**STATEMENT OF**

**Michael R. Lardieri, LCSW**

**Vice President Health Information Technology & Strategic Development**

**National Council for Behavioral Health**

**BEFORE THE**

**OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY**

**POLICY COMMITTEE’S CERTIFICATION AND ADOPTION WORKGROUP**

***REGARDING Voluntary Certification for Behavioral Health***

**January 24, 2014**

The National Council for Behavioral Health (National Council) is the unifying voice of America’s community mental health and addictions treatment organizations. Together with our 2,100 member organizations who employ over 750,000 individuals, we serve our nation’s most vulnerable citizens — the more than 8 million adults and children living with mental illnesses and addiction disorders. The National Council pioneered Mental Health First Aid in the U.S. and has trained more than 100,000 individuals to connect youth and adults in need to mental health and addictions care in their communities.

Our mission is to advance our members’ ability to deliver integrated healthcare. We advocate for policies that ensure that people who have mental health and substance use problems can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement consulting and resources to ensure services are efficient and effective.

Our members provide a wide range of services and a full continuum of care including outpatient mental health and substance abuse treatment, emergency room diversion programs, crisis intervention and stabilization services, intensive outpatient and partial hospitalization programs, community outreach and services to the homeless, and care/case management services, residential services and services to the cognitively disabled.

Many of our members either provide integrated behavioral health and physical health care directly or work with a medical partner such as a federally qualified health center (FQHC) to coordinate these services for this very vulnerable population. Seriously and persistently mentally ill patients require coordinated care. Some studies have indicated that this population has a life expectancy 25 years less than the general population. They are not dying from behavioral health illnesses but from untreated chronic diseases.

Fundamentally we believe and advocate strongly that behavioral health providers need and should be incorporated into the health care system on par with their medical counterparts. We continue to advocate for behavioral health providers being included in HITECH as eligible professionals and have access to Meaningful Use Incentives. There are several bills in Congress that also support this concept including the Behavioral Health Information Technology Act of 2013 (S.1517) proposed by Senator Whitehouse of Rhode Island and the Behavioral Health IT Act (HR 2957) proposed by Representative Murphy of Pennsylvania. We encourage the support for passage of these bills.

The need to focus on the Triple Aims of better health, better healthcare and lower costs is never more apparent than when working with people with behavioral health disorders. A focus on quality and coordinated care supported by new payment methodologies can support our members in providing the best outcomes for their clients.

We are concerned, however, that these efforts such as health homes, Accountable Care Organizations, Coordinated Care Organizations and other developing mechanisms are doomed to fail unless behavioral health providers are able to communicate with their health care partners in care coordination efforts for their shared patients. There is well documented evidence that many patients who have a chronic disease also have a co morbid behavioral health disorder. There is also documented evidence that treating comorbid behavioral health conditions is cost effective as it leads to lower readmission rates as well as lower overall health care spending.

It is through this lens and with a clear understanding of the potential additional costs that a voluntary certification program for behavioral health EHRs can have that we would recommend a modular approach to a Voluntary Certification Program focused in three areas and in the following priority:

1. Implement a voluntary certification program for behavioral health EHRs that identifies that they meet current standards and criteria for interoperability required for other providers covered by HITECH and the Meaningful Use Incentive Program.

Behavioral health providers are being requested to participate in many different forms of care coordination activities with their medical partners, however, unless the behavioral health provider has purchased and implemented a “certified” system their medical partners cannot be assured that they will be able to communicate effectively in care coordination and population management activities.

We believe that certifying “interoperability” according to current MU standards digs deep into the EHR system and will drive many other initiatives. In order to produce a Continuity of Care document (CCD) and as the industry moves to a Consolidated Clinical Document Architecture (C-CDA), EHRs that are certified to this standard will be required to meet other standards as well. They will be required to standardize and conform to the Sections, Entries and Coding systems that are currently in place and are evolving under the ONC S&I Framework and HL 7 initiatives. Where data is required to be structured behavioral health EHRs should structure the data the same as all other providers utilizing the same value and code sets as MU eligible providers must use. This will assist behavioral health data to be incorporated into other EHR systems, processed through health information exchanges, shared via Direct Secure Messaging or incorporated into a shared care collaboration tool without requiring one off interfaces which are expensive and not easily replicable on a national scale. Conforming to interoperability standards will also address privacy and security issues.

It is important to recognize, however, that not all behavioral health providers will have collected all of the data to populate a minimal data set. For example behavioral health providers who are not eligible for MU Incentives would not necessarily record vital signs in their record. If specific data elements are not collected they should still be able to populate and send a CCD to another provider with the data that they do collect.

