of the chapters.

Just to go quickly to the questions, one, the first question about programs that are currently measuring behavioral health issues in some way, there are relatively – there are a fair amount of those, there are structural accreditation programs like the patient centered medical home where the functionality for behavioral health linkage has been augmented recently.

There are a number of reporting programs, quality reporting programs and in some cases value-based purchasing programs that are instantiated in the Affordable Care Act such as the inpatient psychiatric facilities value-based purchasing program. A number of programs have been put in place at a state level. SAMHSA has, you know, sort of in a way embodied some quality reporting with a number of its programs and actually some years ago Ben – did sort of a survey of what is – what initiatives there are measuring mental health quality in the US and I can send you that report.

Number two with regard to standardized vocabularies just to say with regard to SNOMED, and I've been involved with the International Classification of Disease, the ICD-11 development, there is an agreement between the WHO and the, I always forget the acronym for the SNOMED organization, to actually have linkage between ICD-11 and SNOMED which includes the mental health chapter, however, it's not terribly meaningful for the purpose of quality measurement, because the – because of the, you know, a lot of the unreliability in the use of diagnostic codes and we can get back into that in some way and how that's relevant or not relevant in the US.

With regard to LOINC, to my knowledge, there is not a connection but there could be a connection with mental health and substance abuse quality measures, for example, there could be ways for developing LOINC codes for things like the PHQ-9 or for other kinds of behavioral measures.

Number three, with regard to the 14 Meaningful Use measures, you know, basically my thinking is that they're not terrific, first of all not all of them are actually behavioral health measures and number two they're not really, for the most part, not terribly proximal to outcomes and I think it's possible to do better.

Number four, with regard to standards, QRDA standards, you know, in general I support efforts to standardize and to bring behavioral health organizations and providers into the arena of interoperable, communicatable medical information and I think that standardization will be helpful in terms of whatever vendor people go to that having that standardization will ultimately, ideally make things cheaper to get, but I think that you need to go further in terms of standardization and to actually move towards thinking about how one integrates quality measurement into the course of care, to integrate quality measurement into the use of registries and that to have electronic health records that have registry functionality that are used in behavioral health that also have the ability to communicate with other health care sectors.

With regard to additional gaps I have several that I think are the most important –

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

Thirty seconds.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Okay, number one is that there should be some mechanism for shared accountability across general health, mental health and substance abuse.

Number two, I think you need to establish incentives for behavioral health organizations to – you know, for this communication and for this capability.

Number three, I think you need to provide resources and stewardship for the field of behavioral health measurement and implement the various recommendations in the 2006 IOM Report.

Next, I think that we have to move more towards a system of routine measurement-based care across all of these conditions.

And number five, I really think there has to be, you know, kind of culture change within behavioral health to move away from an expectation of total confidentiality and privacy to having communications with consumers about the pros and cons of being able to communicate with other providers so that they can get more comprehensive and coordinated care.

And with regard to measure gaps I would refer you to the NQF recent report from the NQF behavioral health second phase, behavioral health steering committee second phase report which has a whole list of measurement gap priorities. Okay?

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

Thanks, Harold.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Wow, lots of information I appreciate your time and your insights. Our hope is just so everybody knows, you will get more time to talk but you'll be talking as a group we're just trying to get through the presentations and then go back and ask for a round robin that we will time constrain to go look at each of these six questions as a group. So, next would be Mike and I think Mike is on and Mike you also sent some information out that we did share with people.

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

Great and thank you very much and thank you for the opportunity to present to the Workgroup. I represent the National Council for Behavioral Health and we are the voice for the community mental health and substance abuse organizations across the country about approximately 2100 members who serve the seriously and persistently mentally ill adults and children, and adolescents living with mental illness and substance use, about 8 million of them across the country.

In terms of the programs that require measure reporting you need to look at behavioral health it's really a very wide spectrum. There are 30+ different types of services from inpatient, psychiatric services to partial hospitalization programs, intensive outpatient, regular outpatient, care management, home services, residential treatment it's a wide spectrum of services that behavioral health providers provide to those constituents.

Many behavioral health providers are federally qualified health centers or becoming federally qualified health centers. These programs are all regulated by their states Department of Mental Health and/or Department of Substance Use, Medicare, Medicaid many of them are Joint Commission or CARF, the Commission on Accreditation of Rehabilitation Facilities accredited and they all then need to report across a wide spectrum of care in terms of quality measures.

Regarding SNOMED and LOINC I was going to actually punt that off to others because we're not the experts in that, but we did not find a good correlation of SNOMED to behavioral health measures and LOINC to some behavioral health procedures connected with PHQ-9. There are some entities out there that have a LOINC code connected to that, but I think we have folks from the National Quality Forum that may speak to that a little better.

Regarding the 14 quality measures we agree with Dr. Pincus that it's a start, they don't cross all the different types of care many of them are setting specific but in that setting they're only specific to adults versus to adults and adolescents those kind of things.

Going forward, coordinating those measures so that there is shared responsibility again between behavioral health and medical we would support that as well. For instance for all the chronic disease categories if a patient comes into a primary care they should screen for behavioral health disorders, especially depression and if they find that make a referral and then make sure that the patient gets and engages in treatment so a physician doesn't drop the ball.

Regarding a certification program, do we think there should be a certification program that supports capture and export, import and calculate, and electronic submission "no" not at this time. Having those capabilities actually requires the provider to have a Meaningful Use certified product. Even though the current NPRM that's out there for voluntary certification is specific that a voluntary certified product would not have those capabilities.

We also need to understand that behavioral health providers without having the technology resources available to them that medical providers had they're not going to be able to implement a system, a software system EHR that has those capabilities because they just don't have the resources to do so, financial, workforce and others.

