

**HIT Policy Committee  
Certification/Adoption Workgroup  
Transcript  
January 24, 2014**

**Presentation**

**Operator**

Lines are bridged.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification/Adoption 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 not take roll. Marc Probst? Larry Wolf?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Here.

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

Good morning, Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Good morning.

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

Hi, Mike. Joan Ash? John Derr? Carl Dvorak? Paul Egerman?

**Paul Egerman – Businessman/Software Entrepreneur**

Here.

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

Hey, Paul. Joe Heyman? George Hripcsak? Stan Huff? Liz Johnson?

**Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation**

I'm here.

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

Good morning Liz. Donald Rucker?

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Here.

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

Hi, Donald.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Hi.

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

Paul Tang?

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

Here.

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

Micky Tripathi? Hi, Paul. Maureen Boyle?

**Maureen Boyle, PhD – Lead Public Advisor, Health IT – Substance Abuse and Mental Health Services Administration**

Here.

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

Good morning, Maureen. Jennie Harvell?

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

Here.

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

And are there any ONC staff members on the line?

**Elizabeth Palena-Hall, RN, MIS, MBA – Office of the National Coordinator for Health Information Technology**

Liz Palena-Hall.

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

Elise Anthony.

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

Hi Liz and Elise. Is Jennifer Frazier on? We'll make sure that she's in the VIP if she's not and I'll turn it back to you Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you very much. Well, let's bring up the next slide; we should have an agenda slide. This is terrific. So, we're switching gears here, we've been focused on long-term post-acute care for the last several weeks. We still have some loose ends from that, I'm working with ONC to get those summarized and get some materials out to the workgroup members, so that we can get that part wrapped up. But while that's still pending, we're going to dive into behavioral health. So apologize that we still have some loose ends before we continue, but we are continuing because we're trying to get a bunch of things done for March.

So today is our first dive for behavioral health, we've got a pretty packed agenda so I'll keep this pretty focused, my opening comments. This is meant for us to learn about this care setting, the kinds of patients they serve, the kinds of providers that are included, what some of their current challenges are in terms of user information systems. And we will be having a hearing on January 28, which is next week, and we'll have many more hours of learning about behavioral health in front of us. So, with that as intro, go on to the next slide. So, this is a reminder that we have several meetings on behavioral health and then we will have probably a couple of sessions at the end of February, early March to wrap up our work and then get recommendations to the Policy Committee and Standards Committee during March. Next slide. Okay, we're ready to take our dive.

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

Great. So this is Maureen Boyle and I just want to say, thanks for inviting me to present today and thanks Joe and Steve for exploring the developments of voluntary certification for behavioral health. I'm Maureen Boyle, I'm the Health IT team lead in the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration, or SAMHSA and later on in the presentation, Sue Mitchell from RTI and Mike Lardieri from the National Council for Community Behavioral Health will be weighing in at certain points. Next slide.

So SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. And to achieve that goal, we have eight strategic initiatives, one of which is health information technology. Next slide. So the goal of the strategic initiative is to support widespread implementation of HIT systems that will support quality integrated healthcare or behavioral health care for all Americans. We're trying to ensure that behavioral health providers fully participate in the adoption and effective use of health IT. Next slide.

The primary value that we see in a voluntary certification program is in promoting interoperability within the broader healthcare system and promoting confidence in the vendors as in a base level of functionality and in promoting data standards that will allow us to minimize data reentry, improve data quality for reporting and support secondary uses of information such as research. Next slide.

So what we've heard from the field is that some providers are delaying adoption of, and this is behavioral health providers, are delaying adoption for fear that the existing systems will become obsolete in the rapidly changing HIT environment. Behavioral health providers often exist at near subsistence levels and many of them would not recover from the loss of a large capital investment that would be involved in adopting an electronic health record. So SAMHSA's hoping to encourage behavioral health providers to adopt EHRs that are interoperable with those that are being adopted through the Meaningful Use EHR Incentive Program, but without requiring behavioral health providers and technology vendors to commit resources, develop functionality that's not required for their scope of practice. A voluntary certification program would provide a mechanism that would allow us to verify that the EHRs that are purchased using SAMHSA funds and other federal funds could meet a core set of standards and to achieve interoperability. Next slide.

So behavioral health is somewhat unique and presents different issues than those that were presented during the LTPAC hearing and this is because behavioral health consists of many different types of providers with distinct workflows. These include the eligible providers, which are psychiatrists, and under the Medicaid Program, psychiatric nurse practitioners, and those are typically prescribers whereas the majority of ineligible providers are typically non-prescribers. And in the inpatient setting this includes psychiatric hospitals and units within – psychiatric units and substance abuse units within hospitals, residential treatment centers for mental health and substance abuse. And as far as ambulatory settings, clinical psychologists, clinical social workers, licensed therapists and counselors, community mental health centers, opioid treatment programs, marriage and family therapists and substance abuse counselors. Next slide.

**Paul Egerman – Businessman/Software Entrepreneur**

I'm sorry – eligible, eligible for what?

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

Oh, I'm sorry, eligible for the meaningful use incentives.

**Paul Eggerman – Businessman/Software Entrepreneur**

Oh, okay.

(Indiscernible)

**Paul Eggerman – Businessman/Software Entrepreneur**

These are currently eligible – so our focus is going to be more on the ineligible ones.

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

Well we're covering everything, but I just wanted to highlight who the elig – who the ineligibles were.

**Paul Eggerman – Businessman/Software Entrepreneur**

– sorry to interrupt, thank you for clarifying.

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

Umm, next slide. So the workflow and EHR functionality needs of the different provider types are going to be unique. So for example, psychiatrists, as I mentioned before, are prescribers and they will likely have different functionality requirements than say a therapy or counseling focused practice. And these will also be distinct from the needs of a methadone clinic or an opioid treatment program and also distinct from residential programs. And one of the things that we wanted to mention is that in the context of clinical social work, there are significant efforts going on to integrate with social service systems. And so promoting interoperability between health systems and things like housing systems and criminal justice is another priority for this community. And then it's also necessary to have more integrated care settings where programs may be looking to have a meaningful use certified EHR plus additional relevant EHR functionality. Next slide.

So the other way in which behavioral health is unique is in the stricter privacy and confidentiality requirements that govern these data. At the federal level, this is governed by 42 CFR Part 2, which protects the confidentiality of substance abuse treatment information. The purpose of the statute is to prohibit the disclosure of records relating to substance abuse treatment, in order to encourage patients to seek out substance abuse treatment without fear that by doing so, that their privacy would be compromised. Next slide.

So basically, these requirements are that patient consent has to be obtained before sharing information that's subject to 42 CFR Part 2 and there is also a parallel system within the VA, Title 38. And there are limited exceptions to this, but in general, consent is required. And there are nine explicit consent requirements, I don't go into them here, but I can provide more details if anyone is interested. But one of the elements is that consent has to include the purpose of use, and that that information needs to be communicated to the receiver. In addition, there's a prohibition on the redisclosure without consent, so the receiving entity has to be able to protect that information from being redisclosed once they've received it. Next slide.

So 42 CFR Part 2 sets the minimum standard for protecting substance abuse treatment information; however, state laws may be more restrictive. In addition, mental health records are often treated as ultrasensitive by many jurisdictions, but each state approaches this from its own perspective and so there's a lot of variation in terms of the protections that are required for mental health. In addition, states typically have extra protections for things like HIV, genetic data, women's health and most recently – is the HIPAA self-pay rule, which healthcare organizations are going to need to find ways to comply with in order to – so patient consent will be required to share information for which the patient has paid for those medical issues. Next slide.

So over the past few years, some related standards have been developed through the ONC's standards and interoperability Data Segmentation for Privacy Program and this includes standards for communicating privacy policies and obligations with the receiver. I just want to be clear because I know that this has led to some confusion in the past. Compliance with 42 CFR Part 2 doesn't require full data segmentation capabilities, we believe it would be a positive element to give patient's meaningful choice to share their data and it ultimately may be something that is needed for compliance with the self-pay rule. However, compliance with 42 CFR Part 2 basically will require two things – or there are two types of standards that we're hoping to ultimately have included in the Meaningful Use Program and potentially in Behavioral Health Certification Program and that is, standards for communicating with privacy policies and obligations. So things like what's the purpose – what's the authorized purpose of use and communicating whether there are restrictions on the redisclosure of information as well as the receiving electronic health record having the capacity to control the redisclosure of protected information. So this is especially important in places like general healthcare organizations, primary care, hospitals, in order to ensure that we can support integrated care for behavioral health and – including both substance abuse and mental health, depending on the jurisdiction.

**Paul Egerman – Businessman/Software Entrepreneur**

And this is Paul Egerman, I'm sorry to interrupt. Do you want me to hold my questions until the end or is it okay to ask questions while you're going through this?

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

No, that's great timing, I was just about to stop for questions, because I know this is a complicated topic.

**Paul Egerman – Businessman/Software Entrepreneur**

Yes, so I'm wondering if you can tell us the definition of a disclosure.

