HIT Policy Committee
Certification and Adoption Workgroup
FINAL
Summary of the January 28, 2014 Virtual Hearing
ONC EHR Certification for Behavioral Health

Attendance

Members present

Joan Ash
Maureen Boyle
John F. Derr
Jennie Harvell
George Hripcsak
Stanley M. Huff
Mike Lardieri
Marc Probst
Paul Tang
Larry Wolf

Members absent

Carl Dvorak
Paul Egerman
Joseph Heyman
Elizabeth Johnson
Martin Rice
Donald Rucker
Micky Tripathi

KEY TOPICS

Call to Order

Michelle Consolazio, ONC, opened the meeting with the FACA announcement and called the roll. She announced that each panelist would have no more than five minutes.

Opening Remarks, Meeting Objectives and Expected Outcomes

Co-chairperson Larry Wolf apologized for having only one person on the patient panel.

Panel 1: Patient and Caregiver Perspective

Daniel Fisher, Mental Health America, spoke from the perspective of lived experience. Health care workers' need for information and patients' desire for privacy have to be balanced. Like in the general population, medical doctors stigmatize and discriminate against persons with psychiatric diagnoses. Data segmentation may be the solution. He was told by an expert from CDC that the technology for segmentation is available. HIPAA has decreased privacy and confidentiality constraints. Once the door to a record is opened, many people see the contents. Psychiatric medication is information that medical doctors should have. There is a computer system in which medication information can be put in a black box where it is used to generate alerts in the event of a prescription that may result in drug interaction. This technology is expected to be ready by 2017. He recommended that lab and prescription information be shared. Patients should have the opportunity to review and correct their records. Records that reveal too much will inhibit a patient’s willingness to seek both psychiatric and medical care. Persons with lived experience want to be involved in making policy.

Q&A

Relationships and trust are important in sharing information. The medical visit does not allow much time to establish trust. Medications and lab results are more willingly shared than diagnoses. It is important to have a record in the person’s own words. Trust evolves over time. Relationships and consents on both ends should be taken into account. Fisher talked about three tiers. The first is sharing information in the event of a medical emergency and other very serious conditions. He described a task force in which the majority of members preferred opt-in consent for this tier, though he preferred opt-out. Tier 2 is sharing diagnoses and treatment plans. The task force agreed to recommend opt-in. The third tier pertains to progress notes, which are not shared except by explicit consent.

Panel 2: Behavioral Health Provider Perspective

Lori Simon, American Psychiatric Association, reported that of the 44,000 psychiatrists in the United States, 55 percent participate in Medicare, and 43 percent in Medicaid. Their EHR use is low. Not many EHRs support their needs. Many psychiatrists practice solo or in small groups and do not have the resources for HIT. EHRs are expensive due to excess functionality. She outlined psychiatrists’ somewhat unique requirements: recurring and group appointments; 15 minute calendar divisions; automatic display of procedure codes from most recent visit; mental status examination; DSM psychiatric and substance use history; group notes; photo; guardian and capacity information; and privacy and security. Meaningful use functions least relevant to psychiatry include: vital signs; syndromic surveillance; anti-depressant med management; smoking and tobacco cessation advice; and alcohol and drug dependency treatment. Psychiatrists practice in a variety of settings, including homeless shelters, schools, prisons, and long term care facilities, to name a few. Psychiatrists frequently practice within teams and need records that accept input from team members representing a range of occupations. Regarding HIEs, they are reluctant to store information due to privacy and security concerns. She supported the concept of voluntary certification.