In terms of additional gaps we know that there are barriers with the finances, we encourage folks to support the Behavioral Health IT Act which would bring services to folks and dollars. We also know that 42 CFR Part 2 will still provide somewhat of a barrier especially if you're looking at patient level data. A patient can't just – they could agree, but if they don't agree to share the information for operations purposes well that information can't get shared and right now data segmentation is not at a place where it's ubiquitous across all EHRs and HIEs.

Michelle Consolazio, MPH – 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

Okay. So, that could actually work. So, there is a barrier there with that. We recommend that HHS continue to look at that and provide some sub-regulatory guidance that might open that up, but still retain the protections for patients. There are some recommendations to do that.

In terms of clinical questions we would like answered, clinical questions and I know I'm running out of time so I'll probably just stop there.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, thank you very much, Mike.

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

Yeah, I'll get into those other things later.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay. Our next speaker is Chris Millet.

Chris Millet, MS – Senior Project Manager – National Quality Forum

Hi, thank you. I'm Chris Millet Senior Director at the National Quality Forum and I'll try to build on what the last two speakers have kind of really set up really well. Just on the first question around just programs in behavioral health settings the only thing we want to highlight there is that there is a slight nuance there distinguishing between measures that are really behavioral health measures versus programs that are targeting reporting in behavioral health settings.

So, you know, programs mentioned already like inpatient psychiatric facility quality reporting, which really targets the behavioral health setting but then there are measures, there are behavioral health measures used in a variety of programs like Meaningful Use, PQRS, physician compare and value-based payment modifier.

The only other thing I'll add on this first question before getting to some of the other later questions is that there has also been a Behavioral Health Information Technology Act that really emphasizes the need for Meaningful Use incentives like was mentioned earlier like dollars behind covering clinical psychologists as eligible professionals in MU and covering inpatient psychiatric hospitals, eligible hospitals in MU. So, that really further speaks to the need for covering those kinds of groups.

But, I'll jump into just kind of the measures and beyond the 14 measures in Meaningful Use one of the things we looked at were just other behavioral health measures that were endorsed by NQF or recommended or conditionally supported by our measures applications partnership for other programs besides Meaningful Use and there are quite a number of them. So, that might give ideas for the kinds of measures to consider in the future for this Workgroup, for Meaningful Use and also will give some examples of the kinds of data elements that we should look at, which is important because that can speak to question two around what kind of vocabularies are needed to support these data elements.

For example, we noticed in some of the behavioral health measures that are not in Meaningful Use they build – they use different coding systems than what's recommended in the e-Measures, some use NDC as a vocabulary for medications instead of RxNorm and from some discussions we had with terminology experts that might not be as appropriate. So, that's something that perhaps the HIT Standards Committee could further refine as we look at these new data elements what terminologies should really be used with them.

But the point I really want to highlight is, you know, there are three kind of components to certification that really need to move together to support behavioral health well and the first would be what we've been talking about, what kinds of measures do we want to look at, but that really drives what kinds of data elements do we need in order to calculate those measures and those data elements should be included in the common Meaningful Use data set and we should make sure we have Meaningful Use objectives that promote the capabilities in EHRs to collect those kinds of data elements so that we have the right capabilities, we have all the data elements that are needed to measure the things we really want and we're not limited to, you know, the kind of behavioral health measures we have today in MU which are mostly around screening.

Let's see, earlier it was mentioned the theme from some of our reports on gaps in behavioral health which kind of builds on the idea of adding beyond screening but really looking at follow-up and care coordination, shifting towards more outcome measures and patient reported outcome measures to help get at behavioral health measures in better ways.

So, I think as we look through measures that kind of meet that kind of criteria we'll start to see different kinds of data elements. So, that should really help us to really add to, in certification, what's in that minimum data set.

Lastly, I'll just note along the lines for data segmentation. As we start to look at measures that deal with substance abuse and other sensitive topics we should really explore Meaningful Use objectives from multiple capabilities around data segmentation to kind of address the issue that was brought up earlier where data segmentation is not really broadly adopted by EHR systems and as we want them to be – if we want EHR systems to be capable to report on behavioral health measures in general and substance abuse measures they should be able to support capabilities around data segmentation and those really – behavioral health, substance abuse specific, confidentiality requirements.

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

Thirty seconds or you might be done.

Chris Millet, MS – Senior Project Manager – National Quality Forum

Yeah, I think, I was really conscious of time, so I think we might be ahead. Yeah, I think I'll leave it there and we can get in some more when we get into questions.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thanks, Chris. Shaun Alfreds?

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

Good afternoon, this is Shaun Alfreds I'm the Chief Operating Officer of HealthInfoNet which is a statewide health information exchange and a regional extension center in the State of Maine and we're also one of the key partners in the state innovation testing model grant that was awarded to CMMI here in the State of Maine which has a succinct focus on behavioral health and behavioral health quality measurement.

I'm not going to repeat what my colleagues have talked about but I would agree with all three of the last speakers, Harold, Mike and Chris in regard to each of their answers to the six questions. So, I'll just add a bit from our perspective here in the State of Maine.

In regard to question one, what programs require quality measurement reporting in behavioral health settings, besides the ones that were mentioned as part of our state innovation model grant we are focusing much of our work around collecting data from behavioral health organizations and measuring quality. I'll be honest with you, those quality measures have not been developed yet and the reason is because of the challenges that we have had and seen here in the state in collecting behavioral health data from those organizations.

So, we've taken on an approach to both recognizing what's happening in the marketplace, paying attention to what's happening here in the Policy Committee and looking at the NQF measures that the EHR programs, the CMS programs, etcetera.

