



National Association of State Mental Health  
Program Directors (NASMHPD)

NASMHPD Policy Brief

Health Information Technology (HIT)  
and the Public Mental Health System

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# **NASMHPD Policy Brief**

## **Health Information Technology (HIT)**

### **and the Public Mental Health System**

#### **I. Background**

Health Information Technology (HIT) is a critical component in the move to modernize healthcare to increase quality, reduce medical errors, and bend the cost curve of medicine by making healthcare more efficient. Two recent federal laws that have a major impact on overall healthcare HIT raise concerns due to their lack of full inclusion of mental health and substance abuse.

As part of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) contains over \$22 billion to promote the adoption of Electronic Health Records (EHRs) by physicians, hospitals, and other health providers plus funding for the implementation of Health Information Exchanges (HIEs) that will allow health providers to share their EHR data to better coordinate and improve care. Unfortunately, mental health and substance abuse providers are excluded from virtually all EHR incentives and, in some states, are not active participants in the HIE planning and implementation.

The Affordable Care Act (ACA) of 2010 relies heavily on the use of EHRs and HIEs to “bend the cost curve” by making the expanded health coverage affordable to all. The ACA will focus on outcomes through the enhancement of Accountable Care Organizations (ACOs) and Health Homes as well as investing in prevention and wellness by giving service recipients more control over their own care. The ACA will greatly expand the number of individuals with mental health and substance abuse disorders who will now have insurance coverage for some of their treatment. The ability to obtain and share data related to outcomes will be adversely impeded by excluding mental health and substance abuse providers in HIT initiatives.

Persons with serious mental illness (SMI) experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population. NASMHPD believes the benefits of integrating behavioral health data with health data are great and that appropriate policies and practices can be implemented that permit the sharing of behavioral health data while protecting the confidentiality and privacy of personal health information. However, some state HIE efforts are not fully including behavioral health in their planning and implementation. To the extent that state HIT systems have already begun to strategize and plan without fully including behavioral health, strong leadership is needed to ensure that health and behavioral health systems work in tandem.

The expansion of insurance coverage under the ACA will change the financing of mental health and substance abuse services. As states braid current and future funding streams and methodologies, NASMHPD strongly encourages that all of HHS work together to incorporate behavioral health into the design, implementation and use of EHR and HIEs in order to share data, improve outcomes and accountability while eliminating redundancy and burden in reporting.

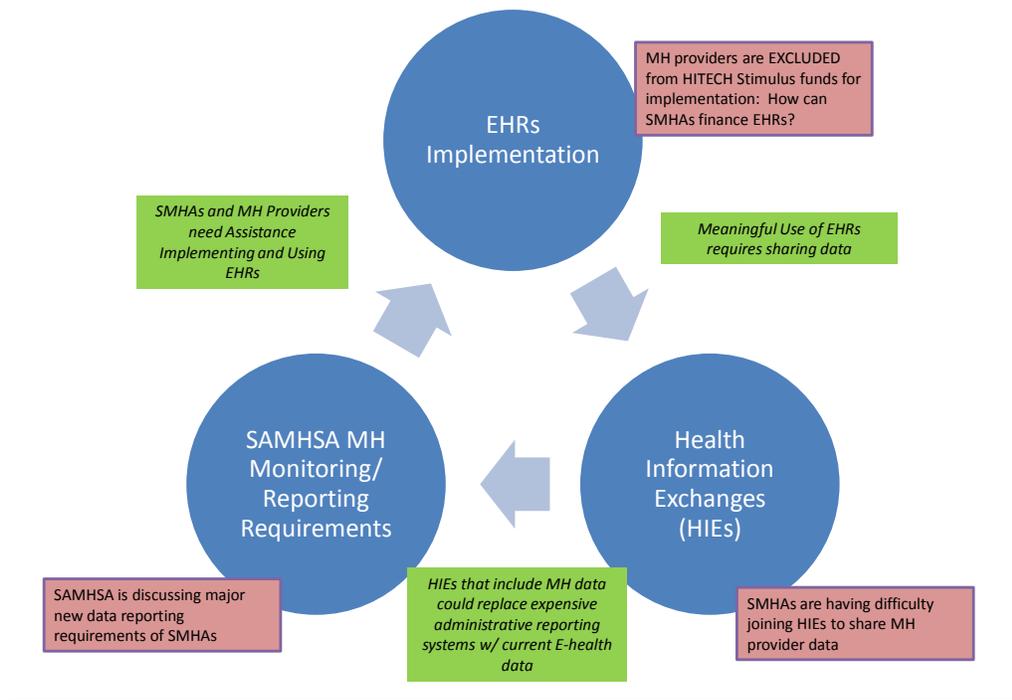
These three HIT areas (EHRs, HIEs, and Federal Reporting) are all interrelated. If mental health providers are unable to implement EHRs, and if state and local mental health authorities are not included in planning for HIE, critical information from the mental health system will either not be fully included or have the ability to be integrated as primary care moves to electronic data-sharing. Without the development of HIEs that can accept electronic data from mental health providers while meeting all of the requirements of HIPAA, 42CFR, and other applicable statutes, even those providers that are able to implement EHRs will be unable to meet the HITECH Act’s “meaningful use” criteria regarding sharing of electronic data. In addition, mental health entities will be unable to utilize their electronic data to