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

So in the context of Part 2, a disclosure is any information that identifies a patient as having either received or sought treatment at a Part 2 program. And so a Part 2 program is a federally assisted substance abuse treatment program and the way that that's typically defined is an organization that holds itself out as providing substance abuse treatment diagnosis prevention. And so there's often a complexity in determining kind of who is a Part 2 program, but really if you're advertising in any way about substance abuse treatment services, and you receive any type of either direct or indirect federal assistance, then the organization, or unit within an organization, is a program.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, and that's helpful, but actually that wasn't quite what I was asking about so I'll ask my question a little differently. Your second bullet on this screen talks about redisclosures.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

Suppose I'm an acute care institution that is treating a patient that has given consent for me to look at their information. What would constitute a redisclosure by the acute care institution? If a patient is transferred to say a long-term – an extended care facility, is sending the information from the acute care institution to long-term institute, is that a redisclosure? What's the definition of a – once you have this protected information, and you've gotten the consent to have it, how do you know when you are redisclosing? What's the definition of that?

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

So in the context that you're talking about, so say a Part 2 program sends information to the acute care facility on a patient that's – for a patient. Any information that came from the Part 2 program that identifies that patient as a substance abuser, as somebody who's received treatment, cannot be passed along to the next – or to that long-term care facility, without the consent of the patient.

**Paul Egerman – Businessman/Software Entrepreneur**

Okay, so – to know, right. So if the substance abuse group sent, with the consent of the patient sent the acute care institution say a medications list on the patient, if they want to transfer that patient to an extended care facility, they can't do that – they can't give any information without consent of the patient?

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

Exactly.

**Paul Egerman – Businessman/Software Entrepreneur**

They can't give that medication list to anybody else without the consent of the patient –

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

Exactly.

**Paul Egerman – Businessman/Software Entrepreneur**

– is what I'm hearing.

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

What about within the institution, what's the definition? I know the HIPAA definition of disclosure is pretty strict in that it talks about whether or not people are employed, so is it – if you give the information to somebody who's not employed by the acute care institution, they're a consultant, is that a redisclosure?

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

Ah, yes. Well – so, everything always depends on the full details so it will partially depend on who's named in the consent form that the patient initially signed to release their information to the acute care facility. So if they're naming a provider versus naming the provider organization, that can be different, but – and then within the organization, they – if an organization is named, they can share information within that organization but there is language in 42 CFR Part 2 about it has to be required for the purposes named in the consent form. So, if the only purpose named in the consent is for treatment purposes, then they're restricted on how they share information for payment.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/ Office of Disability Aging & Long-Term Care Policy**

This is Jennie Harvell I have a question.

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

Yes.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/ Office of Disability Aging & Long-Term Care Policy**

Yeah so, Maureen, I think I heard you say that with respect to these last two provisions, these were requirements that you were hoping or looking to be included in the Meaningful Use Program, as well as to establish for a voluntary certification program for behavioral health EHRs. And so I have two questions, one, I'm wondering if you could describe what, if any, activities have happened to advance these issues forward in terms of the Meaningful Use Program. And then secondly, I'm wondering how you would be able to implement this redisclosure policy without data segmentation.

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

So what's happened so far is about a year ago, a little more than a year ago, we sent recommendations detailing this to the HIT Policy Committee, the standards – sorry, the Privacy and Security Tiger Team. And they have looked at this to some degree; although I'm not sure in – I don't think they've looked at it in kind of the nitty gritty detail. So – and as far as how to do this without data segmentation is, an option is basically creating a data silo, so instead of kind of metadata tagging information to indicate that there are restrictions on redisclosure and that type of thing. You can get a record from a Part 2 program and keep it in some sort of data silo, that isn't the equivalent of data segmentation, if that makes sense.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So Maureen, you're – this is Larry. You're creating a distinction that others might not agree with in terms of what it means to have data segmentation –

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

Well I think –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– done through metadata or done through creating separate data stores.

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

Yeah –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– there would be one case logically segmenting the data and the other case you may be more physically segmenting the data, but in either case you've got to deal with it separately somehow.

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

Yes, no there's –

**Paul Eggerman – Businessman/Software Entrepreneur**

This is Paul; you've really given two separate things that are both very difficult. This redisclosure issue is very difficult, segmentation is also difficult, but it's not necessarily the case that you need to do segmentation and were to implement what you see on this screen, although that would be one way of doing it. But they both are kind of thorny is the best way I could describe it, issues as it relates to both technology and to workflow and policies. So that's just an observation.

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

Yeah, no, and we absolutely recognize that, but it's one of these things where, this is the regulation and the consent requirements are not going to go anywhere. And so if we want to include substance abuse in – or substance abuse treatment in integrated care, then something is going to have to be done to ensure that patients that are receiving substance abuse treatment can fully participate.

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

And this is Mike and this is the reason that most HIEs across the country just don't include behavioral health at all, because most of them lump in mental health and substance use together when they don't have to. Mental health for the most part is regulated under HIPAA, same as HIPAA in terms of sharing information, but there's so much – so many providers provide both mental health and substance use under Part 2 programs that it gets very difficult for the HIE to separate it out as it comes from the electronic health record. So behavioral health providers are, for the most part, excluded from the whole health information exchange process right now.

**Donald W. Rucker, MD, MS, MBA – Associate Dean for Innovation, CEO IDEA Studio, OSU Wexner Medical Center – Ohio State University College of Medicine**

Don Rucker, I also had maybe a question or – a lot of these patients I think, and maybe not exactly Part 2, are actually under somebody else's control, they're sort of the proverbial pink slip. They have a medical hold or a judicial hold or they're just – and some other custodial arrangement either permanent or temporary, so I think you have to have not just a patient-facing things, right, and patients who are fundamentally able to function when they're not sick. But you have a whole group of people, maybe the bulk of them here, who are in these chronic institutionalized settings, who are not really ever in a position to give consent or do this. We sort of think of this a little bit, maybe the model we have in mind is somebody, well you know, proverbial back in the '70s, Thomas Eagleton I think was his name, in the McGovern campaign, so somebody where it would be very embarrassing and sort of a total revelation that they have mental illness. But the bulk of the folks here are just they're in group homes, they're moving back and forth, it's a very, very different situation, I think, than our classic don't let anybody know about my STD or my one nervous breakdown kind of thing. And I'm not sure I've heard structure that would really deal with the sort of chronicity and just lack of consent and then who actually does give consent. And that changes almost every shift.

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah Mike, you raise a really good issue –

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

I would just like to –

**Paul Egerman – Businessman/Software Entrepreneur**

– you raise a good issue and the example I gave of the redisclosure going from the acute care institution to the extended care, Maureen's response is you need to get the patient's consent. But then the question becomes, well is the patient, after whatever happened at the acute care hospital, in a position to give consent at that moment, and not creating a situation where consent is coercive. Because if the patient doesn't give consent, what's going to happen to the patient? The patient's going to be thrown out on the street. I mean, it's like the patient has no choice at that point, except to give consent.

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

The nature of the illness –

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

Well, but – getting a little off topic. I mean, I think this is getting a little off topic in that like there are provisions in place for – there are legal provisions in place for kind of who then has the authority to kind of make those decisions. And I mean I don't think that that's necessarily a critical element of this discussion.

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

Right and I would agree with that Maureen. Yeah, because that's in the 42 CFR regs, the same as under HIPAA if you're incapacitated, your guardian or whoever your legal representative, signs for you. So it's the same as with everybody else. I do want to back up though that the majority of patients that we're talking about are not institutionalized patients. The majority of the patients we're talking about are living – there are not very many institutions left in the country, they've all been deinstitutionalized. And our members in the National Council, we have 2000 organizations across the country, we serve those 8 million or so seriously and persistently mentally ill patients that used to be in institutions, they're no longer in institutions. So, and those consent issues, many of them have substance use disorders, but we should not think of this as a group of people who are in institutions versus people who are in communities, they're safety net populations similar to what you find in the federally qualified health center world. These 8 million people, many of them cross over into the federally qualified health centers, some with insurance, some not, mostly Medicaid are the population that our members serve, these 8 million people.

And these are the part of those 5%, or whatever number you use, the 5% or the 20% of the population that are eating up or utilizing 80% of our healthcare resources. So the types of services that are utilized to service these providers are the full range of services from inpatient acute care, they go in and out, sometimes voluntarily, sometimes involuntarily. They come out; they go to intensive outpatient or partial hospitalization programs. Our members have residential programs for supervised residential services, because we know without housing, you can't really survive in the community. They do home – the provide homeless services, many different kinds of outreach services, home care services as well, so it's that full range of services that you would look for with any chronic and what's the – and fragile medical population. It's that same range of services, but dedicated to their behavioral health needs.

And right now, that is even changing so these providers are not dedicated just to behavioral health, because we find that these patients, the seriously and persistently mentally ill, they die 25 years earlier, on average, than the rest of the population and they're not dying from behavioral health disorders, they're dying from chronic disease. So many behavioral health organizations now are either providing integrated care by bringing medical services in and partnering with medical providers, or some are just doing it in-house. But that's the big move for integration if we're really going to get a handle and provide good, quality care for this population.

**Paul Egerman – Businessman/Software Entrepreneur**

And that's helpful because part of my questions were related to healthcare services that are not necessarily behavioral health related, so it's like patient being treated for substance abuse has to be hospitalized for something like, I don't know, arthritis or maybe needs a hip replacement or something. And so that's what I was asking. You raised another issue I'd like to try to understand. There's sort of like, the way I understand this, there's like an intersection between the behavioral health world and the LTPAC world that we just discussed. So some of these institutions are both behavioral health organizations and long-term post-acute care, is that right? So they would qualify –

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

Yes.