But looking at accomplishing five goals, reducing inefficient healthcare spending, improving chronic disease management, promoting wellness and prevention, promoting recovery and effective management of behavioral health conditions and promoting improved experience of care for consumers and family's and developing measures that promote alignment with other value-based purchasing initiatives within the state including our accountable communities initiatives and our patient centered medical home initiatives relevance to the health and people with serious mental illness and serious emotional disturbances, use of nationally recognized measures when we can, leveraging claims-based measures and/or existing reporting strategies to minimize the burden on providers and I'll talk about that in a minute, and the ability of behavioral health homes and behavioral health practices to have an impact on their measures.

As far as number two, are there quality measures, are quality measures used in getting to the standards piece, certainly as the exchange goes we look at quality measurement from multiple perspectives and certainly from a care coordination perspective measures that are leveraging use of SNOMED, LOINC even procedural coding ICD-9/ICD-10 are very helpful because those are standardized data elements that are being shared by organizations certainly in our trading area to facilitate that piece.

But from the perspective of the measures themselves, as I mentioned earlier, we're looking in depth as to what we have available and what can we leverage both from these standards but also from claims data that we have available.

As far as the Meaningful Use standards and measures we believe that they're useful from the perspective of those behavioral health providers that have the ability to draw down Meaningful Use incentives, however, most of our community behavioral health clinics and providers are not receiving any Meaningful Use incentives and the challenge that we have there and that's important to understand is that we don't have EHRs being implemented that have these metrics included within them or we have EMRs that are being implemented that may have that ability but that's a module that these behavioral health organizations cannot afford to purchase and have not purchased because they don't have the funds coming in that the other – that other providers in the healthcare community have had coming in as a result of Meaningful Use Stage 1 and 2.

Number four, as looking that certification program, at this point, getting to my previous point, we don't necessarily believe that adding another certification program is going to help us to drive more quality measurement out of the community behavioral health arena on the ground unless we're doing that with additional incentives and additional resources to bring forward to these organizations.

What we're seeing is reduced payment for services in these areas, we're seeing a reduction in crisis services being performed around the state because of lower reimbursement coming to these organizations and so as such a voluntary certification program we believe, from our stakeholders in the state, will not drive additional measurement because there aren't the resources to implement such a program.

What additional gaps and barriers are needed to address, certainly, again getting into and recognizing that behavioral health organizations are not as Health IT leveraged or using Health IT at the same level as many of our hospitals and primary care sites is very important and so therefore recognizing what systems they have in place and helping them to build upon what is in place is needed. Certainly, it came up earlier but I –

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

Thirty seconds.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

I cannot stress enough 42 CFR is a barrier to measurement as well as data exchange and you need both in order to have a quality measurement program and I think I'll stop there.

And then finally, number six, clearly when we look at different clinical questions certainly what we're hearing from the communities are the need for measuring psychosocial factors so medication noncompliance, affordability, homelessness or their unemployment status things of that nature helps to facilitate better management and coordination of care for these folks and then finally looking at care coordination at a very specific level is something that we think is very important and will help to drive resources to those sites to be able to share information. So, I'll stop there. Thank you.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Thanks, one more Mady, but Mady is not going to be able to join is that right?

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

That's correct.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, so we can skip that slide and then go to this slide, but before we go to this slide I just want to acknowledge everybody's work and thank you so much for taking the guidance that we gave you and responding to it because it will help us meet our ask.

But the federal agency representatives are on and they helped inform our questions and I just want to give them a brief period of time if any of them want to say anything right now before we go into the specific asks here.

So, I don't who is on, Maureen, Lisa, Alex, Edwin, Denise, Jeff or Elizabeth if any of you want to offer any insights or comments right now?

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

This is Jeff but I don't have any additional comments right now.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, great, okay, so what – first off we asked this esteemed group to answer six questions, what you have in front of you right now are the asks that were developed prior to us asking you the questions and there is a cross walk from some of the questions into these asks, but I think what I want to do is take a little bit of time and ask – and go to through the six questions now that you have each heard each – you've heard your comments and we have the federal agency representatives on also, to just reiterate or if anybody has any additional comments since you've heard other people on what programs require quality measure reporting.

What I heard just to summarize here is that behavioral health is a wide spectrum there are at least 30 types of services available. There are measures that can be specific for behavioral health quality reporting and then there are measures that are across the spectrum and a lot of other specific information, but I think that the overarching response to this is there are multiple programs that require quality measure reporting they may or may not be coordinated and they are – they occur throughout the spectrum of the tradition of what falls under the rubric of behavioral health. Any other comments on that one or questions?

Alexander Turchin, MD, MS – Director of Informatics Research – Partners Healthcare

This is Alex Turchin, I had a question, several of the speakers brought up that Meaningful Use incentive funding is not widely available in the behavioral health setting, I was wondering if you could provide more detail on why it would not be available if, you know, all the same steps are followed as for medical providers?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin Larsen from ONC, I can maybe take that so the Meaningful Use Program under the HITECH Act designated by congress who are eligible providers and in that list of eligible providers a number of types of behavioral health providers are not included. So, for example physicians are included but counselors would not be included. So, it really is the statutory regulations that define eligible providers, defines who is eligible for the payments.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

I would also say –

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

This is Mike –

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Kevin? It's Harold, I would add there is actually, even though it's a little bit, a little bit outdated but actually it still holds true but in the IOM Report on crossing the quality chasm for mental health and substance abuse there is a whole chapter devoted to how – reasons why behavioral health has sort of lagged behind in terms of the capacities for involvement in the national HIT infrastructure.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

This is Westley it's not just counselors its psychologists, its social workers, marriage and family therapists and then the specialty delivery system as part of the MU incentives, the specialty delivery system both for physical health and behavioral health were omitted from the incentives. So, psychiatric hospitals, substance abuse treatment programs, community mental health clinics were all excluded from the incentives.

