February 4, 2015

Office of the 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 Strategic Plan- Federal Health IT Strategic Plan 2015-2020

Dear Acting Assistant Secretary DeSalvo:

On behalf of the National Council for Behavioral Health, and our 2400 member organizations, we are writing to submit an official comment to the recently proposed ONC Strategic Plan "Federal Health IT Strategic Plan 2015-2020." Specifically, we are writing to address the underlying assumption related to achieving *Goal 1* and *Goal 3*, in that behavioral health providers have the resources to adopt electronic health records. Additionally, we are writing to applaud and encourage the continued advancement of health information technology under *Goal 2* as it is the key to coordinated care in integrated settings.

We strongly believe that to have an effective, interoperable health information exchange (HIE), behavioral health care settings must receive meaningful use payments and technical assistance to afford EHRs and provide quality, coordinate care to patients.

Under *Goal 1: Expand Adoption of Health IT*, ONC rightly includes behavioral health providers as necessary to successfully expand health IT adoption and use efforts. However, the underlying assumption that behavioral health providers have the resources to pay for the adoption of electronic health records (EHRs) is incorrect. Behavioral health providers will not have the resources to afford EHR adoption without Medicare and Medicaid meaningful use incentive payments due to their already limited resources.

In comparison with primary care providers, Behavioral Health providers have fewer resources to purchase and implement meaningful use Electronic Health Records than similarly situated health care providers. For example, our 2012 study of more than 500 community mental health and addiction treatment organizations across the nation found the following:

"Only 2% of community behavioral health organizations are able to meet MU [meaningful use] requirements—compare this to the 27% of Federally Qualified Health Centers and 20% of hospitals that have already met some level of MU requirements. The most significant barrier for the behavioral health sector was cost—upfront financial costs and the costs of ongoing maintenance." *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health*, National Council for Behavioral Health, 2012.

The National Council strongly believes that the delivery of behavioral health care for persons with serious mental disorders can be significantly improved if mental health and addiction providers are included in the HITECH Act.

The National Council encourages and is supportive of the approach ONC has taken to extend and advance widespread data segmentation technologies to the overall health provider field.

Under *Goal 2: Advance Secure and Interoperable Health Information,* ONC discusses the necessity to protect the privacy and security of health information and expressly names substance use and mental health treatment as "sensitive in nature." The National Council is supportive of these measures to ensure the safety and security of personal and private patient information.

In May, HL7 "Data Segmentation for Privacy" (DS4P) was released and operationalized. These Data segmentation standards leverage existing information technology to resolve current problems and many other concerns around sharing a wide range of patient health information with varying and often complex special protections. The standards sort all of the pertinent state and federal regulations, along with organizational policies and procedures, into a hierarchy of categories for "special protection."

The availability of these standards brings health care in general and behavioral health as a field much closer to attaining the goal of interoperability. Different information technology systems and software applications will be able to apply these standards in communicating and exchanging data, and then use the information that has been exchanged.

The National Council encourages and is supportive of this approach by the ONC. We are excited to see this technology widely available and operationalized by all providers in the near future.

ONC should expand HIE funding for behavioral health settings.

Under *Goal 3: Strengthening Health Care Delivery* the ONC discusses the role of Health IT in improving and strengthening health care delivery, noting that such technology should be and must be accessible to everyone. However, without behavioral health providers receiving funding for Medicaid and Medicare incentive payments to adopt EHRs, this goal will likely not be achieved because 70% of the populations served by behavioral health providers have chronic, co-occurring medical surgical conditions that mandate quick and quality coordinated and integrated care.

There are 8 million persons in the behavioral health setting - mostly individuals with severe and persistent mental illnesses - served by the public mental health system. A plethora of recent studies indicate that these patients possess an exceedingly poor overall health status. For example, a *Synthesis Project* analysis issued by the Kaiser Family Foundation with support from the Robert Wood Johnson Foundation points to a strikingly high incidence of comorbid cancer, heart disease, diabetes and asthma among Americans with mental disorders. Specifically, according to federal government data for Medicaid SSDI recipients:

- **76.2%** of disabled Medicaid recipients with **asthma and/or COPD** also have severe mental disorders and comorbid addiction disorders.
- **73.7%** of disabled Medicaid recipients with **coronary heart disease** also have severe mental illnesses and comorbid addiction disorders.
- **67.9%** of disabled Medicaid recipients with **diabetes** also have serious mental and substance use disorders.

Among Medicaid beneficiaries, those with serious mental illness (SMI) such as major depression, bipolar disorder and schizophrenia are more than twice as likely to have three or more chronic, comorbid conditions. Furthermore, in a recent study of New York City hospitals, "Two-thirds of adult discharges with major behavioral health conditions had at least two other forms of chronic diseases (three or more in total). Among other hospitalizations, 72% had two or more chronic diseases and most had three or more." ("*Updated Data on Prevalence and Severity of Behavioral Health Conditions among General Hospital Inpatients in New York State*", Arthur Webb Group, December 2014.)

A study published in a Centers for Disease Control and Prevention (CDC) publication *Preventing Chronic Disease* found the predictable consequences. In short, people with SMI – particularly those served in state mental health systems - die 25 years sooner than other Americans while experiencing elevated levels of morbidity. It is important to put these studies in context: there are very few patient populations served by any federal health program that experience such poor overall health. In fact, the available data suggests that people with mental illnesses like schizophrenia and bipolar in the United States have average life expectancy similar to the citizens of poor Sub-Saharan African nations (who lack access to clean water and vaccinations against preventable communicable diseases).

In *"Objective 3C: Improve clinical and community services and population health,"* ONC discusses the timeliness and appropriateness of preventive services and the improved coordinated care health IT can bring to the provider population. The National Council strongly believes that an interoperable HIE is the key to coordinated care in integrated settings. In fact, people living with conditions like schizophrenia and bipolar disorder are in desperate need of the integrated care made possible by HIE. At the same time, the National Council is now deeply concerned that without access to meaningful use payments and HIE for behavioral health settings, it will soon become impossible to provide clinical care coordination for this highly vulnerable population, which requires regular interaction between mental health/addiction services providers, primary care physicians and medical specialty personnel.

In constructing the proposed Strategic Plan for 2015-2020, we ask that your agency revise the language of goals and strategies to include greater emphasis on coordinated and integrated care with behavioral health providers. Additionally, we ask that your agency use discretionary funds to expand HIE funding for behavioral health settings to address the high risk population identified above.

Sincerely,

Linda Rosenberg

Linda Rosenberg, MSW
President and CEO
National Council for Behavioral Health