



# National Association of State Mental Health Program Directors

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February 4, 2015

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Office of National Coordinator for Health Information Technology (ONC)  
Department of Health & Human Services  
Attn: Acting Assistant Secretary for Health Karen B. DeSalvo  
200 Independence Ave. SW Suite 729-D  
Washington, D.C. 20201

### **RE: ONC Draft Federal HealthIT Strategic Plan for 2015-2020**

Dear Acting Assistant Secretary DeSalvo:

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to provide our comments on the Office of the National Coordinator’s Draft Federal HealthIT Strategic Plan for 2015-2020. While NASMHPD—the member organization representing the state executives responsible for the \$37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia—is generally supportive of the HealthIT Strategic Plan, we have two significant concerns.

First, we are concerned that Objective 1A, “Increase the Adoption and Effective Use of Health IT Products, Systems, and Services,” seems to be grounded in an erroneous assumption that behavioral health providers and settings have the same resources to adopt electronic health records (EHRs) as physicians and hospitals. Second, we are concerned that ONC’s Objective 2C, “Protect the Privacy and Security of Health Information,” fails to acknowledge the barrier to care coordination posed by 42 Code of Federal Regulations (CFR) Part 2, the Substance Abuse and Mental Health Agency SAMHSA) regulations restricting the sharing of a patient’s substance use disorder treatment information between health care providers.

### **Need to Extend Meaningful Use Incentives to Behavioral Health Providers**

The recent federal enactments that had a major impact on the promotion of HIT failed to address the needs of mental health and substance use disorder treatment providers. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) Provisions of the American Recovery and Reinvestment Act of 2009, authorized approximately \$20 billion for the payment of Medicare and Medicaid program incentive bonuses to physicians, hospitals, and other health

providers who adopt electronic health records. Unfortunately, mental health and substance use disorder treatment providers were not included in the categories of providers eligible to receive EHR incentives, which were primarily limited to hospitals and providers falling within the definition of “physician” under §1861(f) of the Social Security Act.

As a result, in comparison with primary care providers, behavioral health providers and settings have had fewer resources to purchase and implement meaningful use EHRs than similarly situated health care providers. In fact, a 2012 National Council for Behavioral Health NCBH study of more than 500 community mental health and addiction treatment organizations across the nation found that only two percent of community behavioral health organizations were able to meet meaningful use requirements. “The most significant barrier for the behavioral health sector was cost—upfront financial costs and the costs of ongoing maintenance.”<sup>1</sup>

NASMHPD’s members believe that, to have an effective, interoperable exchange of health information, the ONC HealthIT Strategic Plan should be modified to recommend that behavioral health care providers and settings receive the same Medicaid and Medicare meaningful use payments to implement EHRs and provide quality, coordinated care to patients as are received by physician and hospital providers. More immediately, given the nature of the urgent crisis in the public behavioral health system, NASMHPD urges the ONC to use discretionary funds to expand funding for behavioral health providers and settings to address the high risk populations they serve.

### **Caution in Addressing Privacy Concerns**

With regard to Objective 2C, the ONC states “[t]he federal government also supports the development of policy, standards, and technology to facilitate patients’ ability to control the disclosure of specific information that is considered by many to be sensitive in nature (such as information related to substance abuse treatment, reproductive health, mental health, or HIV) in an electronic environment. . . . The privacy and security of protected health information is a top priority of the federal government, and the government will continue to pursue efforts that ensure confidence and trust for individuals and their families, caregivers, providers, and others.” We are concerned that this language could be interpreted to indicate opposition to recent efforts by SAMHSA to align the restrictions under the aforementioned 42 CFR Part 2 more closely with the restrictions under the Health Insurance Portability and Accountability Act (HIPAA).

As NASMHPD and the National Association of Medicaid Directors (NAMD) noted in a joint June 24, 2014 letter to SAMHSA, 42 CFR Part 2 has kept the development and adoption of electronic health records (EHRs) and health information exchange (HIE) mechanisms from providing new, more efficient and effective tools for coordinating care and improving patient health and outcomes for individuals with substance use disorders. Any health information privacy requirements related to substance use disorder treatment that differ from the privacy requirements related to general medical care and mental health treatment will always be a barrier to:

- increasing access to substance use disorder treatment services;
- integrating substance use disorder treatment services with the rest of health care;
- protecting patient safety;
- providing high-quality medical care to people receiving substance use disorder treatment services; and
- reducing the stigma that acts as a disincentive to seek treatment for substance use disorders.

The separate health information privacy requirements for substance use disorder treatment in 42 CFR Part 2 make it significantly less likely that people with substance use disorders can receive the attention and time to support continuing recovery. It also makes it less likely that these individuals will have early recurrence identified. When general medical providers know a person has had a chronic condition, they inquire about it and look more closely for signs that the person remains healthy in that area. For a patient with a substance use disorder, keeping the condition secret deprives that individual of the additional care and treatment they would receive if they had any other chronic condition. In addition, the risk of an adverse drug event (ADE) increases if access to medication history is restricted, threatening patient safety and increasing costs.<sup>2</sup>

Another consequence of the special requirements of 42 CFR Part 2 is that they impose significant administrative burdens and costs on the providers least able to bear them. Substance use disorder treatment providers and organizations are arguably the most underfunded and undercapitalized providers in the health care system. In addition, 42 CFR Part 2 was implemented well before health information and related technologies were even contemplated, and has not been meaningfully updated to reflect modern technology. As a result, 42 CFR Part 2 adds a financial burden and enormous complexity to health IT initiatives. The added complexity and cost make it likely that substance use disorder information will be omitted altogether from HIEs. If the data is not completely omitted, the requirements associated with 42 CFR Part 2 necessitate expensive customization of EHRs and require service providers to commit additional funds and resources to manage EHR integration into their practice workflow. Attempting to segregate substance use disorder information from the EHR is also exceptionally costly and may result in changes that threaten federal certification status for an EHR.

Finally, our members also believe that having separate health information privacy requirements for substance use disorder treatment is discriminatory and perpetuates stigma. The requirements keep persons with substance use disorders and the providers who treat them marginalized and disadvantaged compared to other patients and providers in the health care system. Addressing substance use disorder information in the same manner as other health information would help to break down the barriers of stigma and normalize substance use disorders. It would also help to acknowledge that these disorders are chronic diseases, making patients more likely to have conversations with their providers about their concerns and seek treatment.

Thank you for your attention to these concerns. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at [stuart.gordon@nasmhpd.org](mailto:stuart.gordon@nasmhpd.org) or 703-682-7552.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert W. Glover". The signature is fluid and cursive, with a long horizontal stroke at the end.

Robert W. Glover, Ph.D.  
Executive Director  
National Association of State Mental Health Program Directors (NASMHPD)

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<sup>1</sup> *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health*, National Council for Behavioral Health 2012.

<sup>2</sup> Zwicker D, Fulmer T, “Reducing Adverse Drug Events,” In: Boltz M, Capezuti E, Fulmer T, Zwicker D, eds. *Evidence-Based Geriatric Nursing Protocols for Best Practice*; 2012. (4): 324-62, <http://www.guideline.gov/content.aspx?id=43938>; FitzGerald RJ, “Medication Errors: the Importance of an Accurate Drug History,” *Br J Clin Pharmacol*. June 2009; 67(6): 671–75, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2723207/pdf/bcp0067-0671.pdf>.