Cheryl Damberg, MPH, PhD – Senior Policy Researcher – Rand Corporation

This is Cheryl Damberg, I had a question about sort of the maturity of measures in this space so I'm pretty familiar with mental health measures in the ambulatory care setting, you know, those types of measures, but, you know, for the array of types of providers just mentioned, I mean, are there clinical practice guidelines that those types of practitioners adhere to and are working towards whether it's certain processes or outcomes such that measures can be developed.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

I can say a little bit about it, there are clinical practice guidelines that have been specified by the American Psychiatric Association by the VA, by the Defense Department and by, you know, you can go to the AHRQ guidelines clearinghouse and there are – you know for any given behavioral health disorder there are, you know, some number of guidelines internationally as well. Whether they're adhered to by across all the professions is a real issue and the degree of consistency across guidelines is also a real question and the other problem is the extent to which they are specific enough that you could actually develop quality – derive quality indicators from that.

There is a newly established Institute of Medicine Committee that has been charged to look at the development of quality measurement, monitoring and improvement efforts with regard to psychosocial interventions and that, you know, that committee has just gotten started.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, this is Terry; I want to remind people, because we are on a call, if you're going to speak to please introduce yourself because people may not recognize the voices.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Oh, that was Harold Pincus.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, oh, thank you, thanks Harold. So, does anybody else have some more generic questions they want to discuss before we go into the specifics? Any other feedback from the group.

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

Yeah, this Jeff Buck at CMS. I just had sort of a couple of observations about the very first question here that the presenters have been addressing and that is I think within CMS quality reporting programs we – if I see the kinds of things we're going to be doing over the next several years one of the things we're going to start doing I think is kind of, for lack of a better word, building out behavioral health quality measurement across our quality reporting program.

So, I think that if you're approaching this as just thinking about how this applies in a mental health center or in a psychiatric hospital or in some type of specialized setting you're not really thinking about the full spectrum of where I think we want to take behavioral health quality measurement which is a recognition of not only the importance of behavioral health issues and overall medical care, but also recognition of the fact that actually the majority of people do not get, to the extent they get behavioral health care, they do not get it in specialty settings.

So, I kind of wanted to call attention to that issue because I think in some ways it shapes the kinds of measures that you might think about or think about how they might be used.

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

And, Jeff, this is Mike Lardieri, so I guess a question – I would agree, I guess the majority of behavioral health services are not in those specialty settings but the majority of services for people who are most vulnerable and are the most high cost clients we serve are probably in those settings.

And then I would just like to know when you say that CMS will be looking across the board will that be driving towards Medicaid as well, because most of these, at least the members that we serve, who serve seriously and persistently ill behavioral health folks their major payer is Medicaid.

So, with measures that are focused towards Medicare it's never going to get to those programs and the individuals that they're serving won't actually benefit from that. So, I'm wondering –

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

Well, that's – let me correct that, because that's a misperception I think. There's a couple of ways in which it gets there. First of all, a lot of our programs, I can't say categorically how many, but at least some, when they – even though they are operated under the authority of Medicare when they require reporting the reporting is for everybody and not only Medicaid but also private insurance as well.

So, we're getting quality measures that's not just limited to Medicare and then I'll just say, also, actually with respect to Medicare and respect to people with serious behavioral health conditions a big chunk of the Medicare population, at least on the inpatient side, consists of dual eligibles for which Medicare is paying the inpatient costs and Medicaid is paying for the –

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

Right.

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

For most of the outpatient costs. So, I think that's a – you don't want to think that, oh, it's because Medicare doesn't really effect any of the other populations we're concerned with, but I think this is the – I'm not trying to argue for the merits of one versus the other, I'm saying though that I think that you ought to explicitly consider what sort of functions and what sort of populations you want your measures to be able to assist and I wanted to call attention to the fact that if we're really talking about behavioral health being an integrated part of overall healthcare I think you may be setting too low a bar by solely focusing on those with the most serious conditions and ignoring the large majority of people who are not getting treated in specialty settings.

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

Yes –

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

Certainly we're not – I'd certainly say, I think that as we talk about this in Medicare that's not how we're thinking about it.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

Jeff, this is Wes –

M

This is – oh –

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

This is Wes Clark, I don't think that's true for the substance abuse phenomenon most of the care does occur in either self-help groups or specialty settings not in the primary care setting, we're trying to change that but we find there is tremendous resistance on the part of the primary care environment. If you only look at the doctors who prescribe buprenorphine there are an estimated 850,000 prescribing a controlled substance but only 25,000 have buprenorphine waivers. So, we still have a way to go with regard to substance abuse treatment.

And other than alcohol screening drugs are just not a part of that calculus. So, we need to keep that in mind, this is about behavioral health writ large not just about minor depression or minor anxiety disorders which are treated in the primary care setting.

Jeffrey A. Buck, PhD – Senior Advisor for Behavioral Health, Center for Clinical Standards & Quality – Centers for Medicare and Medicaid Services

Yeah, now what –

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin Larsen, this is Kevin Larsen from ONC, I want to bring us back to the issue at hand which is how can the voluntary certification program in behavioral health settings potentially be impacted or be improved through quality measurement?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services

Administration

This is Westley, again it's one of the issues that has shown up in several of the other FACA meetings is the issue is the utility of the measures to the actual practices that – in the community – so those practitioners who are providing the services need to be able to use those measures to achieve whatever appropriate goals are in question. So, I think utility and practicality are concepts that we need to keep in mind.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Hi, this is Harold, and I had a couple of comments although there is an echo on the line. So, a couple of things just to comment on a few things, one is I agree that, I think, again the ONC program of standardization can be very helpful but it has to be bundled with incentives unless there is some reason for people to use these tools that will incentivize them to use it, you know, obviously the tools should be designed, as several people have suggested, so that they are actually useful in the course of delivering care and that they ought to be incentivized not simply by, although certainly including, things like the HITECH Act and things like – an inclusion of mental health providers in organizations in that and substance abuse providers and organizations as well.