Stacey Larson, American Psychological Association, agreed that a voluntary, ONC-led certification for BH has the potential to improve care. Presently, there is no guidance on which EHR products have features that would make them well-suited for BH. Guidance by the ONC through a certification process could serve to demonstrate these products' suitability for APA members. However, if the ONC were to go ahead with a voluntary certification process for BH IT, it could lead to two separate certification processes for EHRs—one tailored to primary care and one to BH—which could result in a further disconnect between the two. Part of the reason as to why there is not widespread adoption of fully interoperable EHRs is because psychologists are not eligible for the meaningful use incentive payments under HITECH. But some psychologists do use fully certified EHRs. These psychologists have identified two primary concerns: patient privacy and overall security of health IT. Seeking psychological services is still stigmatized, which leads to an increased sensitivity among psychologists to protect the confidentiality of the patient record. APA recommends that additional guidance related to the inherent security, confidentiality, and privacy concerns of HIT functionality be provided as a part of the certification process. For example, vendors would have to include a training module on privacy/security issues as a part of their client training process. This could then be used to indicate to providers that the product meets all of the requisite standards for privacy and security as determined by HIPAA and 42CFR Part 2. If the certification process is too rigorous, developers may decide that the costs of certification outweigh the benefits. If developers pass the cost of rigorous certification onto consumers, the higher prices will discourage use. Voluntary certification could serve to align existing federal and state programs, but only if it works in conjunction with current certification programs rather than an additional expectation. A voluntary certification process might serve to allow psychologists to collaborate more effectively with primary care by selecting a system that is truly interoperable.

Roger D. Smith, American Association for Marriage and Family Therapy, did not submit written testimony. Although he supported a voluntary certification program, he recognized that the lack of incentive payments constitutes a high barrier. Solo and small groups do not have the financial resources to purchase and implement these systems. Like the other panelists, he expressed concern about the privacy and security of information. In family and group therapy, information on two or more clients may be combined in one record, making sharing more complicated. Certification could be modular or core. He suggested that small- and large-volume providers could be subject to different certification requirements.

Michael Alonso, Seneca Family of Agencies, reported that his organization welcomes the idea of a certification with criteria relevant to BH. However, certification must provide the same assurance of EHR security and integrity as other certification programs. It must be satisfactory as a means to avoid penalties for not using a "certified" EHR. Providers who do not use a certified EHR will soon become subject to Medicare penalties. Providers have reason to expect that other authoritative bodies may begin imposing similar penalties, or requiring some kind of EHR certification as a condition for doing business and receiving payment. It must be a significantly simpler criteria set than ARRA certification. All efforts must be made to eliminate certification criteria that are not critically relevant to the provision of BH services. He recommended that there be separate certification criteria sets for BH and LTPAC. Each criteria set should be carefully designed to be entirely applicable to the respective domain. He went on to say that any certification should promote the completion of a BH Continuity of Care Document (CCD). The CCD specification for exchanging primary care information has gained acceptance. However, less work has been completed toward a CCD for BH information. There is work in progress, such as the work being done by the HL7 CBCC workgroup. Realistic expectations should be set in the absence of financial incentives for BH.

Q&A

Joan Ash asked Simon about progress on the HL7 work. She replied that a functional BH profile has been developed. The CCD workgroup is ready to release version 2 using APA's functional recommendations. The aim is a model that vendors can use to understand the needs and that providers can use as a checklist.

In California, there are certification requirements at the county level. Alonzo acknowledged that the certification proposal does not address variation by counties, which would be an issue. Many providers span county boundaries. All counties implement their own EHRs for public programs, which could mean duplicate reporting and double data entry. Some counties have less stringent requirements and recognize reciprocity.

In response to a question about standards on confidentiality of group notes, Simon indicated that some laws differentiate between group and individual notes. Progress notes are typically more similar to notes maintained by other medical providers and are potentially accessible, but psychiatric notes are kept separate and not made available to anyone without specific consent. Smith concurred and said that generally, marriage and family therapists keep a single record for a group with a listing of names. Practice often depends on the provider and the guidelines of the facility rather than whether the practice is a private one or in a public sector clinic.

Panel 3 Provider Perspective Continued

Paul McLaughlin, American Association for the Treatment of Opioid Dependence, did not submit written testimony. He agreed with voluntary certification and use of EHRs, although he has not solicited information by his association's members. There must be a way to offset costs. His association is trying to decide what software product to purchase. Vendors should develop products that meet certification requirements, particularly the high security requirement. Methadone cannot be mentioned without violation of privacy and disclosure requirements. Certification would require considerable education of members. He noted that this hearing is the first time his organization has been invited to a conversation about exchange and certification.