**Paul Egerman – Businessman/Software Entrepreneur**

– for both sets of optional certification.

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

Actually yes and across the country, you have many – and that's starting to change because of some regulations around congregate care and how many people you can have in the “institution.” But you used to have adult care, adult living care just that level underneath skilled nursing facility, would be crowded with behavioral health patients as they were dumped out of the psychiatric institutions into the community. But then it was just moving from one institution to another institution so now there are limits, I think, is you can only have 12 or 14 people that have a behavioral health disorder in one facility without having other issues around congregate care.

**Paul Egerman – Businessman/Software Entrepreneur**

But also, to be clear, what appears on this screen, these rules only apply to substance abuse patients, not to all of behavioral health.

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

Right, so the 42 CFR Part 2 only applies to substance abuse, but there are similar state-based regulations around mental health, depending on the state. So some states will – mental health, somewhat like HIPAA, but many others have consent and redisclosure requirements.

**Paul Egerman – Businessman/Software Entrepreneur**

And to what extent do you think this is actually already in operation and implemented, where people have HIT systems that are meeting the requirements of Part 2 and are restricting redisclosures and getting consents, to what extent is that currently in operation right now?

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

It's minimal and we survey this and we talk to our members on a regular basis, so, it's minimal. And it's really not an EHR problem; it's a health information exchange problem. It's an EHR problem if you get the data segmentation and can any EHRs today do data segmentation? A couple, maybe. So in that sense, yeah, we're in with everybody else around data segmentation, but once you back off from data segmentation, it's not an EHR problem, it's how you do health information exchange, and it's really – that's the issue. There are other recommendations that organizations have made. If the General Council were to provide a little more flexibility in their interpretation of this "to whom" section of the 42 CFR consent, that would greatly open up the doors for the information to flow, and to be specific about this, the two –

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

Mike, Mike –

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

Yeah?

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

Yeah, I mean, I don't think we necessarily need to go down that route before, because it think it's something that OGC has already weighed in on and so I think – and I don't think that kind of those details are kind of critical in this setting.

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

I'm sorry, I'll handle that in my other testimony, because we think – we do, so I won't do that here though. Thank you.

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

But in response to the question, I do think it's important, especially to have kind of standardized ways of communicating the policies and obligations associated with receiving information. So that would allow for automating this type of information exchange where at this point, that's very difficult if the receiver doesn't understand the – your communications around those obligations.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Maureen?

**Paul Egerman – Businessman/Software Entrepreneur**

Well, yeah, possibly, but I mean the – to me the real issue is why is this being implemented in such a minimal way, even though it's the law? And is it the absence of a standard or is it that there is some policy challenges that if you changed it, made some little tweaks to it, would make it easier to implement. And the reason I say that, I just participated in this whole discussion about the accounting of disclosures provisions in HIPAA, which are not being implemented either. And one of the things that came out of that was the reason they're not implemented was with the definition that HIPAA uses for disclosures, it's almost impossible to implement it.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Maureen?

**Paul Egerman – Businessman/Software Entrepreneur**

And so there was some policy suggestion changes that would make it much easier to implement, and I wonder if that's the case here.

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

I think there absolutely are some policy challenges to the regulation and it's something that SAMHSA has looked closely at, but the one thing that I would say is even if there were kind of attempts to amend those, it takes many years to change this type of regulation. So, if we're hoping to integrate behavioral health in anything in the near term, this is going to have to be addressed as is.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Maureen?

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

Yes.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

This is Marty Rice, how are you? Thanks for the explanation. When you say automated, what are you – what specifically are you automating when you say that? I mean –

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

Sorry. So basically, what I'm talking about is the ability of the receiving system to get the information and so say for example they're going to either silo data or do metadata tagging in order to kind of segregate the data that are subject to these additional protections. That the receiving system could get these – get the information from the documents. And so the DS4P Initiative has basically metadata tagging standards for communicating restrictions on use, purpose of use, that type of thing that could be carried along with the data, depending on how the receiving EHR handles that type of thing. So whether its saying, okay, this whole record needs to be siloed because it's subject to these additional protections or we can pull out the data elements and maintain those protections associated with the data elements. I mean it all depends on how they structure their compliance.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

So, being involved with geriatric psychiatry for many years, most folks don't think that – don't associate psychiatry with geriatrics and co-morbidities and their psych background and their meds or psychotropics, their – everything was just so integral to understanding that patient that it was hard to even separate any of that. I mean it's just all – it's a tough thing –

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

In the context of Part 2, it's really about the facility that initially captures the data and less about what specifically constitutes psychiatric data or substance abuse data. So – but we are beginning to address this in our Data Segmentation for Privacy Initiative at SAMHSA, we're building a tool that does this. And there are major open questions when you start to give patients data segmentation options to say, I want to send my record and redact my substance abuse information, what specifically that means. I mean – and that's why we're not saying that we want the system to jump to that type of data segmentation, because I think there are a lot of policy issues to be addressed through piloting.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Yeah, I think it's easier to talk about in a younger person than it is for an older person because once they have a drug abuse problem, once they have a – because there are so many co-morbidities when it comes to pain. And if the doctors don't really know what's going on going forward, it's kind of like you just create these cycles that you can't get out of. It's almost where you have to share to really produce a good outcome for that patient and that's kind of where I'm kind of split.

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

Well, I mean I think the difficulty here is one, the regulations stand for themselves, even if we think it's a bad idea, we still have to comply with them. But also, while there's evidence that that type of information sharing is valuable to health and safety, there's also evidence that stigma associated with substance abuse leads to poorer care, that there are – there's stigma among physicians for patients with substance abuse disorders. So it is kind of this balance thing where you want the patient to understand both the risks and the rewards of information sharing and to give them the option to make the choice that's best for them. And that may differ depending on whether you're talking about sharing information with your internist versus with your dermatologist.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Well that's very true, but thank you.

**Paul Egerman – Businessman/Software Entrepreneur**

And sorry to ask so many questions, but another question I have is, when consent is given for treatment, can that data be used for things like quality reports or research? Can that data be de-identified and sold or for like the FDA Mini-Sentinel Program? Or do all those things have to be specified in the consent?

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

So there are some complexities with this in the regulations right now. So yes, you can collect data for research and evaluation that's going to lead to de-identified data. Currently the regulation specifies that the Director of the Part 2 program needs to be the one making the decision on what information can be shared in that context. And so it kind of – it still depends on the structure.

**Paul Egerman – Businessman/Software Entrepreneur**

I'm still thinking more of it like what I call the receiving organization, so you've got a substance abuse patient treated at an acute care hospital for – they're having a hip or a shoulder done. It's not a substance abuse issue, but they've got some sensitive information that's got the patient's medications list, which they needed perhaps for a lot of different purposes. Can they use they use then information about that patient in their quality program, in any research programs that they're doing, anything they're doing with the FDA or – in other words, does the consent allow that to occur or is there some downstream restrictions that are also placed on this data?

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

So, as long as it stays within the organization and any information that gets reported is de-identified, I believe that's okay, although I would need to double check on that with our privacy lead.

**Paul Egerman – Businessman/Software Entrepreneur**

So, that patient could be included in quality data, could be included in patient safety investigations, and could be included in anything that's internal. But the data could not be sent, if I heard it right, to like a – say an external tumor registry or an external HIE organization, it has to stay within the organ – within the concept of the four walls of the institution.

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

Yes, although I – like I said, I think it also depends on how the initial consent is structured and whether the patient is giving permission to an individual provider versus an organization. And I think that the purpose of use specified can impact that, so, yeah.

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

– de-identified –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So this –

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

– data, the de-identified data can go, however, like Maureen's saying, at the forefront with a 42 CFR Part 2 consent, the patient has to identify that they would allow sharing their data for treatment, payment, operations. The quality comes under operations and if they only checked the treatment box, then you can't share identified information for quality, you can only share de-identified information for quality.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, this is Larry. Are we confusing primary care delivered by the Part 2 organization and information used by a non-Part 2 provider that they – some of which they may have received from the Part 2 provider, but a lot of which might have been internally generated? So yes, they got a list of meds, but then they did a med reconciliation and now they have a list of meds that they are using in the current setting, so presumably the meds in the current setting don't have those restrictions, even though the decision was based on the Part 2 information.

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

So that is correct. If you kind of ask a patient what medications they're on, and they tell you and you add that to the record, even if it was also given to you by the Part 2 program, then you have collected that data and it's not subject to Part 2.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So the issues that are subject to Part 2 are where you're just passing along the information and presumably that includes the fact that they were at that Part 2 provider.

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

Yes. Right, so if you are –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

If I'm looking at a referral source map of where patients have come to me from –

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

Yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– at a de-identified level I'm probably fine, at a patient-specific level, I'm not fine.

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

Right. And if you talk about kind of, you have a med list and you include who prescribed that medication, and it's a prescriber that can be identified as somebody associated with a Part 2 program, and that can identify the patient as being associated with them, then that's also a violation.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. And similarly if I'm producing a reconciliation report on discharge and part of that includes reference back to the meds they were on prior to this admission, I very well might be referencing those meds.

