National Association for Behavioral Healthcare

Access. Care. Recovery.

March 29, 2024

Micky Tripathi, Ph.D., M.P.P., National Coordinator for Health Information Technology
Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use

Submitted Electronically

Dear Mr. Tripathi and Ms. Delphin-Rittmon:

The National Association for Behavioral Healthcare (NABH) appreciates the joint effort of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of the National Coordinator for Health Information Technology (ONC) to create official BH information technology (IT) standards. BH providers, and ultimately patients, would greatly benefit from consistency of the data elements used by our field, as well as interoperability of key metrics across provider settings. As this is a top priority of NABH, we urge SAMHSA and ONC to work closely with providers and other stakeholders on this long-awaited investment.

NABH members provide the full continuum of behavioral healthcare services, including treating children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient program, medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

NABH recently confirmed that a significant portion of our membership lacks an IT system that is compliant with the ONC standards set in 2015. As a result, the ongoing use of obsolete communication methods, including faxes, emails, and phone calls, remains common. On the policy front, the prevalent use of obsolete IT greatly reduces the field's ability to engage in recent initiatives by the Centers for Medicare and Medicaid that require modern interoperability, such as policies related to new quality reporting requirements, integration of patient care with other providers, electronic prior authorization, data requirements of federal and state health exchanges, and others.

As is widely acknowledged, BH providers were not eligible recipients of the HITECH Act of 2009 funding, and, as such, most IT vendors did not develop viable BHIT systems or

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org

tools at that time or since. More recently, available IT system modules often fall short in capturing the unique needs of BH patients, such as those experiencing suicidality or the potential of harm to self or others. Also, in general, modules are ill-suited to capture the data elements that are uniquely relevant to substance use disorder patients. In addition, systems and modules often do not align with the clinical profile elements that are essential for patients in intensive outpatient programs (IOP) or partial hospitalization programs PHP). Further, some systems and modules do not align with typical clinical data elements and treatments for adolescent and youth patient populations. Finally, to align with BH needs, a portion of our members are combining commercial emergency medical record systems and modules with home-grown databases that store relevant BH data and template reports and documents. As a result, for the subset of providers that have been able to invest in IT, BH modules typically required either design by scratch or customization of off-the-shelf products.

At this point, 15 years after HITECH was passed, a federal investment in BHIT would help our field catch up with the rest of the continuum of healthcare providers, gaining essential functions such as timely and comprehensive exchange of patient health information across local health partners, including hospitals and their emergency rooms, as well as primary care physicians. In addition, a standardized language and electronic medical record specifications would enable, for the first time, joint case-management of patients' mental and physical healthcare and non-clinical needs.

Moving forward, while beyond the scope of this project, we encourage policymakers to proactively quantify the amount and nature of support that will be needed at the provider level to implement the standardized data elements that are ultimately finalized as a result of this project, as well as comply with future standards for BH-specific electronic medical records.

With regard to current problems with implementing BHIT, our members also report these challenges and others discussed elsewhere in this letter :

- Integrating information from BH treatments into a patient's broader chart housed with a general acute-care hospital is cumbersome, especially for lab information and details on appointments. These data are often on different encounter documents/systems and require multiple manual steps to integrate.
- The lack of standardized cross-setting data specifications related to new patient intakes, requires patients to re-enter patient profile data – sometimes multiple times – during the admissions process. This results in inefficiency for the overall

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system and burden and frustration for the patient/caretaker. These avoidable forms of administrative burden also impact key partners, payors, and regulators.

If practical input is first collected from BH providers, our members support the future use of standardized specifications for health information exchange; information on referring hospital EDs and other current providers of physical and mental health services; as well as expected outcomes that are established in a patient plan of care and summary of care notes. In addition, it would be worthwhile to specify any important information that that tends to only be found in notes and should be standardized. As a longer-term endeavor, we also encourage consideration of standardizing common automatic reports, data dictionaries, and metrics for census and capacity reporting.

Our members recommend that ONC and SAMSA consider including in the new BHIT language, standardized definitions of social determinants of health and related items, such as these:

- Housing status;
- Employment status;
- Name and contact information of any external case managers;
- Current access to various levels of follow-up care (PHP/IOP, traditional outpatient, medication management, primary care, and dental care);
- Housing status;
- Food security;
- Substance, tobacco, alcohol use and history;
- Law enforcement engagement (probation, diversion programs);
- Foster care engagement;
- Physical abuse history, as feasible;
- Language and literacy level;
- Physical and cognitive developmental issues; and
- Other similar risk factors.

On a related note, we are aware that some NABH members are successfully using artificial intelligence (AI) tools to identify important terms that are mentioned during an individual patient or group encounter or included in a medical record to enhance medical notes accuracy, advance standardization, and identify any interventions that are needed but may have been missed. Such developments should be on the radar of the leadership of this initiative, as currently in-process and future AI tools likely would be improved through the incorporation of standardized terms.

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NABH appreciates your leadership in this critical area and, as the initiative moves forward, urges close collaboration with BH providers to ensure an effective outcome. As such, we stand ready to partner with ONC and SAMHSA on this and related projects. Please contact me with any questions and/or follow-up at shawn@nabh.org.

Sincerely,

Shawn Coughlin
President and CEO

CC: Donna Davidson, MPH, Policy Coordinator, Interoperability Division, Office of Policy, Office of the National Coordinator for Health IT

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Web: www.nabh.org