Richard Rosenthal, American Academy of Addiction Psychiatry, did not provide written testimony. He expressed support for voluntary certification. The high prevalence of comorbid conditions dictates the need for sharing information and interoperability. Addiction treatment and the Part 2 requirement result in the isolation of treatment for addiction. Data cannot be segmented at this time. He indicated that he supports change in the regulations to reduce the barriers imposed in Part 2. There must be incentives to encourage certification. Certification standards for addiction modules could be developed. Any certification must be designed to reduce, not increase, isolation. He recommended certification based on a flexible module and a minimum data set that would also allow export of care plans.

David Gastfriend, American Society of Addiction Medicine (ASAM), had no written testimony. He endorsed Rosenthal's testimony. He explained that addiction is a longitudinal disease; treatment for conditions is often disrupted by the manifestation of the disease. Certification and interoperability could greatly help patients to understand their addictions. Rigorous quantification of data across the longitudinal dimension would be very helpful in showing patients how the development of the disease affects their behavior. ASAM has developed criteria for placing a patient in the optimal level of care, but the implementation of the criteria is not yet standardized. Toward that end, several SAMHSA projects are going into demonstration status. The most needed function is linking the CDS software to managed care, primary care, and EDs.

Mohini Venkatesh, National Council for Behavioral Health, was absent. Her testimony was presented by Mike Lardieri, a colleague and a member of the workgroup. Written testimony was not available. The council supports voluntary certification while emphasizing the need for financial incentives. ACO, PCMH, and other payment models will not work without integration of mental and physical health services. He prefers modular certification, with interoperability as the most important function. Then BH providers could produce CCDAs. The next most needed modules are for clinical quality measures and CDS. Part 2 needs sub-regulatory guidance to enhance release of information. Patients want integrated care.

Q&A

Wolf referred to the conundrum of the importance of exchanging information for treatment purposes and the barriers of privacy and confidentiality requirements. He inquired about suggestions for reducing the barriers without robust data segmentation. He noted that there are no known constraints on the receipt of information: Is that a place to start? Gastfriend responded that ASAM wants segmentation. No information should be shared without patient consent. The provider should review with the patient what is to be shared. Such a review has educational benefits. Rosenthal agreed, saying that patients who initially decline can be educated about the benefits. Someone said that interoperability is required for segmentation. Wolf referred to secondary disclosure and wondered whether patients understand the concept. Someone said that re-disclosure is standard and difficult to prevent once the information is out there. Prevention is the responsibility of the divulger.

Existing meaningful use certification criteria do require the creation of certain de nova information. Perhaps criteria for BH certification could first focus on the creation and receipt of information and postpone transmission until segmentation is available. A panelist reminded the group that medical-only providers are not covered by Part 2. Without flagging sensitive information, a medical provider would likely transmit the entire record upon request from another provider.

Alonso clarified that Part 2 does not apply to his organization, which does not offer substance abuse treatment. Any sharing of information is part of a usual process based on existing organizational relationships. Fisher spoke about the important of maintaining privacy and security of information beyond substance use treatment. Lardieri noted that HIEs are a way to share information.

Maureen Boyle, SAMSHA, interjected that current standards do not require segmentation. Simon explained that patients are mostly concerned about sharing information outside of the treatment environment. It is generally acceptable to share information with workers directly treating the patient. Insurance coverage is often a concern and providers should talk to their patients about what information and with whom sharing is permissible. Lardieri noted concerns about law enforcement and courts. Wolf asked whether patients needed to grant permission to specific providers and organizations or to classes of organizations. Boyle indicated that according to legal counsel, any release of information must be to a specific named organization or individual.

Panel 4: Vendor Perspective

Melinda Wagner, Cerner, did not provide written testimony. She spoke about the general benefits of certification and the importance of having complete BH and medical health information. Information should follow the patient; some consistency across providers is necessary. Health IT can help bridge the gap between BH and medical health. Cerner supports voluntary certification. BH providers should not have to purchase products with functions beyond their needs. Cerner supports attestation to receive federal funding. Modular certification has great value. She urged consideration of the whole person.