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

Right.

**Paul Eggerman – Businessman/Software Entrepreneur**

I didn't understand what you just said Maureen. So if you get information that a patient is on an antidepressant medication, I don't know, but you're on some antidepressant medication. And then you say to the patient, oh, you're taking Paxil, is that right? And the patient says yes. Once the patient says yes, it's no longer protected?

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

Right, if you –

**Paul Eggerman – Businessman/Software Entrepreneur**

All you have to do is say to the patient, is all this information correct, the patient says yes, then you can redisclose it to your heart's content, all the rules don't apply. Is that what –

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

Well, I mean, you're coming close to the – I mean like there definitely is a blurry line there, and SAMHSA obviously can't give direct kind of legal advice on these issues. But, the way that I heard it interpreted is if you asked the patient what medications they're on and they say, I'm on Paxil, and blah, blah, blah, and blah, blah, blah, blah, blah, blah and you put that into your record, then you've just captured that information in that context. If you are getting that information from somewhere else and perhaps if you say like, is all this information correct, I don't know if that still falls under that versus them explicitly saying to you, I am on Paxil, I am on buprenorphine. I mean, there definitely are blurry lines here.

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

It's a little clearer if you just imagine that a CCD document as a PDF is passing, you couldn't just share that PDF from one to the other without the patient actually explicitly signing. As you get to discrete pieces of data, that's where it gets more difficult, like what you're identifying, if you suck that information in from another system, well that's where the data segmentation comes in to know whether that particular medication from the Part 2 program has the meta-tag on it or not and that's where it gets really difficult. But if you just use the PDF passing through, it's a little easier to visualize how that process works, so that PDF could not just go to another provider, because it just came from the Part 2 program.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so this sounds like the kind of topic we could talk about for hours, we've covered enough that we should move on and I'm sure we'll hear more about it during the hearing next week.

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

That sounds good. So next slide. So this kind of lays out the options that we see for a voluntary EHR certification program. And I recognize that a lot of this has been discussed in earlier HIT – I'm sorry, earlier LTPAC meeting, but basically what we have been thinking about is kind of a flexible program that can meet the needs of diverse provider types, so the modular concepts that we've been talking about. Or, also of value could be kind of a core certification program, so something that looks at the core functionality across all behavioral health provider types, or even, depending on ONCs needs, something going a little – even kind of farther down to the core for all healthcare providers, things like interoperability and privacy and security.

Next slide. So just wanted to make sure that everyone understands that this is for illustrative purposes only, so don't concentrate on the functionality that's in each of these components. But this is how we see a potential modular certification program working, where there's something that's like in absolutely in "A." like it's an absolute chore that like every single EHR across the country should have. And then these other elements such as prescribing, assessment, patient communication, clinical quality measurement, where an organization such as like the American Psychiatric Association or the American Psychological Association could come in and say, for psychologists we recommend that you look for electronic health records that have at minimum, A, C, D and E. And I also wanted you to note again that one of our priorities is enabling care coordination across the social service sector, such as like housing and urban development. So they promulgate standards for a homeless management information system, or HMIS, and that system can be used to enable some level of coordination across homeless services and health services, which is very important in the behavioral health sector. And so some level of very basic interoperability certification could go a long way to kind of promoting that type of coordination in the sector. Next slide.

And I also just wanted to talk a little bit about some history in this sector of some work that SAMHSA was doing with ONC early last year. And we were working together to explore a sub-regulatory behavioral health certification program, looking at applying the current, at the time Meaningful Use Stage 2, well I guess still, the functional criteria and looking at what are absolutely core across all the behavioral health provider types. Next slide. And ultimately, the – results – ONC decided to start exploring through this committee, a certification program that applied across the ineligible providers more broadly; however, we thought some of the initial efforts might be informative. So the meaningful use criteria that we selected to apply across behavioral health fell into the categories listed here. And on the next slide, it kind of gives that in more detail.

It specifies the specific meaningful use criteria that were proposed for inclusion –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Can we move to the next slide?

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

Actually, move two slides, one more. Okay. And I just want to mention that this, because we kind of stopped midway, this wasn't fully vetted across behavioral health providers, but it is kind of a place to – for consideration. And on the next slide, it lays out the criteria that were not included and some of the reasons. And as I mentioned before, the majority of ineligible providers are not prescribers, and so that's why the prescribing criteria were not included in that core, same thing for labs and imaging. And I won't go through the details of the following slide –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I – I'll hold my question for later, let's get into this section.

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

Okay. So next slide and one more. Okay, I also just wanted to highlight some of the findings from the other provider study that was completed by ASPE for Congress and this is basically presenting data on known EHR adoption rates for behavioral health providers. And unfortunately, the data on EHR adoption is very scarce and not of particularly high quality, because for many of them the definition of EHRs is different and how they go about collecting this data varies. But as you can see the data does exist are pretty dismal for psychiatric hospitals and relatively low for community mental health settings. I'm not going to talk about that one in detail because Mike Lardieri is going to speak about that in just a minute. Next slide.

And they also looked at the number of patients served by ineligible behavioral health provider and that totals more than 18 million. Next slide. And they also highlighted in their report the use of EHR functionality in practice, and I just want to note that there's obviously again, significant variability across provider types, and so this was kind of a lumping effort. Next slide. So now, I'm going to turn it over to Mike Lardieri to discuss the work that he did for the National Council to estimate EHR adoption in community behavioral health settings.

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

All right, thanks Maureen. And so we conducted a survey of our organizations. As I mentioned, we have over 2000 members, they serve the, for the most part, the seriously and persistently mentally ill. A large majority of those patients are dual eligibles and they provide a full range of services, mostly outpatient services, but these clients, patients, consumers, recipients; we call them all different things in behavioral health, depending on your setting, also use inpatient services from time-to-time. But those stays are usually short and the focus is on then coordinating treatment back into outpatient treatment. So they serve about 8 million of these underserved clients across the country. Next slide.

So we looked at, and this was back in, we published our study in 2012, so the information is a little dated. However, when we looked at the use of an electronic health record, what we were using at that time was Meaningful Use Stage 1 criteria, and we spelled out the criteria and asked questions specific to Meaningful Use Stage 1 criteria. So, you can see that about 26% of the organizations that responded, and our response rate on our survey was about 25% of those 2000, so that was a pretty good response rate, we think. About 26%...some of our members unfortunately still had their heads in the sand that they are not going to – they weren't planning to implement. We do a lot of work from the National Council to really try to help organizations understand that you really have to have electronic health record or some type of technology that's going to help you manage your clients and do good, quality work. So we continue to work on that. About 35% of the respondents, they had an electronic health record at some sites and a combination of paper or – it was either some paper or a combination of electronic and paper at others. And about 21% were all electronic, but that doesn't mean that they were meaningful use. Next slide.

What we found was that 2% of the organizations that responded identified that they currently had a Meaningful Use Stage 1 certified electronic health record and it met requirements. When we looked at if they were going to be ready by the end of 2012, with their projections, they identified – that number went up to about 7%. We really haven't seen that much change, maybe we're at 12% now, which is not much of a change. When we compared those organizations back then to hospitals and federally qualified health centers, there was a huge difference. At the FQHC level, we know that hospitals, the data coming out around hospitals is around 80% of hospitals now have electronic health records and meeting meaningful use.

And the last numbers I saw on the FQHC world, they're up to around 70% of the FQHCs have meaningful use certified electronic health records today; we're still down around 12%. So, we have a long way to go on the behavioral health side, much of it has to do with the Incentive Program, behavioral health organizations sustain themselves on very low margins. FQHCs are around 1-1.5% margin, behavioral health organizations are around the same, so without having the incentive dollars, it makes it very, very difficult for them to step up and get to a meaningful use certified system. Many organizations, however, as we talk to them across the country, they have technology, it doesn't meet meaningful use right now, and they haven't gone through the process of getting their self-developed technology certified, because of all the expense of doing that. And really having the expertise in-house to meet meaningful use certifications, it's one thing to develop a program that you can process your patient information and have your staff enter into it versus having all the backend infrastructure necessary to have full meaningful use certified system. So, that's really where we found with our members as we survey them and continue to talk to them across the country. Next slide.

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

Thanks Mike. So Larry, do we want to stop here for questions or get through the first factor first?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I think since we're about to change gears, maybe we should wrap up the general stuff before we get on to the specific factors you guys have identified.

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

Sounds good, any questions?

**Paul Egerman – Businessman/Software Entrepreneur**

So Larry, I have a question to try to understand –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Paul Egerman – Businessman/Software Entrepreneur**

– whether or not we should be looking at this voluntary program for the ineligible providers only and a separate program for the eligible ones, how – it's just a little different that some of these providers are already under the meaningful use program. So I'm not sure this is the right place for that question, but I'm just a little bit confused about which community of providers we're addressing or how we address both communities.

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

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes, so I think you're right, I think you're right Paul that we have some overlap here, right? We have people who are covered under the current meaningful use program who are providing care in one of these settings as a, for example, as a physician, an ambulatory physician could be doing this and to make sure that we're not sort of tripping over that set of – that whole regulatory framework as we talk about behavioral health broadly. And I guess that would apply to any of the ineligible providers that they might have eligible providers working in their care setting.

