

Meaningful Use of Health Information Technology

Recommendations

Presented to

HIT Policy Committee

Office of the National Coordinator for Health Information Technology

Presented by

**The National Council for Community Behavioral Healthcare and Netsmart
Technologies**

June 26, 2009

Introduction

The National Health Council for Community Behavioral Health represents 1,600 Community Behavioral Health Centers and other safety net community-based agencies that collectively serve over 6 million children and adults with mental health and addiction disorders nationwide.

Netsmart Technologies is a supplier of enterprise-wide electronic health record solutions for health and human services providers. More than 18,000 customer organizations, including 350,000 care providers and nearly 40 state behavioral health systems, use Netsmart products to help improve the quality of life for more than 20,000,000 Americans. Netsmart's customers include mental health and substance abuse treatment agencies, psychiatric hospitals, private and group mental health practices, public health departments, vital records offices and managed care organizations.

Background & Context

On February 17, 2009 President Barack Obama signed the American Recovery and Reinvestment Act (ARRA). The Health Information Technology for Economic and Clinical Health (HITECH) provisions of ARRA establish new Medicare and Medicaid incentives to stimulate critically needed investments in health information technology (HIT).

The ultimate goal of widespread adoption of HIT – to save American lives through improved coordination of care – is particularly relevant to persons with mental health and addiction disorders. According to an eight state study funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in December 2006, individuals with serious mental illnesses served by public mental health authorities die – on average – 25 years sooner than Americans without mental illness. This horrific mortality rate is linked to the high incidence of untreated co-occurring chronic medical conditions in this patient population including cancer, hypertension, diabetes, asthma, heart disease, and cardio-pulmonary conditions. People with

drug dependence die an average of 22.5 years sooner than those without a diagnosis. More recently, The New York Times reported that hospitalized patients with bipolar disorder have mortality rates that ranged from 35% to 200% higher than any other patient; again, the cause of death was co-occurring chronic diseases. Many mental and physical illnesses are more prevalent and more severe among patients with substance use disorders. Individuals who suffer from addiction often have one or more accompanying medical issues, including lung and cardiovascular disease, stroke, cancer, and mental disorders.

HIT technology is the essential cornerstone of efforts to address this emerging public health crisis. HIT will enable behavioral health and substance abuse providers to effectively coordinate care across mental health and substance abuse service systems, primary care entities and specialty medicine.

As written, ARRA excludes behavioral health providers from receiving any Medicare or Medicaid incentives due to the way eligible providers were defined. This omission is currently being addressed by our clients and organization members as part of the healthcare reform legislation being written in the Senate and House.

Presently, ONC is working towards developing a national definition for “meaningful use” of Health IT. The forthcoming definition is intended to set the direction of the Administration’s strategy for Health IT adoption. According to Dr. Blumenthal, ONC Director, “the definition will inform everything that we (ONC) do that is related to health IT,” including product certification, funding and technical support”.

As ONC shapes its definition of ‘meaningful use’, our organizations would like the opportunity to propose a series of recommendations aimed at ensuring that the needs of behavioral health and substance abuse treatment providers are included in the definitions of ‘meaningful use’.

Key Recommendations from our Members and Clients

As we have reviewed the minutes of your meetings and the preliminary meaningful use matrix released by the HIT Policy Committee, we would like to suggest the following considerations for your review.

General Definition Considerations

1. As you define goals and objectives to improve quality, safety, efficiency and reduce health disparities, we recommend that the care goals, objectives and measures be structured in a way that do not impose requirements on behavioral health and substance abuse providers that are not part of our current and planned clinical practices (for example checking or prescribing colorectal cancer screenings), and which do address the needs of consumers with mental health or substance use disorders that are receiving care from behavioral health and substance abuse providers.
2. The ONC definition of *meaningful use* should underscore the need for HIT to help reduce and ultimately eliminate disparities in treatment and outcomes experienced by severely and

persistently mentally ill populations and other underserved populations, including individuals with chronic substance use disorders, through the delivery of appropriate and high quality services.

3. Because of the disproportionately large rates of co-morbidity between mental health, substance use disorders and primary health care, the ONC definition of *meaningful use* for both behavioral health and primary care HIT should include provisions for interoperability for shared patients seen in both settings, perhaps using the Continuity of Care document as the minimum dataset.

Meaningful Use of Certified Electronic Health Records

4. The concept of *meaningful use* of certified EHRs should include treatment planning for chronic mental health disease and substance use disorders.
5. Systems meeting *meaningful use* requirements in a behavioral health setting should be able to track standard clinical information on mental health and substance use disorders, and not be required to measure/track metrics that do not apply to behavioral health and substance abuse providers.
6. Certified EHR systems should be able to demonstrate the ability to support quality care and patient safety, support public health reporting, demonstrate the ability to monitor or track patient progress over time, support e-prescribing and expand the overall knowledge base of patients and providers.
7. The Continuity of Care Document (or alternative standard that is chosen for interoperability between EHRs) should be able to accept mental health/substance use data (for example the multi-axis DSM IV)

Implementation Considerations

8. The ONC definition of *meaningful use* should allow for a phased or incremental implementation to allow appropriate information and outreach efforts to inform providers of requirements, incentives and penalties. Also important is consideration of various levels of provider readiness (e.g. urban, rural, early and late adopters, providers that have limited access to high speed internet, providers not participating in systems and not serviced by Health Information Exchanges.)
9. ONC should reevaluate the incentives used under Medicare and Medicaid to ensure that there is equity among provider types. (Note: Presently, Medicare and Medicaid incentives do not include behavioral health and substance abuse providers.)
10. Safety net providers should receive additional incentives based on the proportion of Medicaid patients they see. Incentives would also help remedy the limited reimbursements

such providers currently receive despite the need for close collaboration with other clinical disciplines e.g. primary care, emergency departments, and inpatient services (psychiatric, residential addiction and medical-surgical). Additional funding is needed for the initial acquisition of HIT and for on-going system maintenance and subsequent enhancements. “Safety net providers” should be broadly defined to include mental health centers, substance abuse providers, other facilities that may not be federally qualified, as well as small group and solo physician practices serving vulnerable populations.

For More Information, Contact:

Kevin Scalia
Executive Vice President
Netsmart Technologies
(631) 968-2185
kscalia@ntst.com

Alexa Eggleston
Director of Public Policy
National Council for Community Behavioral Healthcare
(202) 684-7457 x243
AlexaeE@thenationalcouncil.org