

ACMHA ARM CHAIR REFLECTIONS
Health Information Technology, Meaningful Use, and You:
HIT Planning is Run by Those Who Show Up

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Health information technology (HIT) and the meaningful use of electronic health records (EHRs) represent opportunities for the health care field to break down silos and for researchers to study a diverse, longitudinal health data set. A fragmented environment for physical and behavioral health services inhibits collaborative diagnosis and treatment of co-morbid physical, mental, and substance use issues. Inclusion of behavioral health records in health information exchanges will revolutionize the treatment and research of co-morbid behavioral and physical health conditions. A lack of federal funding for behavioral health also contributes to fragmentation. Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 provide HIT funding incentives and grants for defined "eligible practitioners," but these provisions exclude behavioral health providers.

Despite these issues, the inclusion of behavioral health services at federally qualified health centers (FQHCs) represents the advancement for integrated health care. Certain FQHCs qualify as eligible practitioners under the HITECH funding incentives, and most FQHCs are required to provide mental health and substance use services. Consequently, behavioral health providers associated with FQHCs may qualify for HIT incentives. Behavioral health agency leaders have been identified as key stakeholders in planning and implementing HIT. For the sake of successful long-term planning and HIT implementation, even private specialty behavioral health providers must take an active interest in HIT implementation.

The HHS Office of the National Coordinator for Health Information Technology (ONCHIT), and the Centers for Medicaid & Medicare Services (CMS) have released rules defining the meaningful use of EHRs. Criteria for demonstrating meaningful use will be implemented in stages beginning in 2011. Initial criteria focus on: capturing coded health information electronically, using the data to track key clinical conditions, coordinating care through data comparisons, and establishing reporting mechanisms for certain clinical quality measures and public health information. The meaningful use rules require eligible practitioners to meet 25 reporting objectives which are divided into a required "core group" and a suggested "menu" of data collection procedures, with qualifying practitioners eligible for federal incentives.

The ONCHIT has acknowledged the importance of security and privacy in an HIT system. The main objective is to establish a system that delivers on all the potential benefits of information sharing among health care providers without compromising patient privacy. As research into

best practices for security and privacy continues, behavioral health practitioners must involve themselves in state planning efforts to ensure that information-sharing guidelines mesh with behavioral health privacy requirements. Specialty practice behavioral health professionals in particular must educate themselves and actively participate in HIT planning, or risk being bypassed as state HIT systems become established.

Recent surveys by the National Association of State Alcohol and Drug Abuse Directors indicate that few behavioral health leaders are currently involved in HIT planning at the state level. Involvement in the planning process requires a seat at the table, and often behavioral health leaders and practitioners must enthusiastically advocate for their own invitation. For overburdened, underfunded behavioral health agency directors and private practitioners, taking an active role in another complicated, long-term project may seem distasteful. However, sustainable success in state HIT implementation depends on early involvement by all stakeholders in the process.

If behavioral health practitioners and leaders remain uninvolved in the planning process, current issues such as fragmentation will worsen. If health information exchange systems initially exclude behavioral health specialty providers, the costs of retroactively providing technology upgrades in the future could prove exorbitant. Early involvement in planning and implementation represents an opportunity to shape HIT systems so that when incentives are extended to behavioral health specialty providers, technology will be in place to facilitate their participation. When behavioral health professionals and leaders involve themselves in HIT implementation planning, a door may open toward the seamless integration of primary, mental, and other behavioral health care.

References and Resources:

National Data Infrastructure Improvement Consortium, www.ndiic.com

Centers for Medicaid and Medicare Services, www.cms.gov/EHRIncentivePrograms/

HHS Office of the National Coordinator for Health Information Technology,

www.healthit.hhs.gov