coordinate care between and among providers whether that coordination is between state psychiatric hospitals and community mental health centers (CMHCs), state psychiatric hospitals and general hospitals, CMHCs and primary care physicians, and other complex linkages required to increase integration and improve care.

As a result, the coordination between behavioral health and primary care via providers' sharing of e-Health data may lag behind the rest of healthcare. HHS could greatly assist mental health systems through training and technical assistance in generating and utilizing incentive payments and Medicaid funds to promote the implementation and use of EHRs. HHS leadership can employ strategies with federal and state partners to assure that mental health is not excluded from HIEs.

If mental health systems are able to implement and utilize EHRs in an integrated fashion with parallel service delivery systems then HHS could potentially access extracts of clinical data from HIEs to obtain outcomes and information about services funded under SAMHSA block grants and other HHS funding streams. These information extracts from EHRs and HIEs would need to incorporate data elements agreed upon by states while protecting consumer confidentiality and privacy. In a world where mental health information systems include functioning EHRs that can share and coordinate e-health data through HIEs, HHS would potentially no longer need to maintain its current and separate administrative reporting systems from state mental health agencies and local providers since it could access information through HIEs.

Health Information Technology and Public Mental Health: How Policies Interrelate



## **ELECTRONIC HEALTH RECORDS (EHRs) INFORMATION SYSTEM IMPLEMENTATION**

### **Importance and Key Facts**

The HITECH Act provides over \$22 billion in Medicaid and Medicare incentive payments to health providers to subsidize and reward their implementation of EHRs. However, psychiatric hospitals and community mental health centers are classes of organizations that in the HITECH statute are not eligible to receive ARRA funds. While national mental health organizations support a bill introduced in the 111<sup>th</sup> Congress by Rep. Patrick Kennedy (D-RI) and Tim Murphy (R-PA) to add mental health providers as entities eligible to receive EHR Implementation funds, the likelihood of enactment is low. If the Kennedy/Murphy bill does pass, behavioral health providers would greatly benefit from training and technical assistance in how to implement and use EHRs.

At a recent SAMHSA-sponsored meeting on EHRs and the HITECH Act, officials from HHS's Office of the National Coordinator (ONC) responded to questions in such a manner as to suggest that it would be permissible for mental health providers that use certified EHRs to have qualified health practitioners receive incentive payments for their services, even though the mental health provider agency could not receive such payments. While the overall agency may not be eligible for the Medicaid and Medicare incentive funds, individual psychiatrists and nurse practitioners employed by the agency may be able to apply for incentive payments for their individual professional services. Clarification of exactly how this reimbursement could be accomplished, or the potential amounts that mental health providers could receive in incentive payments, has not been determined at this time. Mental Health providers need to know not only if this is a viable approach to support EHR incentives, but also that the potential reimbursements would warrant pursuing this approach.

In a 2010 NASMHPD Research Institute (NRI) survey, over half the SMHAs reported they either have an operating EHR or are currently installing an EHR in their state psychiatric hospitals. In addition, many community mental health providers are implementing their own EHR systems. SMHAs have indicated that they could use assistance to ensure that the EHR systems they purchase will meet future HIE (data exchange) and emerging federal standards for the meaningful use of EHRs. Mental health providers have also indicated a need to learn how to best implement and utilize EHRs and determine how they might participate in future funding for their staff psychiatrists and other physicians. HHS has funded HIT Regional Extension Centers to work with providers on the implementation and utilization of EHRs. However, in many states, SMHAs do not appear to be viewed as a focus of HIT Regional Extension Centers.