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

Yeah and that's true – this is Mike again, and again, the organizations I'm talking about are community mental health centers. You'll hear different when hear from American Psychological Association, American Psychiatric Association and those folks because they have many individual providers. But our mix, if you imagine what happens in a primary care facility, you should have one physician that's supported by probably four other types of staff. In behavioral health, in these settings, it's much different. You have sometimes as much as 10 to 12 providers, psychologists, social workers, marriage and family therapists, other care managers, who will be providing care to the patient, and you'll have maybe one psychiatrist or you'll have one FTE made up of two or three different psychiatrists that then do the medication management for all of that. So, it is a little different.

The reason this voluntary certification program would help for those organizations that have this mix would – it would really help them nail down which EHRs actually can meet their needs and when we get to the end, I'll talk about what our recommendations are, similar to what we've talked about so far, but just a little more focused in scope. So, it really would help them on the front end making those decisions as, okay, where do I go, based on how much money I have, which one of these EHRs will actually help me? Because they're much the same as when meaningful use first started, the same issues that prevented medical providers in small practices from being able to join the program, they don't have the money, okay, we'll get the money – it's a problem for everybody. But then once you get past that, it's the same issues of not having the technical expertise to implement, not having the technical expertise to sustain the technology, workflow issues and reprocessing workflows and those type of issues. The same things that we had with medical providers when meaningful use first started, they have those same challenges.

**Paul Egerman – Businessman/Software Entrepreneur**

That's helpful. And should we also be making a distinction between inpatient settings versus professional settings.

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

Yeah, I would think so as well, from our point of view, because inpatient it is a little different than what you do on the outpatient side.

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

I agree the functionality will definitely –

**Paul Egerman – Businessman/Software Entrepreneur**

Well, it – the issue that if you have an inpatient organization that as an organization will have its own EHR and so it would be different. So in some sense it's almost like a grid of four things, there's the inpatient side, there's the professional side and then there's – so like currently eligible and currently not eligible for meaningful use. So those are – that gives us – it's like four parts to our grid to consider. Is that right?

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/ Office of Disability Aging & Long-Term Care Policy**

Well, so this is Jennie and I'm looking back at the slide that Maureen walked us through, slide number 8, where it talks about the eligible providers being the psychiatrists and the psychiatric nurses in the Medicaid EHR Incentive Program. And then the ineligible providers, which it divides those ineligible provider types into two categories, the inpatient and the ambulatory ineligible provider. And it seems to me that we should be thinking about those ineligible providers and then as we go through our domains, we can talk about – it seemed useful when we were having the long-term post-acute care conversation when we came upon the notion of modular certification. If a particular module is useful for a psychiatric hospital or useful for a psychologist, then that provider type could pursue use of that certified technology that certified technology module. So I'm suggesting that we focus on these ineligible providers and the EHR certification criteria that will be needed to support their workflow.

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

Yeah, I would go along with that Jennie, this is Mike again. The eligible ones, they don't need some of the technology, like reporting to immunization registries would be just one example. But when you're talking about psychiatrists and psychiatric nurses, well I think they should be getting vital signs. However, when you move to the ineligible providers, very rarely are you going to get vital signs from psychologists or social workers or licensed counselors. In a community mental health center setting, that's starting to change because with – that is going to be needed. But for individual providers that are ineligible, they're not going to need that part – those components of the meaningful use program, or they won't use them.

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

Yeah, and I would just say that I think if we went in the direction of the modular certification program that you end up meeting the needs of the broad base, including the eligibles.

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

Right, and that's just – I'd like just two minutes when we get through the end to talk about what our recommendations are regarding the modular – how we view the modular approach.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay, so –

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

Any other questions before we go to the framework?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So sounds like we've got at least a resting place, although I think these are all things we're going to need to look at again as we start to look at turning what we're hearing into recommendations.

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

Sounds good. Okay, well, we'll go into the five-factor framework. So, next slide for factor 1. So factor 1 is advancing national priorities through the program and the main national priorities that we want to highlight are the National Quality Strategy, the National Behavioral Health Quality Framework, as well as health reform efforts – promoting integrated care as well as a shared savings program. Next slide. So I won't really speak much to this, because I think everyone knows this very, very well, but these are the same principles that are used in both the National Quality Strategy as well as in SAMHSAs National Behavioral Health Quality Framework. Next slide.

So in the following slides I'm going to present a bunch of data, but I'm going to go through the slides relatively quickly, just kind of highlighting the main points. But I've included kind of links to the data sources and references in the notes so that committee members can go back for additional details later or can address them in questions. So basically, this slide just looks at the prevalence of behavioral health disorders, which shows that in 2011 nearly 18% of individuals experienced mental illness and 8.1% experienced substance abuse disorder. Next slide.

So Mike mentioned earlier, and it's been well established, that life expectancy is significantly shortened in individuals with behavioral health disorders. So American's with mental illness die 14-32 years earlier than average, and this is mostly due to physical health problems such as cancer, cardiovascular disease, stroke, diabetes, the same chronic conditions that are affecting the general population, just at a higher rate. And studies have suggested that implementing a collaborative care approach for depression in the Medicare system could result in cost savings of approximately 15 billion annually. I should also note that it's been shown that patients with severe substance use disorders die approximately 15 years after heavy use begins. Next slide.

And so there are significant co-morbidities with 68% of adults with mental illness having co-morbid physical illness or chronic health conditions and 29% of those with chronic health conditions having mental illness. Next slide. And psychiatric co-morbidities are very common among Medicaid beneficiaries, and especially among the most expensive 5% of patients. Next slide.

So the addition of mental illness to these common chronic physical health conditions such as COPD, congestive heart failure, coronary heart disease, diabetes, hypertension is associated with healthcare costs that are 60-75% higher than those without a mental illness. And this is a dramatic increase when both mental illness and substance use are present. Next slide. So mental illness and substance use disorders are also associated with a very high number of emergency department visits each year, as well as social factors such as increased arrests, housing instability and unemployment. Next slide. Also, note that mental illness and substance use disorders are associated with high 30-day readmission rates in Medicaid recipients and are among the top five diagnostic categories associated with 30-day readmission. Next slide.

And this data from New York State kind of highlighted that these readmissions are preventable and that mental health and substance abuse related readmissions account for about 80% of preventable readmissions at an enormous cost. Next slide. And it didn't detail all of the studies that have gone on to look at this, but there have been a number of studies that have shown that readmission rates can be reduced with a care coordination model. Next slide. And I also just wanted to note that I think it's important for people to realize that the prevalence of behavioral health disorders is very high among the Medicaid Expansion population with approximately 7% with serious mental illness, nearly 15% with serious psychological distress and 14% with substance use disorders. Next slide. And this is also true of the exchange population, with about 6% with serious mental illness, 13% with serious psychological distress and 14% with substance use disorders.

Next slide. So the potential benefits of implementing certified EHRs in these settings are similar to what you see in other settings and that have been discussed with LTPAC. We can gain efficiencies, improve patient safety, improve patient and family engagement, support data analytics, quality coordination and cost improvement, improve data re-use and help with competition in the marketplace. Next slide. So just in conclusion, the certified EHR program has the potential to kind of improve the health information exchange, quality and continuity of care and health IT is going to be a critical tool that's going to support many of the elements of health reform and a new sort of delivery model. And that success is going to depend on the adoption of criteria that support the most critical functionality, alignment with existing standards, the extent of use within behavioral health EHR products as well as our abilities to get behavioral health providers to adopt the certified products. And we're going to stop here for questions on factor 1.

**Jennie Harvell, PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy**  
Maureen, this is Jennie. On slide 41 you're talking about the exchange population, what is the exchange population?

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

Oh, I'm trying to figure out which slide 21 was – so the exchange population is the individuals who will be signing up for the insurance exchange, exchanges through health reform.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/ Office of Disability Aging & Long-Term Care Policy**

Got it, thank you.

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

Anybody else or should we go on to factor 2? Okay, we'll go to factor 2, which is, aligning with existing federal and state programs. And of relevance to this are standardized screening and assessment tools as well as using EHR transport standards for federal and state reporting and quality measurement program standards. And this issue, the assessment issue was one that was discussed in LTPAC and really, a lot of the same issues apply here. So assessments in behavioral health support multiple purposes from screening, care planning, outcome tracking, payment, quality monitoring and these elements tend to vary across instruments and also kind of across programs. So we reached out to a number of states to kind of get information about what the reporting requirements were in different jurisdictions and I think we received 10-15 emails and so far, no two were alike. Everyone that we heard back from there were kind of specific standards such as in Michigan the child and adolescent functional assessment scale or Alaska, there's an Alaska screening tool, and the client status review. But each state that we heard from had different standardized requirements. And we also heard from California, which noted county-specific standard requirements. Next slide.

And I just wanted to note the presence of – or the availability of an HL7 implementation guide for capturing patient assessments in the CDA. And also kind of – one of the kind of values that we can see in this type of modular program is that it can be a foundation for using standard EHR transport standards for enabling automated federal and state reporting. And obviously, this is not a fast or easy path, but I think it's one of the potential long-term values of promulgating electronic health records that use these types of standards. Next slide, sorry, I didn't say that last time, one last slide.