But efforts to enhance the expectation of purchasers and payers who are contracting with organizations and providers in their network, these kinds of expectations around these organizations having those standards should be applied.

I just want to go back to the point that Jeff was discussing and other people were that I think the issue in some ways is that it's not just that different measures are being developed for different programs that don't necessarily intersect, so I think there certainly does need to be an effort to harmonize those, but it's really the problem is that there is no organization, no entity that is funding or stewarding the more fundamental development of measures and it's not a kind of open science back and forth around that like you would see in other areas of science and study, because I think that's a real problem.

There's a lot of many different organizations are supporting measure development but there is no organization to it. It appears to me that there is a lot of duplication, a lot of looking where the – under the lamppost kind of thing and I really think that the various federal agencies, as well as private organizations, ought to get together and really develop a more fundamental plan.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry, so I think we hear that from many people and the role of the Quality Measure Subcommittee is really to address part of that not that we are the convener or the arbiter but it's to try to get your feedback in a way that we can then make process forward.

So, I'm going to now bring us back to our discussion questions if that's okay, because we have about 30 minutes left, we have to have time for public comment at the end just so people are aware of that. I think some of this we've already hit on. We are not in the position in this committee to or in this subcommittee to really discuss what the incentives would be and we recognize that there are no incentives right now as has been discussed previously.

What we wanted to look at though as we go to these questions were really are there some functions that the EHR systems in these settings, and I recognize that there's at least 30 types of these settings out there so it's a catch all phrase, that would be helpful to ensure that quality measure could be performed and we heard, and we know this from, for instance the community health centers where there may be mental health being provided or behavioral health services they may already be on an electronic health record, we did hear at a recent meeting, and Kevin correct me if I'm wrong, but I think the data showed that 8% of behavioral health providers are on a Health IT system, a very small number.

And so some of what we wanted to get at was, are there functions that you think the EHR system could perform for quality measurement that would be helpful for the behavioral health setting?

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

This is Mike Lardieri –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim Walker –

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

Oh, go ahead.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

One thing, if whoever has the list of 30 settings could share that and particularly if there were relevant characteristics of those settings, you know, services they do and don't provide prescription medications, other, you know, any procedures, whatever, that kind of standardized list would enable HIT developers to start to build that kind of information into their products so that if the rest of the system ever got interested in coordinating it would be able to support it.

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

This is Mike Lardieri, I sent it as part of my – .I have a written testimony so maybe they can distribute that it's in there.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Oh, you have the 30 settings in there?

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

Yes.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Oh, thanks.

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

It's approximate, but that's, you know, what we came up with.

M

Yeah, it's in there. Mike, it's in there.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, that would be really helpful.

M

– from NQF.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Yeah, and this is Eva, this is Eva Powell just one comment I wanted to make in thinking about and listening to the conversation is that when I think about behavioral health and I'm certainly not a deep expert but I do sense, based on what I do know, is that there is an even greater need for behavioral health measures to have the capacity for patient reported outcomes.

If you look just at depression scales and various tools that are already in use whether electronic or not, most of them probably not given the uptake of electronic health records in behavioral health for all the reasons that have already been mentioned, they really, just the nature of behavioral health itself really relies on patient reporting and we've not yet really tackled that in Meaningful Use, we've begun that, we've put our toes in the water but it seems to me if we're ever really going to get to effective quality metrics in behavioral health we have to have the capacity to collect data from the patient.

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

Yeah, I would agree with you on that, this is Mike Lardieri, that's going to be especially necessary as we, you know, with the shrinking workforce or not expanding workforce and more patients, clients coming into the system we're going to need to have that patient information in order to monitor and remotely treat the clients.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
Right and –

Chris Millet, MS – Senior Project Manager – National Quality Forum

This is Chris Millet from NQF, just kind of building on those comments and relating it back to this kind of idea that is inherent in this question around capabilities that EHRs have through the certification program. I think we were mentioning a lot of them and a lot that, you know, we wanted to make sure it came across in the discussion. Certainly the ones that we just heard around capturing data from patients or tracking things around patient reported outcomes but also the capabilities that meet other kind of behavioral health needs.

So, we talked about data segmentation and those items but making sure that that's actually something an EHR can be certified against that they have the capability to segment data when needed or that modules are not complete EHRs but maybe modules that are used in some settings that are, you know, not a hospital but are used in a setting where that kind of information needs to be tracked and maintained thinking about the kind of systems or interfaces that social workers or the other number of professionals that were mentioned earlier might need to work with.

I think the certification program, due to the way it's structured as a modular certification program, kind of sets itself up for allowing some of those capabilities to be certified for different groups. So, in that aspect the modular nature of certification is really helpful and it's just a matter of identifying what are these capabilities which I think there is a good list to go around.

One more thing I'll add to the list is the capabilities for dealing with care plans for exchanging and interpreting them and being able to track the kinds of data elements that are in care plans and I know there is a lot of work going on in defining care plans, but some of that work really speaks to tracking a lot of the data elements that will be relevant for behavioral health like tracking non-clinical concerns, so, concerns that won't be on a clinical problem list.

So, having that capability as separate Meaningful Use objectives that can be tied to modules that are really specific for behavioral health measures and really specific to "behavioral health settings" I think that will be really relevant for the voluntary certification program.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Yeah, and this is Eva again, and I would point out that all of those things are things we really need to have in medical EHRs as well, but we don't because they've been so focused on clinical and process measures.

So, in a way I really view this opportunity for behavioral health starting really at kind of ground zero to really not just boost measurement in behavioral health but also measurement writ large, because when we start talking about population health, which is really what we need to be shooting for, it absolutely has to integrate clinical and behavioral health and that is really regardless of what setting they're getting their behavioral health in.