Kevin Scalia, NetSmart Technologies, Inc., pointed out that any BH certification should be a sub-set of the full meaningful use certification so that a system certified to the Complete EHR standard would automatically meet the BH standard. The lower adoption of clinical systems is driven more by lack of capital resources and the fact that BH providers and human service organizations are not eligible for meaningful use funding than by the lack of a specific BH certification process. He said that his new clients are buying certified systems and most of them are applying for the EP incentives. But the rate of adoption would not increase with a new certification system without commensurate incentives to help justify the investment. State mental health systems are collapsing under current financial burdens and are making reimbursement systems so complex that some providers do not have the skills to bill. For example, some large, well-run organizations do not even bill for Medicare Part D because one state has taken an outpatient process for reimbursement and placed it on top of an inpatient setting. Several bills have been introduced in Congress to address the disparity in funding to BH providers. He supported the requirement to capture vital signs by BH organizations because many are focusing on integrated care due to co-occurring physical health issues. Being able to share data between BH and physical health IT systems will drive positive clinical outcomes. The privacy regulations, especially 42CFR Part 2 needs to be harmonized with physical health privacy regulations and updated to reflect current technology and consumers' desires. This can be accomplished with sub-regulatory guidance from SAMHSA. SAMHSA's interpretation of Part 2 is a barrier.

Paul LeBeau, SMART Management, Inc., did not submit written testimony. The costs of EHRs are substantial. Without incentives, wide adoption will not occur. EHRs per se will not really improve care. A holistic approach to patient treatment that coordinates primary care and substance use care is required. The concern is not so much sharing information across providers, but with secondary disclosure. Part 2 inhibits uploading patient data to HIEs and the maintenance of the record over time. The regulations must be revised. He said that his organization favors voluntary certification for BH to the extent that incentives are offered, measures are oriented to BH, and Part 2 is revised.

Katherine Peres, Synergistic Office Solutions, Inc., disclosed that she had previously decided not to pursue ONC certification for her products. The possibility of voluntary certification raises many questions. First of all, it seems ironic that providers and organizations that are not eligible for stimulus funds might find themselves needing to purchase ever more highly certified EHR products. Certification adds costs. She delineated a number of questions, without answers. Why would a product that does not have basic ONC certification consider pursuing voluntary certification? Would they even be allowed to do so if their product does not meet the Base EHR standards? Will products without certification be allowed to send a CCDA? Will additional certification increase competition among software vendors, or merely drive further consolidation gradually removing small vendors (and ultimately small providers) from the marketplace? Is there a need for certification in areas where there are clear standards and testing methodologies and platforms? Is it possible to use the NIST testing platform to accomplish some of these goals in a less formal fashion? She indicated that her company would not likely pursue voluntary certification. She went on to suggest that certification may force small scale operations out of the field.

Joe Viger, Software and Technology Vendors' Association, did not submit written testimony. He observed that providers are subject to many regulations; meaningful use imposed additional requirements on top of existing requirements. Standards can improve the integration of care. But they may result is standards fatigue for providers. Complexity and cost are barriers to the adoption of EHRs. Certification of BH EHRs raises new issues, such as the definition of a client and treatment goals and plans. Standards should speak to BH in conjunction with the standards already in place. He indicated agreement with other panelists on the need for sub-regulatory guidance on Part 2.

Q&A

Scalia declared that there are many misconceptions about sharing information. His experience indicates that medical doctors have no interest in psych notes or progress notes. They are mostly interested in meds, diagnoses, and repeat labs. Few or no existing products can handle the current interpretation of Part 2, making individual point-to-point solutions the only option. LeBeau indicated his agreement on medication information. An effort to partner for e-subscribing resulted in Part 2 violation as soon as the med list came up. Privacy and security are administrative and regulatory issues rather than technical ones.

Wolf inquired about capture of information about allergies. A panelist said that in his work this information is being shared. Also, care plans are shared via Epic. The physical health system should be required to capture certain information pertinent to BH. Each state defines quality and outcome measures. Federal requirements could help this lack of unanimity.

Stan Huff observed that the Part 2 security of data requirements reduce patient safety insofar as allergies and drug interactions cause harm. Part 2 is not well thought through.

Regarding the black box data base available for CDS, several panelists agreed that in the absence of information describing the drug interaction, the prescriber would not know what to do. So although technically possible, it would have little real value.

Regarding BH clients, different code sets and assessments are required.

Part 2 restricts access to records by law enforcement officials. In considering access, the workgroup should take into account the existing legal restrictions. Electronic access actually enhances tracking and enforcement current laws.

