

## **Harold Alan Pincus, MD**

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Testimony before Health Information Technology Policy Committee of the  
Office of the National Coordinator of Health Information Technology

I am Harold Alan Pincus, MD and am Professor and Vice Chair of Psychiatry at Columbia University, Director of Quality and Outcomes Research at NewYork-Presbyterian Hospital and a Senior Scientist and the RAND Corporation. I am delighted to provide testimony regarding the issues surrounding “Meaningful Use” as they pertain to psychiatry and mental health and substance abuse care more broadly.

Before addressing the specific questions posed by the Committee, I would like to briefly describe the special context of mental and substance use conditions in relation to health information technology. My comments are informed by the IOM report in the Crossing the Quality Chasm series entitled Improving the Quality of Health Care for Mental and Substance Use Conditions (I was a member of that committee).

- a) Don't split “mind and body”. The most important context-setting comment is embodied in the first overarching recommendation of that report: “Health care for general, mental and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body”. Mental illnesses are prevalent, costly and highly comorbid with other medical conditions. Keeping behavioral health outside the mainstream of health care (including health information technology) is not only a dualistic anachronism, it hurts patients and families and wastes resources. Sharing of information (with patients’ knowledge and consent) and

coordination of care across the silos of mental, substance use and general health care is essential. Monitoring and improving the quality of behavioral health care is no less important than for general health care. Contributions to quality improvement and knowledge development through participation in registries (with proper privacy safeguards) relevant for public health and comparative effectiveness research will be just as important (if not more so) for mental and substance use conditions.

There are however certain attributes of health care for mental and substance use conditions that have evolved quite differently from general health:

- b) Structure of Care. There is a greater diversity of health care professionals involved in the treatment of behavioral conditions (primary care providers, psychiatrists, psychologists, social workers, counselors, etc.) and mental health specialists are much more likely to work in solo practice or small groups. In addition, as previously noted, mental health care is often separate from substance use care and both have greater separation, structurally and functionally, from other components of the health care system. In addition, a great deal of care is delivered through non-health care sectors, e.g. education (especially for children), criminal justice, social services. All of these differences in structure of care argue for more not less need for involvement in the national health information infrastructure.
- c) Resources. Deployment of HIT requires significant financial investment. The proportion of health care dollars going to the mental health and substance

abuse sector has dropped significantly over the past two decades. This has occurred despite the fact that mental disorders represent an increasing proportion of societal disease burden, with many of these costs hidden by comorbidity or in disability, absenteeism, presenteeism, criminal justice and the like. Psychiatrists are at the lower end of the pay scale for physicians and they and other mental health providers often operate in a minimalist office environment. As such, the availability of resources to invest in and maintain HIT is more limited and therefore the use of these technologies is less widespread (but also more needed for connectivity).

- d) Quality Improvement Infrastructure. There is a substantial evidence base for effective therapies (pharmacologic and psychosocial) and systems interventions (e.g. assertive community treatment) documented in practice guidelines and further elaborated in quality measures. For example, I am currently leading a Congressionally mandated evaluation of the VA mental health system conducted by the Altarum Institute and RAND in which we are applying over one hundred quality metrics across four different data sets. The New York State Office of Mental Health has developed and implemented a set of quality indicators to monitor and improve medication practices that incorporate both mental health and cardio-metabolic domains. There are a number of mental health quality indicators in NQF, NCQA and AMA/PCPI measure sets, but there are large gaps and, as the IOM documented, the quality measurement and improvement and infrastructure is less well developed than in the rest of health care. I recently co-chaired the NQF Steering Committee on Medication

Management Measures and we identified important additional needs for measures including outpatient mental health. Also, apparently the HITECH Standards Committee Quality Work Group Grid for Meaningful Use (dated 7/15/09) includes no quality measures directly addressing mental health issues.

- e) Privacy and Consumer Choice. Maintaining the trust of consumers is essential in implementing this ambitious HIT agenda. Information about mental illness and substance abuse is especially sensitive and requires special safeguards and consumer authorizations. As the American Psychiatric Association and other groups have advocated, these elements need to be built into the system from the beginning.

In response to each of the questions posed by the committee:

- 1) In the context of the policy priorities, care goals and objectives that are part of the definition of Meaningful Use, what is the best way for specialists to be integrated into that framework?