And I think Chris just said it perfectly and it comes together in the care plan and right now there is no such capacity anywhere that I'm aware of that actually can produce a care plan that is comprehensive, it simply doesn't exist in our world today and that's not acceptable given where we need to go.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services

Administration

Yeah, this is Westley; the standardized language for prescriptions attached to diagnosis would be also helpful. When we look at the integrated setting it is at least one project estimated that almost 60% of the psychiatric medications prescribed were not attached to a psychiatric diagnosis, which I think is a complication.

So, if in the behavioral health setting we don't have standardized medication language then that creates a problem as we extend from the behavioral health setting to the primary care setting.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim Walker, just real quickly I want to refine my comment. If the 30 settings were accompanied with a standard set of characterizations what kind of training, what kind of licensed professionals they have, what kind of services they provide that would be useful to developing an information system that would support really coordinated – support that integration between clinical and behavioral.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay this is –

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

And this Mike Lardieri, that would take some work to put that together because many of the programs differ, although it's called the same thing –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah.

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

They differ state to state with different requirements, state to state –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

But without that work –

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

Yes.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

The idea of trying to provide an information system that would help to coordinate that it becomes even more work.

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

Yeah, I understand, yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, this is Terry, let me just reiterate what I've captured here, this has been incredibly helpful so far and I think there's probably more we want to get.

So, when we look at capability for this minimum function we've – collect data from the patient and Eva I kind of expanded this a little, data from the patient related to measures to collecting that data over time so people can see changes in it and to then have it be able to be collected remotely so not necessarily in the office, so that's kind of a bidirectional –

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health
Yeah, absolutely, yeah.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Things related to data presentation and I'm assuming that's – I'm going to say that's specific for behavioral health but I know it's more than that. The ability to have data segmentation even though we may not define those data elements now, but to be able to do that and to have – because this will lead to the next question about data elements but to have data elements being included that are traditionally in the realm of what we call non-traditional determinates or non-clinical concerns and then finally the standardized prescription reporting from the psychopharmacology perspective I believe is what that meant.

Is there anything else specific for what capabilities you think are – and Eva I do want to play on what you said that we may think are unique to behavioral health but in the long run they're probably not unique to behavioral health but it's where we're going to start with them because they haven't been included in the certification process up until now. Any other ideas?

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

This is Mike Lardieri, I mean, I don't like the go down the road of, you know, behavioral health being different, I think we need to look at it all the same things we need for medical and for us as a person receiving medical services and all the different ways that we think of data coming in and quality measures they're all the same for behavioral health patients, they're really not different, so all the things that Eva was talking about we need, and she even said it, that, you know, we need the same thing on the medical side.

So, I think we need to have more of a – it might help us to have the view of more of an incorporated, holistic approach to it that behavioral health isn't separate and apart, behavioral health is included in the matrix and everything that we need for medical we also need for behavioral health, we're really not that much different.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

This is Harold, let me completely agree with that, when I talked about the notion of shared accountability it's the notion that it's somebody has schizophrenia and diabetes, the behavioral health people taking care of that person have responsibility for both their schizophrenia and their diabetes and the primary care people have responsibility for both their schizophrenia and their diabetes which means they have to communicate and they're equally accountable for both those – for outcomes on both sides as well as for their preventive health activities that the patient should be getting.

And so I really think that it's...that there has to be this sort of integration or linkage going both ways and I think that measurement and health information technology should facilitate good outcomes on both sides.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah, this is Jim, just quickly let me add, you know, if the patient has a problem it's the patient's problem and we need to, you know, communicate clearly, we need to acknowledge pre-existing stovepipes but we want to make sure we don't do anything to reinforce them.

We need to, you know, say, if the patient has problems then they need an integrated care plan, an integrated approach, coordination among whoever the care team is that's providing those services and not do anything to reinforce the very counterproductive division between clinical and behavioral health or whatever, you know, it is.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry again, so let me follow-up on that, is there anything – so many of the concepts you've talked about are not currently in certification, however you probably know that, so we're going to capture them from a behavioral health perspective with the acknowledgment that the framework this gets wrapped around is the goal for health and there is really a continuum and they would be as appropriate for overall minimum capabilities for EHR settings.

Is there anything that's unique however to behavioral health? I did capture data segmentation, some people would argue that's not unique to behavioral health but there may be a greater need in behavioral health.

Any other capabilities that you may think – that either you know are lacking in current EHR systems and we could use the push from behavioral health to grow from and/or are once again unique to the setting you work within.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Well, I think one thing, this is Harold, one thing I think is that there's a great deal more psychosocial interventions on the behavioral health side and the ability to capture the fidelity with which psychosocial interventions are provided as kind of process measures I think would be a useful technology focus area of effort and that is something that is not irrelevant on the general health side because there is a fair amount of psychosocial interventions that are not, you know, procedures or medications or things like that.

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

This is Aldo Tinoco and I think I want to build on that, it's not just the interventions themselves but also this is behavioral health, these are patients or people behaving in a certain way, so as we think about measures I'd like to think about also how can we provide behavioral feedback to those folks that are in charge of their own lives and we're trying to engage them to do this work.

So, as you mentioned, psychosocial interventions it's also, you know, is the patient adhering to that, how do these systems actually help them stick to the plan to achieve those goals.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

This is Shaun Alfreds I couldn't agree more with both the last speakers, you know, one of the areas that our behavioral health community – and we have about 140 stakeholders from multiple community behavioral health clinics working with us on the state innovation grant and the work that we've done prior to that and prep for it and two areas of information collection and measurement that they deemed most critical for them that go beyond the general medical information that we've talked about that EHRs generally collect around housing status as well as employment status understanding the socioeconomic as well as the social issues that the patients are going with are critical from the behavioral health stand-point but also from a general medical management stand-point.