So, there are numerous behavioral health related clinical quality measurement and reporting programs so from the inpatient psychiatric facility quality reporting, Joint Commission, inpatient psychiatric services as well as their substance abuse measurement set and ACO data reporting. And I should note that this is not by any means an exhaustive list, there are many different quality measurement programs across the states. As far as federal reporting goes, SAMHSA has our government performance reporting or GPRA. There's also state Medicaid reporting and cross-programs there's a push to use electronic quality measurement as well as performance measurement to reduce re-entry and improve the quality of data. Next slide. And the use of clinical quality measures is obviously a great thing and it's going to be driving many of these new service delivery models and we think it's very important that behavioral health be able to participate across these efforts. Next slide.

And as noted in the LTPAC hearing, an ONC certification program on its own is not going to address these issues, but it starts the process for having that type of policy alignment between federal reporting, state reporting and electronic health records. Next slide.

So just to conclude factor 2, your identification and inclusion of key EHR certification criteria could provide the foundation for alignment across programs and could create efficiency gains to permit the reuse of data and support quality measurement and care coordination at both federal, state and provider levels. And we'll stop for questions in case anybody has them on factor 2? Ah silence, I like it. So, we'll move on to factor 3 then. Next slide.

Okay so factor 3 is utilizing existing – the existing technology pipeline. And in preparation for these hearings, SAMHSA engaged with RTI to develop materials to inform the committee on current behavioral health related standards, so I'm going to turn this over to Sue Mitchell from RTI, who's going to discuss their efforts and their results. Sue?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Okay. Yes, good morning everyone. Could we move to the next slide please? Okay great. So, just wanted to take a moment to try and talk to you about what documents we are using in our process for doing this analysis. So there were actually three different efforts where criteria had been developed and identified for behavioral health EHR products, one is a Behavioral Health Functional Profile through HL7, very much like what we had identified with the LTPAC community. There are also certification criteria in the programs that were developed through CCHIT and then finally the American Psychiatric Association developed an EHR functionality requirements document for their members. So those were our three source documents. As we had done for LTPAC, we actually prepared comparative spreadsheets where we were able to align the ONC requirements for certified EHR products and compared those requirements to what we were seeing in these other three documents. We also convened several calls with behavioral health subject matter experts to go over this mapping and identify again high priority functionality for behavioral health providers. Next slide please.

Okay so just a quick description in a little more detail about our three documents here. So for the Behavioral Health Functional Profile, this was actually developed back – or actually, I should say, it was finalized as an official ANSI approved standard back in December 2008. So that means that there were several years prior to that where they were actually working through developing the requirements and going through the ballot cycle. So, this is getting more long in the tooth, I guess. But, again, it's a great resource document and it's based on the 2007 HL7 EHR-System Functional Model.

And again, if we had ascribed back where we were talking about the LTPAC work, your functional model is again it's a superset of functionalities for an EHR system. And the intent from HL7 is that special segments, care settings or provider types, whatever, would go to this functional model and identify which of those requirements are appropriate to a given care setting, a given provider type. So, again, that's what behavioral health had done. And again, the idea is that you take the superset and you modify it as appropriate to actually reflect whatever the unique needs and services are that are needed from an EHR system within your environment. Again, that is an ANSI approved standard.

So the functional profile was broken up into three main sections we have direct care criteria, which are those that are focused towards the actual users of the product. There are supportive functions, which are those that help in the administrative area and those that drive information infrastructure. And as you go through and look at this, there's probably close to a thousand different performance criteria altogether, as you look at these three different components. Next slide please.

So – what happened with CCHIT? So there are actually two types of programs related to behavioral health that you can be certified for through CCHIT. The first program would be what they would call a standalone behavioral health product and this is actually designed for those that are working in an outpatient setting. And so again, it would be a full EHR for these outpatient service providers. And then secondly, because we do have behavioral health providers who are in an actually ambulatory clinic environment, they also offer a behavioral health certification that's an add-on to the CCHIT certification for ambulatory EHR products. So the criteria that are part of that certification for the add-on to the ambulatory product, it's basically a subset of the criteria that you would find in the certification program for a standalone product. There are about 300 certification criteria altogether in the behavioral health certification modules and 86 of those are actually applied to the ambulatory EHR products. And again, what you're going to see in the behavioral health requirements from CCHIT, they're going to look at functionality, interoperability and security, just like what we saw with LTPAC. Next slide, please.

Okay, so then in talking about the EHR requirements that were identified by the American Psychiatric Association. So this particular resource document is a little bit different in structure than what we saw from HL7 or from CCHIT. The goals of those two products, HL7 and CCHIT is to actually in the case of CCHIT, you have to be able to test the performance of an EHR against the criteria, so the wording has to be very precise and what we would call testable. And the same thing for the HL7 requirements, they need to be worded so that people can assert compliance with these various statements, so they're much more structured. You have to have an optionality for the requirement, is it a "shall," a "should," a "may." And you have to be very specific and precise in your language.

The requirements document from the APA, but it's worded with less precision than what we find in the other two source documents. So, it's a little – not as easy to kind of map against the ONC requirements but it has got a wonderful basis of showing conceptually what the psychiatric community feels are important requirements in their EHR functions. You'll find that they talk about – they do a very nice job of analyzing the various sectors, or I don't want to say sectors, practice environment perhaps is a better way of phrasing it, that they'll find for their APA membership. So you'll find that they have members in private practice, in outpatient clinics, in inpatient units, so they've gone through with their EHR requirements and said this is a requirement that you would expect to see for somebody who practice base is an inpatient unit. They also do separate definitions for child and adolescent psychiatrists where they have some special functionality required. So again, it was a very informative document, but a little bit – not as precise in its wording, as what we had seen from HL7 or CCHIT.

If you'll move on to the next slide, please. Okay, so this is just kind of an overview of our description of the three source documents that we just went over, so you'll see approximate numbers of criteria and functions, whether its testable or not. The levels of optionality that you'll see as opposed to the – imposed on the different criteria and then we've given you some example language of how those actually translate in the written document itself. And then if you move on to the following slide, again this is a more full-blown depiction of – for a sample criterion set, how the three different documents tackle the same topic matter.

So we're showing you here the criteria from ONC on the far left that's related to a family health history, and then you'll be able to see how Behavioral Health Functional Profile addressed it, at the end, showing that we have criteria that are "shalls" and "should" and "mays." Versus the CCHIT, which are all you have to do these requirements because you're testing for certification. Versus the broader conceptual language that you'll see out of APA. Next slide please.

So after we looked at all of this plethora of criteria from these different source documents, what exactly was the end result? So again these are just some high level statements, we can certainly go much further into the weeds and do more precise reporting, but for the purposes of the call today, we just wanted to kind of keep things up at the 20,000 foot view here. So the general themes that we found are, surprise, not surprise, very much what we saw with long-term post-acute care.

So the first issue was that with the ONC certification requirements, they are really, really good about saying, you need to comply with specific standards, be it vocabulary standards such as SNOMED or LOINC or – exchange standard such as Consolidated CDA, or transport standards. They will tell you chapter and verse what you need to be following as opposed to what we would find in looking at the HL7 requirements and also largely in CCHIT's requirements is that they said that you need to be able to perform this service and they largely did not call out explicit standards to meet that requirement. There are, of course, a couple of exceptions but by and large, they didn't say, you have to use RxNorm when you're doing medications or you have to use SNOMED when you're doing diagnoses or reporting conditions. So that was the biggest issue that we're dealing with. Conceptually a lot of stuff was very close; you're just missing that explicit requirement of a certain standard to make that transaction occur.

So we've given you some examples – let's see – so, move on to the next slide, please. Okay, so other things obviously that we were finding is that there's bidirectional gaps in our requirements. We'll see obviously that ONC is going to be making requirements that were not found the behavioral health requirements from HL7 or CCHIT or APA they just didn't match up. And so a couple of examples would be, the recording of your encryption status end-user devices, so that if you've got jump drives, ONC says that you need to be able to record whether those drives were encrypted or not. We've already mentioned the transport standards for doing summary of care records. When you get into clinical decision support, ONCs going to go ahead and say, your clinical decision support also needs to look at the stuff that you're incorporating from a summary of care record or from lab results, and that's missing from the behavioral health requirements. The requirements around the attributes and the – go with CDS, that's absent from the behavioral health requirements, so again, there are a number of times where you'll see different focuses from the ONC requirements.

And then conversely there are times where the behavioral health requirements are going after stuff that ONC hasn't touched. So Maureen mentioned earlier, assessments, it's a big deal with the behavioral health providers, just like it is with long-term post-acute care, but that's not been a focus of the ONC requirements. More basically, in the behavioral health world, DSM coding, it's a big deal as our HCPCS are very important for their billing, and those are not being mentioned under ONC. And then certainly we've had a fairly robust discussion already about access and disclosure safeguards around our information that may be coming from substance abuse Part 2 providers. So, those are kind of main topic areas there. If you'll move on to the next slide please.

Okay, so this is just talking about some information on products that are out there and SAMHSA has looked at the behavioral health EHR market, back in 2012. And they've identified approximately 100 EHRs who are being marketed in the behavioral health community and approximately 20% of those were actually Meaningful Use Stage 1 certified. So, again, that's some background on our market environment for EHRs. Next slide, please.