1. We recommend that the next level of certification be focused on Clinical Quality Measures. A Voluntary Certification Program that can identify an EHR as having the capability to track and report on Clinical Quality Measures (not MU Measures) would provide behavioral health providers a position in their medical neighborhood that assures they can work with other organizations and focus on the same goals and population management activities. There are now approximately eighteen (18) CQMs that are specific to behavioral health or to behavioral health working in integrated environments. Being on the NQF Behavioral Health Workgroup I know that more CQMs specific to behavioral health are coming down the road. Knowing that their system can capture and report on these measures will allow behavioral health providers to participate with their medical partners who are using these measures as part of their shared savings and other care coordination programs.
2. The third and last certification level we recommend is around Clinical Decision Support (CDS). EHRs that have certified their ability to track and report on Clinical Quality Measures could then certify that they have CDS tools in place to support the CQMs. We recognize that CDS is not “one size fits all”. This certification should require that the EHR has incorporated “accepted” CDS rules for each of the current MU CQMs and also has the capability to add CDS rules or modify rules based on the users request. There should also be consideration for the clinical decision support to be provided by a third party vendor outside of the EHR itself.

Other modules could then be identified that might be important to the industry.

***All of the above recommendations can be carried out within current certification programs without having to implement a new and burdensome set of requirements on vendors or behavioral health providers that have developed their own systems over time.***

We do not believe that there should be a voluntary certification process for system “usability”. We do recognize that usability of EHRs and other electronic health information systems is important, however, “usability” is somewhat subjective. Having been involved with and reviewed many different EHRs there are many ways to get from here to there. Some I and my staff liked better than others. In other situations cost and sustainability were very real issues and there were tradeoffs between what the system could do to make it more “usable” and what the organization could afford. How group progress notes are processed is one such example.

As stated previously behavioral health providers serve a wide range of client needs and provide a wide range and continuum of services which include Services to the Homeless. An example of federal programs not working together where their ability to share dta would have significant benefits to clients and their providers is the current HUD Recipient Tracking System which is not compatible with MU and the many behavioral health providers serving the homeless across the country, whether they are MU eligible providers or not, have to double enter data for their homeless population. We recommend that an effort be launched to ensure that the HUD Service Point system come in alignment with MU at least in the area of interoperability. Having the ability for a behavioral health provider serving the homeless population to have one data entry point from their EHR which could then be shared with the HUD system would save thousands of person hours in data processing and also allow the integration of data to improve population management efforts and initiatives. The National Council would welcome the opportunity to work with ONC, HUD and SAMHSA in this area. We have already identified providers and partnerships across the country that could serve as pilots for this effort.

Confidentiality remains a concern for behavioral health patients/clients/consumers/ recipients (depending on what the behavioral health provider calls the people they serve in their particular environment) and their providers. This is especially true with substance use and 42 CFR Part 2 (Part 2) which is the federal regulation governing the sharing of substance use information from specific providers that are covered under this regulation.

This is not really an EHR certification problem at this time but a health information exchange problem. Few health information exchanges across the country can appropriately process Part 2 consents and conform to the regulations. They were not built to comply with Part 2. Sharing Part 2 data will remain a problem until full data segmentation for privacy is universal across the country. This, however, remains a few years away. Care coordination for substance use disorders cannot wait for years. Why should these patients receive sub par care during that time? Sub regulatory guidance allowing a patient to identify “current and future providers in the HIE involved in my care” as an appropriate title under the “To Whom” requirement of a Part 2 consent would help to allow sharing data now.

A voluntary certification program focused on the interoperability priority identified previously would then set the stage for those EHRs to be able to process consents and data sharing in accordance with future data segmentation for privacy standards.

A voluntary certification program focused on interoperability and CQMs as referenced above would allow for the alignment of federal and state data collection and quality improvement efforts. I participate in two specific ONC Standards and Interoperability HL 7 Workgroups (Longitudinal Care and the Behavioral Health Workgroup) and the specific data elements needed for behavioral health reporting are being identified and balloted. These two sets still need to be harmonized, however, this effort is moving forward. Once this occurs and the data elements are specifically identified as being part of a C-CDA data will be able to be shared from an HER and sent to state and/or federal partners relieving providers of the burden of double and sometimes triple entry into multiple systems.

**Five Factor Framework**

We believe that implementing a voluntary certification program for Interoperability, and/or CQMs and/or Clinical Decision Support (a vendor might certify for one, all three or a combination of the three) will

* Advance the national initiatives to meet the Triple Aim of Better, Health, Better Health Care and Lower costs
* Align with Existing Federal/State Programs
* Utilize the existing technology pipeline
* Builds on existing stakeholder support, and
* Appropriately balances the costs and benefits of a certification program.

We thank you for this opportunity to submit our recommendations on implementing a voluntary Certification Program for Behavioral Health electronic Health Records.

If you have questions please contact Michael R. Lardieri, LCSW, Vice President Health Information Technology and Strategic Development at [MikeL@thenationalcouncil.org](mailto:MikeL@thenationalcouncil.org)

Thank You,

Michael R. Lardieri, LCSW