### **Recommended Policies and Action Steps for the Federal Government**

1. CMS should clarify the potential for psychiatrists and other qualified medical staff to become eligible for incentive payments for the meaningful use of EHRs.
  - a. States need guidance about the ability to receive EHR incentive payments for qualified medical staff and help in determining if the potential incentive payments would be worth the cost and effort of applying for them.
  - b. HHS could sponsor training sessions for mental health providers on how to access the ARRA HITECH incentive payments for psychiatrists and other medical practitioners.
2. CMS could provide further technical assistance, using the MITA and other CMS Information Technology funding, to SMHAs and state Medicaid agencies to modify information systems and assist them in implementing HIT that meets behavioral health needs.

3. CMS and HHS could develop case studies and training in best practices that promote the development, implementation, and use of EHRs in behavioral health settings. SMHAs have reported that the implementation of EHRs can be expensive and complicated. Consultation and assistance for SMHAs and behavioral health providers using experts that have already made this transformation to implementing and using EHRs would be timely and helpful to other states that could learn effective approaches and outcomes. Related to this is a concern that the implementation and use of EHRs cannot be seen as merely an “IT” issue. Clinical perspectives must be included in assuring the use of EHRs in behavioral healthcare.
4. HIT Regional Extension Centers should ensure that they address behavioral health EHR issues and should include SMHAs and local provider agency representation in their target populations.

## **STATE HEALTH INFORMATION EXCHANGES**

### **Importance and Key Facts**

As indicated above, in mid-February 2010, HHS announced nearly \$1 billion in Recovery Act awards to advance the adoption and use of HIT. This assistance at the state and regional level is intended to facilitate the adoption and use of electronic health records (EHRs). To date, nearly \$386 million has been distributed to states and qualified State Designated Entities (SDEs) to facilitate health information exchange (HIE) at the state level. An additional \$375 million was distributed to 32 non-profit organizations to support the development of regional extension centers (RECs) designed to aid health professionals who implement and use HIT<sup>[1]</sup>. RECs are expected to provide outreach and support services to nearly 100,000 primary care providers and hospitals within two years. Over the four year funding period, there will be an evolution and advancement of key governance, policies, technical services, business operations, and financing mechanisms for HIEs and SDEs. HIEs are a key component to reach the goal of sharing electronic health data, including EHR data, prescriptions, and medical test results as a means to improve the quality of health care and reduce costs.

As indicated above, many SMHAs are either currently operating or installing EHRs in their state hospitals, and some community mental health providers have functioning EHRs that could both benefit from and contribute to HIEs. The major health-mental health disparities that include premature mortality and co-morbid physical health issues (e.g. high rates of diabetes, obesity, and coronary heart disease) among mental health consumers suggests that sharing EHR data among mental health providers and physical health providers through HIEs could improve care, maximize outcomes, and reduce costs.

On July 6, 2010, HHS issued a Program Information Notice (PIN) titled, *Requirements and Recommendations for the State Health Information Exchange Cooperative Agreement Program*<sup>[2]</sup>. The PIN indicates that states and SDEs are mandated to (“shall”) outline in their *State Strategic and Operational Plans* (state plans) a concrete and operationally feasible plan to enable three HIE capabilities in the next year: (a) E-prescribing; (b) Receipt of structured lab results; and (c) Sharing patient care summaries across unaffiliated organizations. States and SDEs “shall” use their authority, programs, and resources to initiate a transparent multi-stakeholder process; monitor and track meaningful use HIE capabilities in the state; assure trust of information sharing; set strategy to meet gaps in HIE capabilities for meaningful use; ensure consistency with national policies and standards; and align with Medicaid and public health programs.

The PIN further indicates that the state HIT Coordinator should (vs. “shall”) coordinate HIT efforts with Medicaid, public health, and other federally funded state programs. Examples of the Coordinator assuming this role include ensuring “...state program participation in planning and implementation activities including, but not limited to Medicaid, behavioral health, public health, departments of aging”.

Despite the inclusion of behavioral health in the list of services that HIEs should address, many SMHAs report that they (and state substance abuse authorities) are not being included in their state’s HIE activities. In 2009 when HHS first announced state grants to develop HIEs, the NRI surveyed SMHAs to determine their roles in the development of state HIE applications and the funded HIEs. At that time, few states either had a role in the development of the states’ HIE or anticipated a role in their state’s HIE grant. In fact, only one SMHA had received any commitment of funds (\$10,000) from the \$564 million in HHS’s HIE grant funds to states.

NRI’s SMHA Profiles System is currently compiling information from SMHAs on their involvement in HIE activities during 2010. Preliminary results show that only two-thirds of SMHAs are involved at all in

state HIE activities and several of the SMHAs report their roles are quite minor. Slightly under half of the SMHAs report that their state hospitals and community mental health providers will be able to participate in their state's HIE in the next several years.