Panel 5: Health Information Exchange (HIE) Perspective

Laura McCrary, Kansas Health Information Network (RHIN), described the RHIN as having more than two million unique patients and 628 members, with 59 organizations in production. Membership includes BH and substance abuse treatment providers. Products consist of: secure clinical messaging by DIRECT; provider portal with query functionality; Web-based access; PHR; and interfaces with the state public health agency for immunizations, syndromic surveillance, reportable diseases, and cancer registry. Alerts and data extracts are also available. The enabling legislation started with passage of legislation normalizing all patient consent requirements with HIPAA in 2011. Regarding 42 CFR Part 2, she described two options: block data at the EHR level or at the HIE level. With the former, data are not available in an emergency, even when a patient gives consent. With the latter, concerns include ongoing communication between the provider and the HIE and notification of security override without patient consent. She presented the following key areas for consideration for data sharing: interoperability, TOCs, patient engagement, and 42 CFR Part 2 data.

Charlie Hewitt, Rhode Island Quality Institute (RIQI), did not submit written testimony. The RIQI operates CurrentCare, the state HIE that acquires patient information from multiple sources and establishes a longitudinal health record. CurrentCare currently receives information from two Part 2 providers. There is voluntary sharing of diagnoses, imaging, admissions, discharges and transfers, labs and CCDAs. Providers can subscribe to receive information for individual patients. Alerts with CCDAs are then sent. With CurrentCare, patients give voluntary consent to share their information with other treatment providers. EHRs and CurrentCare are interoperable. The CCDA can be attached to secure messages. The gateway checks for consent before forwarding a CCDA to CurrentCare. He said that he supports voluntary certification with the same requirements for meaningful use.

Wende Baker, Electronic Behavioral Health Information Network (eBHIN), observed that safety net BH providers are resource poor, and disparities in system capabilities between organizations are large. The resources that are available for HIT are focused on lower costs systems with basic capability so they can yield the lowest hanging fruit. The disparities in system capabilities also contribute to extreme limitations in cross setting communication and coordination abilities. CFR 42 Part 2 requirements are not broadly understood outside of this provider group. Privacy practices in the primary care settings governed by HIPAA, and the requirements for the information management of SUD patient data in the public system are not well known. eBHIN has made significant investment in customizations to allow the exchange of BH information in a closed network environment. Mechanisms to encourage vendors to build systems that comply with these requirements incorporated into their base products would contribute significantly to the integration of BH providers into the larger health care system. Interoperability is crucial not only to linking safety net services, but also connecting them to the primary care partners. Treatment is characterized by episodic need for acute care. Availability of information with these transitions in care may prevent adverse events and facilitate better determination on level of care, which contributes to faster stabilization and decreased readmission rates. HIT can contribute to the establishment and use of evidence based practices. The availability of a certification standard to spur utilization of the National Quality Forum measures would help to increase the amount of standardized measures in use and strategically target areas for improvement. Regarding vendors, she noted that her organization’s vendor, NextGen, has been so busy with meaningful use that repeated delays in development and deployment of BH functions have occurred. The availability of the IT technical assistance resources is even more constrained in the public system. This is all the more reason for standardization, since CDS support mechanisms can help spur the use of EHRs as well as eliminate more labor-intensive capacity management processes, such as the use of spreadsheets to track referrals and waiting lists.

Q&A

Kansas normalized health information to HIPAA. Part 2 patients are opted-out from the exchange. But the system allows patients to give consent for sharing at the point of care. The consent is very explicit for sharing within a specific time interval. Medical emergencies are excepted. BH providers are very agreeable to this process. Diagnostic codes and meds are shared, the most critical data in emergencies.

Panel 6: Regulatory and Quality Improvement Perspective

David Lloyd, MTM Services, described challenges with comparative data elements. The “average” number of data elements collected during the intake to treatment planning process is 1,750 to 2,100. In one state alone, 1800 different diagnostic assessment forms styles or versions are in use. The number of data element variances in current EHRs for first payers is great – over 875 in one state with the number of data elements variances from 15 states in the thousands. There is great variance within and across states for each service type. There are multiple access-to-care processes and costs. Fifteen BH centers in one national grant had 191 different process flows to treatment with an average wait time of 30.5 days to treatment. He recommended the establishment of meaningful use incentives that will: improve standardization of data elements within EHRs and enhance interoperability standards on the back-end; support more standardized access to treatment processes that reduce practice variances; and enhance the comparability of service encounter and process data to support better statewide and national measurement of outcomes.