The best way to integrate psychiatrists and other mental health clinicians into that framework is simply to fully integrate the care of mental health and substance use conditions into every element. Given the prevalence and societal impact of these conditions and their presence in primary care practices it is hard to justify excluding them any more than excluding diabetes or hypertension. The data capture, decision support, e-prescribing, medication reconciliation, care coordination elements being considered should apply to behavioral health as we try to break down these silos. Of course, the consumer choice and privacy elements must also be integrated.

- 2) Are there relevant national registries in your specialty? Would participating in those registries be a good measure of meaningful use for the HIT incentive?

In mental health and substance use, national registries are, for the most part, just beginning. The VA has had a psychosis registry for some time. The National Network of Depression Centers is developing several registries, including one for brain stimulation devices. There are also registries developed as part of quality improvement efforts at a state level (e.g. the DIAMOND Project in Minnesota and PSYCKES in New York). Local groups have also begun to develop registries that link multiple data sources (e.g. within Columbia's Irving Institute for Clinical and Translational Research [NIH-funded CTSA] and NewYork-Presbyterian Hospital's ambulatory care network). The point is that opportunities to contribute to enhance knowledge development in public health and comparative effectiveness should be facilitated through meaningful use and behavioral health should not be excluded.

- 3) How can specialists and the societies that represent them help accelerate the development of HIT-enabled quality measures that are appropriate for the definition of meaningful use?

One of the major problems in the quality measurement field is the lack of clear leadership, resources and stewardship of the field (and the subfields such as behavioral health). This is apparent when serving on an NQF panel and seeing the spotty responses to a call for measures and especially apparent with regard to mental health and substance abuse. There is little mandate or interest at the NIH for investing in

research to develop and validate quality measures. AHRQ has had limited mandate and resources to spread very far into behavioral health. SAMHSA has not been able to play a major role, given its limited resources. NCQA no longer has a behavioral health measurement advisory group (although they have collaborated with AMA/PCPI incorporating some behavioral health measures), and the Joint Commission has just developed measures for inpatient care. Some states have taken the lead in developing measures as has the VA. There has been some foundation support, but it is quite limited. Pharmaceutical companies have probably been the most active. The mental health professional societies need to take a more active role in developing measures, but their resources are limited (at least without pharma support).

One area that could help propel additional quality measurement development would be to enhance the capacity of coded medical data (i.e. ICD 10/11 and DSM 5) to provide more clinically textured information. The WHO has developed a Technical Advisory Group on Quality and Patient Safety for ICD 11 and arrangements are being made to provide input to ICD 10 CM in the U.S. However, WHO has limited resources to accelerate this process.

- 4) What other measures would you propose be considered to assess the meaningful use of EHRs by specialists? Are there any cross cutting measures that could be added to the MU definition today?

There are a number of other measures that could be considered for specialty mental health care (and applied in primary care as well). One type of measure that I would advise against is a focus on screening, without including some measure of follow-up. The U.S. Public Health Service Preventive Services Task Force has, for example,

recommended screening for depression, but only if there is the capacity to ensure systematic follow-up. Measures should be built around consistent, systematic longitudinal follow-up using standard assessment tools (i.e. so called “measurement-based care”). Simple assessment measures at initial intake such as suicide risk assessment, presence of firearms in the home, etc. might also be considered. Medication monitoring measures such as periodic lithium blood levels, lipid and fasting glucose and assessment of BMI for individuals with antipsychotic medications are also relevant for psychiatrists and primary care providers caring for these patients.

- 5) Which measures could be incorporated in the definition of meaningful use that would help drive more communication and coordination between specialists and primary care? (also incorporating a response to the question of primary care involvement)

Improving PCP/specialist communication is especially important for behavioral health, given the hardened silos that exist. In addition to medication reconciliation, referral tracking and follow up, the following strategies might be considered:

- Build a measurement element in both primary care and specialty mental health care for screening and follow-up with systematic measurement for depression or other common mental disorders (and formally incorporate into the Patient Centered Medical Home (PCMH) requirement)
- Consider making both primary care providers and mental health providers and mental health providers mutually responsible for quality care for patients with comorbid conditions, e.g. both the PCP and the psychiatrist

are responsible for quality metrics for both depression and diabetes for a patient who is comorbid with both conditions

- Expand the concept of a PCMH and related metrics to a population with severe mental illness and include both behavioral health and preventive and chronic care metrics

Thank you for providing this opportunity to present my views. I would be delighted to answer any questions or provide additional information.