Okay, just wanted to touch really quickly on other stuff that's going on in the standards world. We've been focusing on actual EHR requirements documents. And one thing that I can add is that even though I mentioned that the HL7 Behavioral Health Functional Profile was originally stamped with ANSI approval back in December of 2008, in this past balloting cycle, the January 2014 HL7 balloting cycle, they did actually go through and reaffirm the Functional Profile for Behavioral Health. So that's still – that's a standard, if you would. Some other activities that have been going on is that they had work on a Domain Analysis Model for summary behavioral health records. So this would – it was a predecessor step for coming up with a Consolidated CDA behavioral health summary, similar to what we've done in the long-term post-acute care world. And then there are a number of different standards that are going through HL7 that talk to and support Data Segmentation for Privacy efforts that Maureen had talked about earlier.

Next slide, please. So conclusions, pretty straightforward, the private sector efforts are out there. Conceptually we've got a lot of stuff that's matching up very nicely. The devil in the details is not always really pretty, so there are definitely things that don't align. Again, as we've said, we are missing the specificity on standards. And then there are, of course, elements of functionality that are important to the behavioral health provider community that currently is not showing up under the ONC. So, with that, folks, I tried to do it pretty quick, let's stop and see what kind of questions we have.

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

Thank you Sue, this is Jennie. And so I have a couple of questions. It sounded like when you were reviewing the past standards certification criteria activities, CCHIT, the HL7 Functional Profile, it sounded like nobody had addressed the residential/institutional behavioral health setting, is that correct? Like psych hospitals and residential treatment facilities.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

So Jennie, the – I don't know, that's an extreme way of wording the question there. So the requirements that were identified by HL7, I would think you would find that there are a number of those functions and criteria that would be appropriate in both ambulatory and inpatient. So they do talk about things like doing provider directories and creating single medical record and being able to do orders and so, I would say that the profile probably has a number of functions and criteria that would definitely be applicable in the inpatient setting. So, whereas on the CCHIT side, you're correct Jennie, I mean that definitely was outpatient and ambulatory focused. So –

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

And this is Mike, I was on the CCHIT behavioral health workgroup committee there that developed that, and we were focused just on ambulatory, but there are some pieces in there even that are appropriate for inpatient, but that wasn't the focus, inpatient and residential, it was focused on ambulatory. But some of these functionalities cover both.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Right. And Jennie, so I guess the long and the short answer would basically be, if you were to pick up the Behavioral Health Functional Profile, you're not going to see a flag that says, this function is for outpatient or inpatient, I mean it just lays it out there. You've got to, like I say, got – the single medical record, so there would need to be more culling, I guess, based on our setting specific focus that we've talked about earlier in the call today.

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

Thank you. And the other question we're kind of mulling over here is it accurate that the ONC Health IT standards to date do not reference DSM?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Let me put it this way, if it's there, I didn't see it. So, no, I did not see it called out. Mike, did I miss something?

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

No, no, they don't yet, but that's being balloted now and we're trying to get that pushed through so they will in the future. So that's some of the work that SAMHSAs doing with the behavioral health "continuity of care" document, to make sure that DSM is included in that as one of the code sets that are used. So we're moving to make sure it's included.

**Jennie Harvell, PhD – Senior Policy Analyst – Department of Health & Human Services/ Office of Disability Aging & Long-Term Care Policy**

Yeah, so I understand its inclusion in being referenced in the emerging Consolidated CDA, but I was just wondering, a – and I'm not a DSM expert at all, but I was just wondering if a value set – if there was a reason why to date the DSM was not recognized – to ICD or SNOMED in previous ONC rulemaking?

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

I think the issue there is that just behavioral health is overlooked at some points, because this program is so focused on medical, and very few behavioral health providers were covered under the program, so they didn't step up to the plate and say they need to be in the program. And it's, I think it's fairly – I think that's the answer.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, we had a similar situation – this is Larry. We had a similar situation, if I recall right, with dentists, there was an update that ONC issued to include procedure codes that dentists would use.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So I guess I'm wondering, Jennie, just thinking out loud, whether in fact psychiatrists and others who are included in meaningful use might not be looking for a similar extension to the code sets that they're using?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Yeah, exactly. I mean I had known that there had been a request from the dental community to extend the identified vocabularies –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Um hmm.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

– to include the dental terminology, I'm not sure if the behavioral health community has made a similar request to extend the identified vocabularies to include DSM.

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

What you'll find is, because there is the crosswalk between DSM and ICD-9 and now going to ICD-10, that they use the DSM for diagnosis. So if they're using a behavioral health EHR, those behavioral health EHRs already have the DSM codes there, and then they just crosswalk when you do your claims process and then you spit out an ICD-9 or now ICD-10 code to get paid. So if they're using, and that's why they'd buy behavioral health EHRs versus a medical EHR and then modify the medical EHR. So, they cover themselves that way, but it should be a code set that's required and everybody uses, so that even if as we go into the integrated environment, as more medical EHRs begin to build behavioral health functionality, they'll need to have the DSM codes built into that.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Okay. That was helpful. Sue, you mentioned that there's an HL7 Data Segmentation for Privacy effort under way, do you know where that is? Is that beginning, middle, end, has been balloted, hasn't been balloted? Can you give us an update on where that is?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

They did a second round of normative balloting in January and Maureen; I don't know how that turned out. Have you heard – ?

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

I believe they're reconciling the comments now, but I think they believe that they can be reconciled.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So that's something that's still at some level in the works within HL7.

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

Right. Larry, they had done balloting in September and then, like I said, they re-balloted in this January cycle. So, that's the best I can tell you right now.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Right. Thank you.

**Paul Egerman – Businessman/Software Entrepreneur**

This is Paul Egerman. There are a number of references to CCHIT, the CCHIT behavioral health, it says program, I don't know if that's the same thing as their certification process, to what extent is that like operational, are there vendors that have passed through CCHIT behavioral health certification?

**Sue Mitchell, RHIA – Health Information Technology & Long-Term Care Professional – Independent Consultant**

When I looked at the CCHIT website, and Mike, you may have more experienced than I am right now, but I believe there are only two products that were certified for standalone and just a handful that may have the ambulatory add-on for the designation.

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

Yeah, that's correct and it's been that way for probably two years, because the CCHIT was – they really did that right before meaningful use came out and then folks just went to meaningful use and no one else certified CCHIT for behavioral health –

**Paul Egerman – Businessman/Software Entrepreneur**

So, and they're using CCHIT as sort of like a reference point for a number of things, and so I'd like to have some understanding as to why that program or process hasn't been successful? Is it because the Meaningful Use Program took the oxygen out of the room and people focused on that or is it because it's – is there some other reason why that hasn't been successful that perhaps we should understand?

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

No, I think it's correct that meaningful use really sucked all the resources out and all the vendors said, okay, there's really not that much benefit to CCHIT certification, none of the behavioral health providers are eligible, except for a few psychiatrists and nurse practitioners, and nurse practitioners only under Medicaid, so where am I going to put my dollars? Well, I'm not going to put my dollars to that, I'm going to put my dollars to meaningful use, and then things just moved forward quickly from there.

**Paul Egerman – Businessman/Software Entrepreneur**

And I think that's an important issue to understand because we're talking about sort of like an unfunded program here, so it would seem to me that the challenge that you just described will continue.

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

Yeah, I think you're correct. Absolutely.

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

Well, I would say – I mean, it's largely unfunded, but as I, I don't think I mentioned this in detail before, but in – on the LTPAC – on the earliest calls I did, that SAMHSA is intending to use this within their program. So currently, we allow the majority of our grantees to use a percentage of their infrastructure funds to adopt certified electronic health records and that's because like we need some standard for the electronic health record, but the meaningful use standard obviously is not the appropriate one for us to be using long term. But the intention is that once there is a behavioral health relevant certification that's more appropriate that we will be, throughout SAMSHA's grant programs, encouraging the adoption of certified electronic health records and providing whatever funds we can, whether it's infrastructure funds or even direct funds, direct supplemental funds to help our grantees adopt certified health records. And we are also working with the states through the Block Grants to encourage – or any other grant programs, to encourage state programs to do the same thing, to get the on the ground providers adopting certified technology.

**Paul Egerman – Businessman/Software Entrepreneur**

So what you just said is very helpful and very important. I don't know very much about what SAMHSA is doing there, but it sounds to me like it's really terrific work. I'm taking a guess; correct me if I'm wrong, so that funding is limited to your grantees? It's not available on any kind of a national scale.

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

It, yes – limited to the grantees, yes.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, but let's address the national scale piece. Are these like demonstration project grants where they're talking a very small number of providers or are these very broad grants that are part of supporting substance abuse treatment in general?

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

They're – at this point, so largely what we've been doing is within our discretionary grant program, which is more demonstration projects, but also within some of our larger, kind of state based grant programs. And the intention is over time that this will also kind of spread into the Block Grants that go to states to fund mental health and substance abuse treatments.

**Paul Egerman – Businessman/Software Entrepreneur**

Could you give us a rough estimate of how large these grant pro – the grant program is total? Is it a 10 billion dollar program or a 1 billion, 100 billion, or what?