Justin Harding, National Association of State Mental Health Program Directors, said that a new system that is incapable of working well with both state hospitals and emergency departments would likely be ineffective. Being able to work with prisons would be an added bonus. A system must also be able to work with substance abuse providers. A new system also needs to be on the same IT platform, or close to it, to CMS and the exchanges; otherwise, ACA and other health integration efforts will not be met, or cause the new IT certification effort to be ignored. He mentioned serious hurdles, saying that privacy barriers, be it HIPAA or 42 CFR Part 2, as well as other state, federal, and even local laws could be insurmountable obstacles. Increasingly, providers and grant recipients are required to provide data to the federal and other governments. The certification project needs to be scalable so that long-term functionality can ultimately link to other settings.

Rick Harwood, National Association of State Alcohol and Drug Abuse Directors, did not provide written relative. He explained that relative to prevalence of addictions, few persons are in treatment. Many persons who abuse substance access services via the ED and other medical services. Overuse of prescription drugs is one of the most frequent abuses. Interoperability within Part 2 is much needed. SAMHSA initiatives are building on EHRs, for instance, for block grant reporting. Data policy is very important to the state directors, who are responsible for a combined budget of $5 billion and 8 million providers. The main challenge for this sector is getting patients into the door. Approximately 2.5 million patients receive care, primarily in the public sector. NASADAD members are adamant about addressing the Part 2 barriers. There are strategies that can be used to get the necessary data. EHRs are also important for quality and managing resources.

Tim Lutterman and a colleague, National Research Institute, reported on findings from a survey of state mental health agencies (SMHA). In 2013, 26 states expended $83.5 million dollars implementing and operating EHRs. The cost of EHR software, including needed customizations, averaged $2.6 million per state. SMHAs spent an average of $453,465 per year on EHR maintenance fees. Expenditures for staff training to use and maintain EHRs averaged $1.6 million. Twenty-four states allow sharing of client EHR information between state psychiatric hospitals. Eleven states allow sharing of EHR information between community providers and state hospitals, and 11 allow sharing of EHR information through HIEs. Twenty-six states have laws or rules that provide additional privacy protections beyond the federal laws. In 17 states, client authorization is necessary to share EHR information between providers and HIEs. In six states, unless the client opts-out, EHR information is shared between providers and HIEs. Benefits perceived and reported by 13 or more states were: enhanced quality assurance; improved data reporting; improved productivity; reduced billing errors; and generation of client outcome measures. They support voluntary certification.

Q&A

Regarding whether state psychiatric hospitals provide substance abuse treatment, someone said that substance abuse is treated as a co-morbidity. EHRs create new documents for transfers and discharges. The extent to which policy allows transfer of these documents would have to be examined state by state. Exchange of information on TOCs depends on organizational policy. Members asked several questions about the SMHA survey. Lutterman agreed to supply information at a later time.

Regarding standardization within and across states, Lloyd said that each state effort was a unique challenge. Traditional review history has accumulated and resulted in a proliferation of procedures that delay entry into treatment. A mean of 5.8 hours of staff time is required to collect these intake data from patients. There should be incentives to examine these processes.

Wolf closed the hearing by noting consistency in messages regarding the value of sharing information with providers. But current policy and the available technology pose challenges to sharing needed information.

Public Comment

Susan Fendell, Mental Health Legal Advisory Committee, a Massachusetts state organization, objected to the presumption that integration of information will result in better care. Her organization’s research on sharing psychiatric information revealed that the medical profession stigmatizes and discriminates against these patients, with the result that they receive less care. Patients report that they are often told that the presenting illness in “in your head.” Certification must include the function of segmentation. Otherwise, BH patients may not receive the care needed. The three-minute time limit was called.

SUMMARY OF ACTION ITEMS

None

Hearing Materials

- Agenda
- Submitted testimonies and presentation slides
- Bios