Some SMHAs have reported that concerns about confidentiality and privacy rules for mental health and substance abuse are being used in their state as an excuse/rationale to exclude the SMHA from HIE activities. Although a frequently cited concern is the federal Substance Abuse privacy rule 42CFR, SMHAs generally believe that sharing behavioral health EHR information with HIEs is possible technologically and procedurally. SMHAs note that a standard *Consent for Release of Information* form that thoroughly informs consumers that their behavioral health information will be shared with the HIE, explains the reasons why this is positive for the consumer, and provides an option for refusal, should be used to alleviate this issue. The primary justification for sharing the information is that many medications being used may cause or be a contributor to metabolic, cardiovascular, and diabetic disease. Knowing what medications a mental health consumer is taking during a primary care visit or ER visit is critical to quality patient care. Unfortunately, some SMHAs have not even had the opportunity to resolve these confidentiality issues since they are not active participants in their state's HIE initiative.

In addition, some SMHAs have been told that since specialty providers do not qualify for the federal HITECH Act's EHR incentive payments for "meaningful use", their programs are judged by the state HIE to be lower priority in favor of the HIE's meeting the needs of health providers receiving the stimulus incentive payments. Exclusion from participation in HIE planning activities has prevented SMHAs from weighing in on these issues.

NASMHPD has recently been asked by the National Governor's Association (NGA) to participate in a one-day meeting sponsored by ONC on the inclusion of Behavioral Health in Health Information Exchanges. NASMHPD looks forward to this initial meeting as a first step to insure the full inclusion of behavioral health in HIE, but looks to CMS and HHS for additional leadership to assure full behavioral health participation.

### **Recommendations for CMS/ONC/SAMHSA**

1. HHS (both ONC and SAMHSA) should strongly support the inclusion of mental health within HIEs. This may include changing language in HHS's PIN on the inclusion of behavioral health from "should" to "shall". Federal action could also include strong statements and support from HHS, including examples and models demonstrating how mental health can be part of HIEs. Part of this activity should include assuring that SMHAs and behavioral health providers have direct access to funding from HIE initiatives.
2. Address the need to respect the privacy requirements of mental health consumers while simultaneously permitting the sharing of EHR data within exchanges. This may include addressing apparent confusion among some state HIEs that the federal substance abuse privacy statute (42-CFR) limits the inclusion of mental health providers in HIEs. Models or examples of the appropriate client consent agreements for sharing behavioral health patient-level data with HIEs should be developed for states, and descriptions of technology safeguards that can be used should be shared with multiple stakeholders (e.g. providers, consumers and families).
3. Develop models, case studies, and trainings for SMHAs that contain examples of how some SMHAs with varying state statutes governing confidentiality have successfully negotiated a relationship with the state HIE entity.

## SUMMARY

A longer term goal for SMHAs and HHS regarding data for measuring services and outcomes may be for HHS to devote resources to assure the full implementation of EHRs by mental health providers (issue #1 above), the full inclusion of mental health providers in HIEs (issue #2 above) and by advocating for resources to support participation in these activities, thereby providing a potential vehicle for HHS to access and use these clinical data to generate outcomes reports and monitor the performance of mental health systems. Over the next decade, general health care will move to a system where administrative reporting systems are seen as duplicative, burdensome, and ultimately unnecessary as higher quality clinical data sets of outcome measures and performance indicators are able to be extracted from EHRs and HIEs. However, if mental health is precluded from HIEs because of funding limitations, exclusion from design and implementation, and concerns related to privacy and lack of incentives, it may be relegated to become a stigmatized separate system that may have available only poorer quality data and an inability to coordinate with overall healthcare.

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## FOOTNOTES

1. For each state's federal funds allocation, see:

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&mode=2>

2. Retrieve from:

[http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS\\_0\\_0\\_5545\\_1488\\_17157\\_43/http%3B/wci-pubcontent/publish/onc/public\\_communities/a\\_e/arra/state\\_hie\\_program\\_portlet/files/state\\_hie\\_program\\_information\\_notice\\_final.pdf](http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_0_5545_1488_17157_43/http%3B/wci-pubcontent/publish/onc/public_communities/a_e/arra/state_hie_program_portlet/files/state_hie_program_information_notice_final.pdf)

3. See:

[http://healthit.hhs.gov/portal/server.pt?open=512&objID=1329&parentname=CommunityPage&parentid=15&mode=2&in\\_hi\\_userid=11113&cached=true#](http://healthit.hhs.gov/portal/server.pt?open=512&objID=1329&parentname=CommunityPage&parentid=15&mode=2&in_hi_userid=11113&cached=true#)