



ONC EHR Certification for Behavioral Health

Virtual Hearing

[Certification and Adoption Workgroup](#)

Behavioral Health Provider Perspective

AAAP is an academic professional membership organization founded in 1985 with approximately 1,100 members in the United States and around the world. Membership consists of psychiatrists who specialize in treating addiction in their practices, faculty at various academic institutions, medical students, residents and fellows, and non-psychiatry healthcare professionals who are making a contribution to the field of Addiction Psychiatry. AAAP supports the National Quality Strategy Aims of Better Care, Healthy People/Healthy Communities and Affordable Care. As such, AAAP supports the development of voluntary certification of BH EHRs to further these aims.

Given the well-documented high prevalence of co-occurring mental disorders and/or medical illness with substance use disorders, addiction treatment must have collaboration and/or integration with the rest of medicine, including mental health treatment. Reliable and standardized EHR is necessary but not alone sufficient for the Health Reform priority of clinical integration. Addressing these co-occurring disorders concurrently and with voluntary certified EHR-supported care coordination will begin to mitigate the disproportionate cost of these clinical populations through altered illness trajectories and reduced use of emergency and inpatient care, advancing a National Quality Strategy Priority.

Paper charts can create delays in obtaining information and misinformation due to unreadable notes. Many programs do have electronic records covering some areas and paper charts in other domains, which produces significant problems that providers have commented on:

1. Communicating patient information, especially critical information (allergies, current medications, etiology of primary problem, existence of secondary and tertiary problems) is dependent upon what is written in the chart and or communicated verbally by the clinician. These issues need to be documented by all, and so should be in one electronic record easily accessible to all from a workstation or other device, rather than at several discrete locations.
2. The pace of treatment of acutely ill patients can be rapid. The likelihood of treatment errors is increased when providers must access several different sources to get accurate information about their patient.
3. Even in the absence of paper charting, having multiple software platforms to access different information is counterproductive. For example, needing to check one system for lab work and another system for physician orders and another system for plan and course of treatment makes it difficult to get an accurate picture of what is happening with a patient in an optimal amount of time.

Addiction Treatment is Separate, but not Equal

In the evolving digital health system, the very protections that were constructed in the era of paper records through 42 CFR Part 2 to keep addiction treatment data discrete for patient protection and to reduce stigma, tend to maintain the isolation of addiction treatment from appropriate mainstream medical providers. This is in part because the current state of mainstream EHR and HIE development does not typically include the ability to segment addictions treatment-related data and to make it individually available to authorized recipients. We believe that proper use of patient data and linkage to care coordination information either directly or through HIE will improve non-addiction specialist clinician's perceptions of patients with SUD and other mental disorders, especially as they recognize through patient and care collaboration interactions over time that they are important and effective stakeholders in patients' recovery. EHRs might control the re-disclosure of protected clinical information through development of standards that promote use of metadata tagging to auto-cohort and restrict data on the receiving end.

(In general, AAAP supports that patients' personal health information should be available to parties providing health care services to the patient, and not to other parties; but, within the health care delivery system, free exchange of basic health information, via sharing of electronic health records or through the placement of basic health information into an electronic health information exchange, should be permitted by the patient's initial written consent for treatment. Disclosures of information from the medical record should contain only the information needed for the intended purpose, which would include basic health information, encounter information, and release to related business entities through qualified service provider agreements. Patients who decline to sign the consent should be educated about the implications for the quality of the health care services they may receive, and potential detriments to their own health care outcomes.)

Although the time required to accomplish regulatory change will be lengthy, AAAP supports regarding 42 CFR Part 2, regulatory changes that facilitate lowered barriers in the HIE for appropriate caregivers, while strengthening protections against and penalties for unauthorized reception or redisclosure.

In order to foster systems change, there also must be proper incentives to purchase and implement BH EHR in treatment programs that frequently operate within very narrow financial margins, especially free-standing ones. Without incentives, these programs are likely to continue to lag behind the rest of medicine. As such, AAAP supports the passage of the Behavioral Health Information Technology ACT of 2013 (HR 2957) and the Behavioral Health Information Technology ACT of 2013 (S 1517), which would create eligibility for MU incentives to be applied to certain behavioral health providers. Other Federal opportunities to offer incentives to practitioners and programs would accelerate the much-needed adoption of EHR in addiction and mental health treatment.

Certification Standards should be supported for addiction treatment–related modules in mainstream EHR systems, which would promote SAMHSA’s Health IT Goal of Quality Integrated Behavioral Health Care.

Agonist, antagonist and other pharmacotherapies for substance dependence are efficacious, yet greatly underutilized interventions, a quality concern due in part to the addiction treatment community’s traditional distance from the scientific evidence base, philosophy and practice of mainstream medicine. In order to address this isolation, which has created barriers to access to treatment, we must promote use of EHR for addiction treatment providers and programs. However, creating a new non-MU based core certification standard for BH may propagate systems with idiosyncratic and potentially expensive interfaces that concretize it in its currently siloed state, and, without direct access to the medical functionality such as prescribing, labs and imaging, render it less capable of necessary clinical evolution. Specialty BH EHR may offer basic functionality in the short term, but may not be able to keep up with the rate of change in mainstream systems over time, and is likely to be increasingly divergent.

AAAP proposes that a flexible, modular program structure can meet the content standards needs of diverse provider types, provided there is a minimum data set for any clinical encounter that encapsulates core interoperability, privacy and security functionality for all providers, aligned with MU. Rather, presenting a flexible program will push the field towards development of unified integrated EHR systems that have capacity for both current MU certification, as well as modular components for clinicians who are not currently eligible for MU, but would have another certification pathway. This will better support care coordination, and the generation of exportable standard care plans, if not the ultimate goal of clinical integration. Addiction treatment centers that use specialty EHR may also have issues with interoperability that could be greatly reduced or eliminated with adoption of the modular EHR approach and conformance to MU interoperability standards.

Separate but equal approaches typically result in a less robust solution for the separated entity. We need standards that do not build up another information silo within BH, rather we must build functionality that optimizes medical practice for the benefit of patients – necessary for diagnostic evaluations, e.g, ruling out substance-induced disorders, assessing delirium, assessing current medications, etc.

In concert with the modular approach, we propose that these new certifications fall in line with MU standards for interoperability, and that data structures within the Modular EHR conform to those of MU certified systems, so as to improve the utility of information offered through an HIE, and to reduce the need for interface customization. This would utilize the existing technology pipeline, and support vendors to move in an integrative direction.

Standardized screening, assessment and quality standards are another driver of improved care and should be high level for any voluntary BH EHR certification. Regarding quality standards in addiction treatment, even though there are few current MU–based quality measures pertaining to addiction treatment, there are a host of appropriate NQF measures that pertain to addiction

screening and treatment. Quality metrics populated through EHR can begin to drive needed clinical systems change along with or even without incentivization.

Thank you for your invitation to participate in this panel.

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