August 12, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

The Honorable Chuck Grassley
United States Senator
135 Hart Senate Office Bldg.
Washington, D.C. 20510

RE: Finance Committee Health Care Data Inquiry: Interoperability and Adding Mental Health and Addiction Providers to the HITECH Act

Dear Chairman Wyden and Senator Grassley:

On behalf of the Behavioral Health Information Technology (BHIT) Coalition, we are writing in response to your June 12, 2014 letter seeking policy ideas that will enhance the availability and utility of health care data, while maintaining and strictly protecting patient privacy. In general, the Coalition strongly believes that electronic health records (EHRs) can play a critical role both in reducing health care expenditures as well as saving the lives of persons with serious mental health and addiction disorders.

Background Information: Health Status of Patients/Consumers with Mental Health/Substance Abuse Disorders is Exceptionally Poor

Before responding to some of the questions raised in the Senate Finance Committee correspondence, it's important to provide brief background. **Comorbidity between mental and medical conditions is the rule rather than the exception. Specifically, people with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic medical/surgical conditions compared to Americans without these mental disorders. In the Medicaid/Medicare context, it's estimated that fully one-third of the 9 million dually eligible beneficiaries have a primary diagnosis of severe mental illness.**

As a result, a wide array of recent studies show that this patient population possesses 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 (68%) of comorbid cancer, heart disease, diabetes and asthma among all Americans with mental health disorders. An earlier study published in a Center for Disease Control (CDC) publication *Preventing Chronic Disease* found that patients/consumers served in state mental health systems die 25 years sooner than other Americans while experiencing evaluated levels of morbidity. It's important to put these studies in context: the available data seems to show 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).

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The BHIT Coalition is deeply concerned that without access to meaningful use payments and Health Information Technology (HIT), it will soon become impossible to provide clinical care coordination for this highly vulnerable patient/consumer population, which requires regular interaction between mental health/substance abuse providers, primary care physicians and medical specialty personnel. Further, the above referenced data makes clear that unlike clinical laboratories, pharmacies and nursing facilities, behavioral health providers serve a patient/consumer population with highly acute mental illnesses, substance use disorders and comorbid medical/surgical chronic diseases.

Brief Responses to Senate Finance Committee Health Care Data Questions

1. *How, in what form, and for what purposes should this [healthcare] data be conveyed?*

The Office of National Coordinator (ONC) has endorsed Direct -- a confidential email system -- as the means of communicating health information between authorized care providers. Direct supports meaningful use measures, enabling the communication of summary care records, referrals, discharge summaries and other clinical documents in support of continuity of care and medication reconciliation. In turn, these confidential emails must adhere to HL7 messaging standards which provide the technical framework (and related standards) for the exchange, integration and sharing, and retrieval of electronic health information. These standards define how information is packaged and communicated from one party to another, setting the language, structure and data types required for seamless integration between systems. There is a vigorous debate about whether this architecture adequately supports interoperability, and the BHIT Coalition will not enter that debate in this correspondence.

At the same time, the purposes are very clear because the patients/consumers we serve need interoperable EHRs due to the public health crisis they confront. For example, private actuarial studies commissioned by the Coalition show the potential for substantial savings to the health care system flowing from reductions in adverse drug-to-drug interactions and reduced emergency room use.

More specifically, during a recent congressional staff briefing co-sponsored by Senator Sheldon Whitehouse and Senator Rob Portman, Dr. Joseph Cvitkovic, Director of Behavioral Health Care at the Jefferson Hospital, part of the Allegheny Health Network in Pittsburgh, Pennsylvania, testified on behalf of the American Psychological Association: "We utilize HIT for scanning patient identification wrist-bands for medications, provision of a secure network to provide psychiatrists, psychologists, and other professionals with the capacity to connect to the medical record from a remote location to improve continuity of quality patient care. These technologies can enhance the connectivity between the inpatient and outpatient treatment services and reduces readmission rates and better assures recovery on an outpatient basis."

2. *What reform would help reduce the unnecessary fragmentation of health care data? What reforms would improve the accessibility and usability of health care data for consumers, payers and providers?*

Two key reforms would substantially advance interoperable health records by improving the accessibility and usability of health care data. First, in mid-December 2013, the Senate Finance Committee adopted, on a bipartisan basis, S. 1871, the SGR Repeal and Medicare Provider Payment Modernization Act. S. 1871 contained key legislative language that: a.) defined interoperability in federal law for the first time, and b.) set a date certain for the implementation of interoperable electronic health record systems nationwide. These provisions are essential and the BHIT Coalition strongly supports them.

Second, the Senate Finance Committee must adopt the Behavioral Health Information Technology Acts (S. 1517/S. 1685) introduced by Senator Whitehouse and Senator Portman. These bills would make psychiatric hospitals, Community Mental Health Centers, practicing psychologists and outpatient/inpatient addiction providers eligible for meaningful use payments under the HITECH Act. To answer the question directly: the status quo guarantees fragmentation of behavioral health data -- by consigning mental health and addiction providers to antiquated health record management systems -- and actively obstructs the integration of behavioral health into the larger health care system.

In closing, enhancing the availability and utility of health care data involves setting specific interoperability standards in federal law and including behavioral health providers in the HITECH Act.

Thank you for your attention to these important matters.

Sincerely,

American Psychological Association

Association for Behavioral Health and Wellness

Centerstone

Jewish Federations of North America

National Association of County Behavioral Health Directors

National Association of Psychiatric Health Systems

National Association of State Alcohol/Drug Abuse Directors

National Council for Behavioral Health

Netsmart