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

Yeah, one area, this is Mike Lardieri, one area where, you know, behavioral health is different is some of the data that we collect, if you look at the CCD that's collected, the data that's collected from on the medical side, we collect a lot more social history data and use that social history data, and the data around the social determinants of health, for instance housing status initially was not included in the CCD.

We did some work under a SAMHSA grant, worked with five state HIEs, Shaun and Maine HealthInfoNet was one, and we recommended to the Longitudinal Care Workgroup under ONC that they add some of these things housing status and employment status and other areas like this that are missing because – only because they didn't have behavioral health people when they were building it out.

So, those are some things that are useful for us when we're dealing with a client as they change over time that we find the medical side doesn't always pay as much attention to.

Chris Millet, MS – Senior Project Manager – National Quality Forum

So, this is Chris Millet just to –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, Mike that's really helpful and –

Chris Millet, MS – Senior Project Manager – National Quality Forum

Sorry, just to add onto that, you know, all of those fields that are those extra fields in addition to what, you know, already exists in CCDs and in the other standards that are, you know “unique” to behavioral health that relates back to the capabilities we're dealing with. One of the questions was regarding QRDA and is that – is processing QRDA an objective and a capability that should be applied to behavioral health and I think generally it is, but it should be able to support QRDA which is the standard for a quality report, should be able to include all these other data elements that we also want to track.

So, as we want to track the things that were just mentioned we want to make sure that can show up in a quality report if that's important to us for behavioral health quality reporting.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great that's really helpful –

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

Yeah and I –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

I'm going to move us to the second question because you guys are going there anyway, the minimal data elements, assessment tools, standards I would love for you to talk just a little bit about standards and ongoing work. It sounds like there is a lot of ongoing work that you guys have done with HIEs but any – if you guys just concentrate on that I think we're there anyway. Go ahead.

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

Yeah, this is Mike again, so I'm – under SAMHSA Richard Thoreson, and he's in SAMHSA, and Suzanne Gonzales-Webb are two Co-Chairs of the HL7 Community Behavioral Care Coordination Workgroup that is focusing specifically on getting additional behavioral health data elements added to the continuity of care document.

So, that process is – that's in process now and we had Workgroups with providers and the guilds and we've also brought in the vendors to that, at least Richard has, and so some of that work is ongoing already it's not finished and I think what still needs to be done is some of the harmonization, because we sort of did it in vacuum all these things sort of work on their own tubes so to speak or their own silo and what still needs to be done is to take those data elements marry it with what's on the medical and I'll say “medical side” data elements for CCD, identify what's the same all across the board, make sure we're all using the same code sets and then we'll be able to identify, okay, these are the additional ones that are behavioral health specific. So, it's started and it's in process but it's not quite there yet that I see.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Any other comments on data elements and assessment tools? Early on I think, Harold I think it was you, you talked about extension of LOINC or somebody talked about extension of LOINC?

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Yeah, so I think again one of the things, going back to the IOM report in 2006 there was a recommendation for the development of a greater variety of standardized and agreed upon behavioral health measures that could be incorporated into something like LOINC that could become essentially a set of standards, what might be called mental health, behavioral health vital signs that could be used in a routine way.

And again, some of this, you know, cuts across. I mean, some of this would also look at the patient functioning and other kinds of things, and you know, some of the work that was done with the NIH PROMIS Program and other kinds of efforts should be looked at and then thinking about how can that be brought into both clinical practice as well as sort of standardized data elements.

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

This is Aldo again, this is a question for the mental health experts, are goals – is the setting of goals a routine and prevalent step in behavioral health management?

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

So, it should be and the question is there is no real standardization about how to establish and set goals and how to determine whether those goals have been accomplished.

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

Okay, thank you.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

And I think – , but I think that this is something that is not limited to behavioral health because I think if we think about, you know, the whole notion of patient centeredness framing what patients want to achieve for themselves in every area of healthcare, you know, entails collaboration with them on setting and trying to develop strategies to achieve those goals and so I would not limit that to just behavioral health.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim, just back on stove piping those psychosocial measures that behavioral health pays more attention to than the rest of healthcare that's an example where we need to make sure those get integrated with and that they inform clinical practice rather than being something that's separate –

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

Yeah.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

That's one of the ways in which clinical practice needs to be enhanced and that could be a value that this behavioral health focus provides.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Can I ask specifically are there any standards for data elements in behavioral health that we may not be aware of? I guess that means you know what we're aware of, so sorry for asking it that way, but that the general medical community doesn't use in delivery of –

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

I –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Care.

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

I think so from the – this is Mike, so from the work that we've done with identifying these additional elements for the CCD I think there are and then we, you know, trying to, you know, bring those to the medical side.

So, I guess the best thing for that would be to get to the work that Richard is doing over at SAMHSA and we have a whole grid that's built out that identifies the different elements, the different sections if you would of the record and the different elements that would go in there and the different code sets that are attached to it. So, that work is well underway.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thanks for that, any other information or guidance for us as a committee on data elements, standards you think we should push on, things you think that might be beneficial for us to bring back to the Health IT Policy Committee overall in this arena?

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

I would just want to step back one step to the statement before about the QRDA format and that could work, but if all the states don't adopt it either the state mental health or at the State Medicaid Agency level and providers are not using that same system to report up to the feds at the same time they're reporting up to the states it's not worth the money to do it, because then you're double entering anyway.

So, it has to be something that when you do the measures, report the measures you can report it once and it goes everywhere.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, report once as well as have alignment, okay, that's something we –

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

That's correct.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah that's something we keep hearing from many people. So anything else on this one?