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

You know what, I should know that and I will get back to you on that.

**Paul Egerman – Businessman/Software Entrepreneur**

I'm just trying to understand it in relationship to the size of the meaningful use activity. I'm just trying to get a feel for I think the same question that Larry is asking, which is, sort of like how much of the world does it impact?

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

From our experience with our members, it doesn't have a "B" in it.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Maybe the relevant question should be relative amount, right, so there is a "B" on the hospital side and a slightly smaller "B" on the physician, eligible professional side of what meaningful use has paid out. And I haven't done the math, but there's a total Medicare spend in that space and you could do the divide through and get, okay so this percent –

**Paul Egerman – Businessman/Software Entrepreneur**

Yeah.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– and so –

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

So this is Kelly Cronin, can you hear me?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yes.

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

From ONC, I just wanted to also remind folks, I think we brought this up in the long-term care discussions that we sort of said publically over the summer that we're working with CMS on a variety of policy and program opportunities that would tie voluntary certification to other types of payment policies. So for example, Medicaid waiver's our state plan and then – or 90:10 funds, a variety of Medicaid funding mechanisms could be going to support voluntary certification. And given the Medicaid covers a lot of the behavioral health and long-term care that's a particularly relevant payment mechanism that's hard to quantify, per se, but clearly they cover a lot of the cost in the country. And then –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So it might be an incentive for adoption.

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

Yes, exactly. And then the other, more direct funding is through the state innovations model, and there are already states that are funding, through that cooperative agreement vehicle, the adoption in behavioral health, such as in Maine, for electronic health records. So that would again be sort of an opportunity to assess why they would have to be done through voluntary certification in the future, when it's available. So there are existing innovation centered dollars that could be tied to certification and other Medicaid dollars, which could potentially be tied to certification and other opportunities that we have not yet fully explored. But the intent – the policy intent is very clear that we intend to link certification to these various vehicles. So SAMSHAs is the most direct and clear example, which is great to clearly articulate now. But, these other things are in the works and the state innovations model is a real program and they're gearing up for round two of that funding.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So –

**Paul Egerman – Businessman/Software Entrepreneur**

That's helpful.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Yeah, but –

**Paul Egerman – Businessman/Software Entrepreneur**

It's helpful to understand. I'm on the board of an organization that gets Medicaid waivers. It's a little frightening to hear also, but I appreciate the information.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Any other questions about sort of the state of standards before we move on, because we're getting pretty tight on time here. Let's try and wrap up the other two factors, because it's now 6 minutes of noon.

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

Great. So if we can go to the next slide. So factor 4 is related to stakeholder feedback and you just heard some of the kind of federal stakeholder feedback, of our intentions of how to use the program. Next slide. So the majority of feedback – direct feedback that we've received has been around the CMS/ONC released RFI on accelerating HIE. We received significant input from behavioral health stakeholders; I believe there are 90 comments from behavioral health organizations. And there were varying comments on the need for certification within the behavioral health space ranging from the need for basic interoperability to more extensive programs to help guide the purchase of electronic health records that address clinical processes and information needed by behavioral health providers. In addition, there were many comments around the need for standards related to compliance with privacy regulations, including 42 CFR Part 2.

Next slide. So stakeholders expressed support for standards for consent management, those for computable privacy obligation codes and using available levers to ensure that behavioral health providers can be included in health information exchange efforts. Focused on key areas that are barriers to – one of the recommendations was focusing on those key areas that are barriers to the integration of care and the need for alignment of state privacy policies to allow for kind of more national standards on this – the related EHR functionality. I'm just going to stop for a second and ask – I know Mike has been reaching out to stakeholders on this issue, Mike; do you have anything to add here?

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

Yeah, a couple of things and so as our members, we have both providers and some of the behavioral health vendors are our members, so reaching out to them. And what we presented, and based on our recommendations, a little different than what you see on slide 18, but what we were talking to them about was three different certifications. And we're recommending a modular certification process starting with interoperability. And we know that drives deep into the systems, so if you can be interoperable means you're going to be able to send appropriate sections in a Consolidated CDA, the entries, you're going to be using the appropriate code sets. That could be one level of certification. The next modular would be clinical quality measures; there are now 18 that are NQF behavioral health clinical quality measures under Meaningful Use Stage 2. And then the third module would be clinical decision support to address those 18 clinical quality measures. Presenting that – that's what we presented and both vendors and providers felt that that would be very useful to them to move forward.

We didn't go down the route of functionality "usability." For instance, how you process a progress note within the EHR. You can do that in a number of different ways and what's usable to you may not be usable to me and that's what differentiates the EHRs out there. So we're not recommending that level of certification, but in these three modules is where we think, and our providers and the vendors that we spoke about, were supportive of that. Thanks Maureen.

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

And on to the next slide – actually I'm going to skip this slide because I think most people on this call probably know about the HIT Policy Committee recommendations. And so just in conclusion, we incurred near unanimous support for some level of certification program for behavioral health, extending the interoperability infrastructure to behavioral health, aligning HIT and HIE infrastructure across the care continuum and the need for standards within the behavioral health community. And, do we want to stop here for questions or get to 5?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, let's get –

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

This is Kelly Cronin, can I just add one –

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

– since we're out of time, why don't we continue to 5 and –

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

Larry, can I just make one brief comment?

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Sure.

**Kelly Cronin, MS, MPH – Health Care Reform Coordinator – Office of the National Coordinator for Health Information Technology**

I just wanted to point out that we had over 200 respondents, very thorough comments on the RFI and it was a very group of stakeholders, a lot of providers, payers, consumer groups, really sort of the spectrum of stakeholders. And there was really overwhelming support for both voluntary certification for long-term care and behavioral health. So these RFI responses that she's summarizing are from quite an extensive group of organizations.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Thank you, I got it.

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

Okay, so factor 5 is related to the cost/benefit considerations. You can skip the next slide, and the next one. Next slide. Okay, so obviously the key challenge here is going to be finding the right balance between promoting standards and interoperability while also promoting innovation. And we're looking to leverage policies and programs to encourage the effective use of certified EHRs, so this can be as we discussed the requirements within federal grant programs, reducing burden on the community by aligning standards across programs. So kind of taking these EHR certification standards and trying to promote their use in things like the Homeless Management Information System, as well as using similar kind of transport standards and state reporting. And another thing that was kind of mentioned as being helpful is including ineligible providers in the technical assistance programs that exist. Next slide.

So I think as we've heard quite a bit, I think some of the priorities are – the primary priorities are around interoperability as well as privacy and security. And we think that the committee should look at the feasibility of a staged approach, where kind of starting from a modular certification program. We can start with modules for interoperability, privacy and security and then over the longer term, kind of if it's seen as useful to expand out to more behavioral health specific issues that could be addressed by certification. Next slide.

So basically the – what the voluntary certification program, if focused on core standards for interoperability could, we hope, increase the number of EHR products that support interoperable health information exchange. We can improve the integrity of the system by having across the board standards in privacy and security. And ideally decrease the cost of EHR products that utilize these standards and functionality. And a more extensive certification program could serve to promote product enhancements within the behavioral health EHR structure, as well as provide support for behavioral health providers' acquisition decisions around electronic health records. And as we've mentioned across the slide deck, kind of help to align programs by solidifying these kind of policy levers that could be used to reduce re-entry and improve kind of quality reporting and that type of thing. Next slide.

So the value proposition we think is going to be a product of the degree of implementation, the utility of the criteria across behavioral health provider settings, whether the identified criteria support policy objectives and whether they continue to promote enhancements and innovation. And the last slide, I just include contact information myself, Mike and Sue, who presented today. And I know we're a couple of minutes over so I'll turn it over to Larry.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

So, let's get any pressing comments from the workgroup members before we go to public comment. Okay, well for those who feel like they're sitting on things but are concerned about the time, the hearing that's coming up on Tuesday – let me get my notes up, is Tuesday, January 28. It is from 9 a.m. to 1 p.m. Eastern, so we will get a lot – the next level of detail, if you will, on many of these. We've got quite a range of stakeholders who will be presenting. And I guess we still need to get a final agenda out for that, so, stay tuned for who the panelists will be, and we should have a pretty full day Tuesday morning. So thanks for the presentation today Mike, Maureen and Sue, a lot of good material here. And the committee members for a lot of the discussion. And let's open it up for public comment.

**Public Comment**

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

Thank you Larry. Operator, can you please open the lines?

**Caitlin Collins – Project Coordinator, Altarum Institute**

If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press \*1 at this time. We do not have any comments at this time.

**Larry Wolf – Health IT Strategist – Kindred Healthcare**

Well thanks again everybody for their time and attention this morning, for the good presentations and we'll talk again on Tuesday.

## **Public Comment Received During the Meeting**

1. Please note that the DS4P capabilities enabled by the new HL7 standards do contain provisions for emergency access/break glass access to the protected information.
2. The concept of "silos" can be a bit misleading. When using DS4P, an organization that has the sensitive data can still access it. The metadata tags used by DS4P are applied to data as they are sent outside the organization so that the receiving organization becomes cognizant of any obligations such as "do not re-disclose without consent". DS4P metadata does not prevent authorized access to the sensitive information.