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim on standard terminologies, probably obvious unless there is an incredibly robust and universally accepted new language I think the task would be to make sure that SNOMED, LOINC or whatever the appropriate existing standard terminology is, is quickly extended to include the things that it's missing rather than creating more babble.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay. So work from what we already have as foundational terminologies is that what you're saying?

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah unless there is a strong case made for something else.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, great, okay and I'm going to skip to the last question so hopefully we'll have just a few minutes for open dialogue. We've kind of hit on some of this, what gaps need to be addressed, barriers need to be removed to support electronic quality measure construction and reporting?

I think if you were privy to the last Health IT Policy Committee the reason why we got this thrown over the fence at us was the evaluation they did about the pretty limited use of electronic health records in these settings today and so the issue is, this is really specifically obviously for quality measures, but are there gaps, barriers need to be removed or addressed to support electronic quality measure construction and reporting.

We've heard consistency with the measures, report once or have one reporting mechanism at least, it may divvy up to multiple places that receive the report, but one way to do that, consistency in the terminology.

There does seem to be – I don't want to put words in your guys' mouth, but there does seem to be a need to develop more robust clinical quality measures in this area, that might not be what you said, but with that I'll be quiet and ask for you guys to respond to this question.

Harold Alan Pincus, MD – Professor & Vice Chair, Department of Psychiatry – Columbia University

So, this is Harold, so yes, it does need to be a lot more of, as I said, the more fundamental science and stewardship of the field around developing measures that are more robust that go beyond where the, you know, looking under the lamppost kind of thing.

I think that the development and utilization of clinical registries as a methodology for both, you know, measurement-based care, care management integrated directly into care as well as for quality measurement is also something that I think needs to be developed and the specifications and standardization of that could be very helpful that was built into some of the EHR standards.

And then, you know, I just want to re-emphasize the importance of culture change. I think several other people have mentioned that also and culture change not only, with regard to the issue of sort of, you know, standardizing care in a more evidence-based way, which is very complicated in behavioral health because of the very extensive heterogeneity of both provider organizations and provider types with different forms of training, but also the culture that I alluded to before of, you know, of trying to – well, obviously we want to maintain sort of HIPAA compliant privacy, we also want, you know, consumers to understand that there are pros and cons of maintaining privacy and that there is in fact utility in sharing some information with other providers so that you get more safe and effective and coordinated care.

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

So, this is Aldo, real quick, with respect to that last comment its culture absolutely, it's also policy because we're developing quality measures for pediatrics in this behavioral health space and part of development is also field testing and you can imagine the practical day-to-day hurdles and recruiting sights that actually have access to information across the primary care behavioral health interface. So, culture is great but there are some significant policy hurdles in the development of these measures.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

Shaun, your project is in Maine and Maine has an opt in informed consent process, has that been a problem for the project that you're working on?

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

No it has not at this point. We have yet to see. We have had the opt in consent and then it's opt in for mental health information and opt out for general medical information, it's a tiered consent process.

At this point we're seeing multiple patients opt in but again it's very young, it was just deployed last fall. So, as we engage with these practices, and there are 20 behavioral health organizations that are participating in the CMMI Grant, we are doing a very close analysis as to how the communication with the patients is going.

The key to behavioral health is communication and so we're working very hard with the provider community in the behavioral health side to educate them as to how to talk directly with patients about the value of sharing information and using that information for measuring quality.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

This again is Wes with one further question, you're offering some incentives, a modest incentive, \$70,000.00 to the behavioral health providers is that having a positive impact on your recruitment process for behavioral health providers?

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

Yes it is. We released a request for proposal and are going to be announcing next week the 20 organizations that were selected to be part of the program. We do have \$70,000 available to each of those organizations that's going to be delivered to them as they, one, agree to participate in the program. Two, connect to the health information exchange and actively start sharing data and then number three, participate in the quality measurement program over the next two years.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

Great, I think we want to highlight that CMS is providing those incentives to the behavioral health providers.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

That's correct this is from CMMI and this was an approved funded program for their state innovation model testing grant.

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

Thank you very much.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, so in the interest of time we have about 2 more minutes if anybody else wants to say anything right now to help us wrap up and then we're going to open for public comment. Before we open I really want to thank you all. I think we did incredibly well today and we have a lot of food for thought and information that will help us move ahead in this space. Okay, why don't we open for public comment would that be okay?

Public Comment

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

Operator, can you please open the lines?

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, anybody on the call want to make a final comment?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration

I'd like to thank everybody who has contributed, this is Westley, I really enjoyed the discussion and the materials that they submitted, thank you.

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

Welcome.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, I'd like to thank everybody too, this was a great call, thanks for the members for joining, thanks for the federal advisors that helped guide us in the questions and the work we did, and we'll be getting out with some results of this call. So, thanks everybody for spending Friday afternoon with us, have a great weekend.

M

Bye, thanks.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Okay, thanks, you too.

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

Bye-bye.

M

Thank you, bye-bye.

Public Comment Received

1. For those interested in VA/DoD Clinical Practice Guidelines for Mental Health, check <http://www.healthquality.va.gov/>

2. Additional comment for the record: VA has been working on an outcomes-oriented MH measurement framework. This has been a challenging task, since many of the most important questions one would want to know about mental health care are not yet captured in a structured, standardized way. There also is a critical need to factor in 1) patient reported outcomes (which are often NOT best collected during the clinical encounter) and 2) patient and family experiences with care (which demand a survey-type approach). I can connect you with VA subject matter experts if you are interested in greater detail - just email joe.francis@va.gov
3. One final comment: it is easier to measure pharmacotherapy via the EMR than it is to determine if appropriate, evidence-based psychotherapy is being delivered, even though the latter may be more effective. Last week's NEJM had a good editorial in this regard, hinting at how performance measurement may have driven (in part) the massive rise in psychopharmacologic drug use.